MARYLAND
Department of Health and Mental Hygiene
Office of Health Care Financing

Medicaid Nursing Facility Rate Reform

Implementation beginning January 1, 2015

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What changes on January 1, 2015?

- Revenue code changes for dates of service on and after January 1, 2015.
- Maryland Monthly Assessment is no longer required for dates of service on and after January 1, 2015.
  - Patient assessment reviews by Delmarva will continue for days of service through December 31, 2014.
- Days of service will be paid in full at the time of claim (no cost settlement).
- Everything else – business as usual.

Assistance Along the Way

- Please refer to the following manuals for instructions on the new process:
  - Uniform Billing (UB04) Nursing Facility Billing Instructions
  - Nursing Facility Reimbursement Manual
- Information and forms are available on our website:
  - https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Nursing%20Home%20Services.aspx

New system has 11 revenue codes

- Facility-specific rates will be mailed at the beginning of each quarter (see appendix 1 of Reimbursement manual).
- One Resident Care Day rate replaces the previous acuity system (light, moderate, heavy, heavy special).
- Ventilator residents are billed separately from the Resident Care Day rate.
- Certain nursing and therapy add-ons were consolidated into the Resident Care Day rate; others specifically listed in the reimbursement manual should be claimed separately.
- All billing is done using the Uniform Bill for institutional providers (UB04).

Revenue Code Title	HIPAA Compliant Revenue Code Description	Revenue Code
DAILY RATES		
Resident Care Day	Rm & Brd Semi-Private - General	0120
Ventilator Resident Care Day	Rm & Brd Semi-Private - Other	0129
Administrative Day	Administrative Day	0169
Therapeutic Bed Hold Day	Leave of Absence Therapeutic Lv	0183
Coinsurance Day	All Inclusive Rm & Brd	0101
OTHER COSTS (BILLED IN ADDITION TO DAILY RATES)		
Class A Support Surface	DME – General	0290
Class B Support Surface	DME – Other	0299
Bariatric Bed A	Complex Medical Equip-Rout	0946
Bariatric Bed B	DME – Rental	0291
Negative Pressure Wound Therapy	Medical/Surgical Supplies and Devices – General Classification	0270
Power Wheel Chairs	Complex Medical Equipment	0947

Resident Care Day (0120)

- For each day of direct service, with the exception of a resident on a ventilator, bill this code.
- Previously, additional add-ons were billable. Under the RUGs-based methodology for paying nursing services, many of these add-ons are now included in the Resident Care Day rate for each facility and may not be billed separately.
- Ventilator residents are billed separately (see next slide).
- See page 7 of the reimbursement manual.

Ventilator Resident Care Day (0129)

- The facility must be approved by OHCQ to provide ventilator services. Claims will not pay if the facility is not approved.
- Ventilator Resident Care Day rate is inclusive of a Resident Care Day rate and additional costs associated with ventilator care.
  - Ventilator rate and other daily rates cannot be billed on the same day.
- Records must be kept to validate the claim.
- See page 7 of the reimbursement manual.

Administrative Day (0169)

- May be billed if the resident no longer qualifies for nursing facility level of care.
- No changes from the previous process.
- The DHMH 2129 must be completed.
- See page 7 of the reimbursement manual.

Therapeutic Bed Hold Day – Leave of Absence (0183)

- Payments for the cost of reserving beds for recipients for therapeutic home visits or participation in State-approved therapeutic or rehabilitative programs.
- No changes from the previous process.
- See page 8 of the reimbursement manual.

Coinsurance Day (0101)

- Billable for residents in both Medicare Part A and Medicaid.
- No changes from the previous process.
- See page 8 of the reimbursement manual.

Support Surface – A (0290)
Support Surface – B (0299)

- No changes from the previous process.
- These codes are billed in conjunction with a daily rate (i.e., 0120, 0129 and 0169).
- See page 9-11 of the reimbursement manual.
- Information on Decubitus Ulcer Care available in Appendix 3 of the reimbursement manual.

Bariatric Bed – A (0946)
Bariatric Bed – B (0921)

- No changes from the previous process.
- These codes are billed in conjunction with a daily rate (i.e., 0120, 0129 and 0169).
- See page 11-12 of the reimbursement manual.

Negative Pressure Wound Therapy (0270)

- Claims only for supplies associated with therapy. Nursing time is included in the Resident Care Day rate.
- This code is billed in conjunction with a daily rate.
- No additional changes to the current process.
- See page 12-14 of the reimbursement manual.

Power Wheel Chairs (0947)

- Preauthorization form must be submitted and approved by the Department. (See appendix 4 of the reimbursement manual.)
- You must receive a letter with instructions and a billable amount prior to submitting a claim.
- Payment is made in full through the above revenue code.
- See page 14 of the reimbursement manual.

Billing for Services

- UB04 instructions outline required fields for billing.
- Submitting invoices and adjustments process are the same.
- Facility must check Medicaid eligibility (EVS).
- Claims must be submitted within 12 months from the date of service.

Facility Responsibilities

- Submit accurate MDS data.
- Maintain a secure email on file with the Department (to receive resident rosters and rate letters).
- Review resident rosters quarterly.
- Maintain resident records.

Resident Roster Review

- Delivered electronically through secure email.
- Rosters are delivered on the 5th day of the second month after the quarter has ended. Revisions are due by the 25th of that month.
  - For example, for quarter ending March 31, rosters will be distributed on May 5th. Revisions are due May 25th.
- Resident Roster Correction Process Manual and calendar available online.
- Case mix from the reviewed roster will be used to set the next quarter's rate.

Resident Roster Quarter	Rate Quarter
January – March	July – September
April – June	October – December
July – September	January – March
October – December	April – June

Getting to a Resident Care Day Rate

- Calendar year 2012 settled cost reports were used to calculate each facility's current rate.
  - Incorporated all four cost centers, certain add-ons and cost settlement adjustments.
- Used the new model to determine a rate under the new methodology.
- Blended the two rates together to get a phase-in rate.
  - Phase-in planned over 18 months.
  - Facilities should adjust as necessary to new payment system.
- The first phase, effective January 1, 2015, is based on 75 percent of the current methodology and 25 percent of the rate under the new methodology.

New Methodology – Nursing Cost Center

- Nursing Cost Center
  - Five regional prices
    - Median + 8.25%.
  - Regional price is case mix adjusted to determine a facility-specific rate.
  - If a facility's projected cost is less than 95 percent of the rate, then the rate is reduced by the difference.
  - Case mix is determined from MDS data sorted into RUG-IV 48-group classification system.
- Ventilator Add-on
  - One consolidated payment for each day of service.
  - Carving out ventilator RUGs from the Resident Care Day rate, assigning a value and adding $280 per day.

New Methodology – Administrative and Routine Costs and Other Patient Care

- Price-based system using cost report data by region.
  - Admin and Routine = Median + 2.5%
  - Other Patient Care = Median + 7.0%
- Unless rebased, the Department will adjust the price annually based on Skilled Nursing Facility market basket inflation index.
- Re-base using cost report data to align with regional costs every two to four years.

New Methodology – Capital Cost Center

- Fair Rental Value + real estate tax pass through.
- Appraisal value per bed maximum set at $110,000 with no minimum.
- Two rental factor percentages:
  - Baltimore City
  - All other jurisdictions

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