Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-90 – Methods and Standards Establishing Payment Rates for Long-Term Care
Department of Medical Assistance Services
December 18, 2013

Summary of the Proposed Amendments to Regulation

The proposed changes update 1) the calculation of the per diem reimbursement ceilings for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to account for state facility closures and 2) the nursing facility credit balance reporting requirements to reflect more current Medicaid policies.

Result of Analysis

The benefits likely exceed the costs for all proposed changes.

Estimated Economic Impact

One of the proposed changes updates the calculation of the per diem reimbursement ceilings for ICF/IID to account for state facility closures. Facilities that are owned by the Commonwealth or by the federal government are reimbursed retrospectively on the basis of their reasonable costs in accordance with the Medicare principles of reimbursement. The private facilities on the other hand are reimbursed prospectively. However, the private facility rates are limited to the highest rate paid to a state ICF/IID institution as determined for each fiscal year.

The need for the proposed changes derives from the Department of Justice (DOJ) suit against the Department of Behavioral Health and Developmental Services which is resulting in the closure of the state's training centers. According to the Department of Medical Assistance Services (DMAS), most of the individuals who have been residing in these facilities are being transitioned into community settings to be cared for by one of the Medicaid home and community based care waiver programs. This transition to communities is set out in the settlement agreement between the Commonwealth and DOJ.

As the training centers' individual populations are declining, the centers' per diem operating and overhead costs are increasing. These centers' operating and overhead costs include utility payments, staff salaries and health/welfare benefits, and administrative costs. Declining facility populations generate fewer and fewer patient care days for which these facilities can bill DMAS. At the same time that declining patient care days are generating fewer billable days, these centers are experiencing increasing costs from employees who are retiring or are eligible for severance pay.

This imbalance of declining billable patient care days with increasing operating costs is causing the ratio between these two items to drive per diem costs higher and higher. Since DMAS uses this per day cost from these state centers to set the reimbursement rates for both public and private facilities, this rate setting methodology is proposed to be updated.

DMAS proposes that the current methodology be replaced with one that uses a benchmark amount (from fiscal year 2012) which is then slightly increased by the annual nursing facility inflation factor that is based on the percentage of change in the moving average of a nursing facility's market basket of routine service costs. This revised methodology will be more appropriate in the long term for the declining number of state-owned ICF/IIDs and the increasing number of private ICF/IIDs. However, no significant economic impact is expected from this change upon promulgation of these regulations because currently none of these types of facilities are being paid their potential ceiling amounts.

The proposed changes also update the nursing facility credit balance reporting requirements to reflect more current Medicaid policies. Nursing facilities are required to report credit balances to DMAS no later than 30 days after the close of every quarter. Then either the facility issues a check for the credit amount to DMAS or submits claim adjustments to rectify the credit balance. In the absence of either of these two repayment options, DMAS retracts the credit amount owed from future payments owed to the facility. DMAS is also permitted to impose penalties for failures to report and repay such Medicaid credit balances.

Beginning in 2003, the Center for Medicare and Medicaid Services required that all state Medicaid agencies conduct this activity for hospitals. At that time, DMAS promulgated these regulations for nursing facilities which follow the Medicare model for hospitals of reporting and recovery. For several reasons, this approach has been found to be problematic.

There are differences in how Medicare covers nursing facility services as compared to Medicaid. Medicare covers only relatively short lengths of nursing facility stays for its beneficiaries whereas Medicaid's lengths of nursing facility stays can range over years. Also, Medicare patients are responsible for annual deductible and coinsurance amounts determined at discharge. Medicaid patients have patient pay requirements that reduce allowable costs by individuals' financial means including Social Security payments since Medicaid is a payer of last resort.

Furthermore, there are 262 nursing facilities that are currently enrolled in Virginia Medicaid. DMAS estimates continuing to require nursing facilities to make quarterly reports would generate annually 1,048 reports that would require manual review and adjudication. This manual review/adjudication process would require an additional 2 to 3 more full time staff at salaries and fringe benefit costs exceeding $150,000 per year. Similarly, the facilities would be required to devote additional staff time to prepare and submit these reports.

According to DMAS, a recently completed federal audit determined that nursing facilities owe only a small amount, at any one time, of overpayments (less than $25,000) back to DMAS.

DMAS proposes to regularly remind nursing facilities providers, via their weekly remittance advice documents (computer generated reports that explain the resolution of submitted claims), that they are expected to review their account ledgers, at least quarterly, to determine if they have any credit balances with DMAS. If providers identify credit balances, they would be able to easily adjust such amounts through the claims processing system by filing claim adjustments.

DMAS also proposes to follow up, during site visits at nursing facilities for audits of personal fund accounts, to ensure that this activity has been occurring and that the nursing facility account books are balanced.

DMAS believes that combining this credit balance look-behind with personal fund audits with nursing facilities is the most efficient and least cumbersome way to ensure that nursing facilities are not inappropriately retaining large amounts of credit balances.

Businesses and Entities Affected

The proposed regulations apply to 252 nursing facilities and 46 private and 5 state-owned Intermediate Care Facilities for Individuals with Intellectual Disabilities.

Localities Particularly Affected

The proposed regulations are not expected to have a disproportional impact on any locality.

Projected Impact on Employment

The proposed credit balance reporting is expected to reduce facilities' and DMAS' demand for labor as they will not have to hire staff to create and review quarterly reports.

Effects on the Use and Value of Private Property

Reduced credit balance reporting would provide some administrative savings to the facilities and should have a positive impact on their asset values.

Small Businesses: Costs and Other Effects

The proposed changes do not introduce additional costs on small businesses. Other effects on small business would be the same as discussed above.

Small Businesses: Alternative Method that Minimizes Adverse Impact

The proposed changes do not have adverse impact on small businesses.

Real Estate Development Costs

No impact on real estate development costs is expected.

Legal Mandate

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.04 of the Administrative Process Act and Executive Order Number 14 (10). Section 2.2-4007.04 requires that such economic impact analyses include, but need not be limited to, a determination of the public benefit, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or

entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has an adverse effect on small businesses, Section 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.