Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-90 – Methods and Standards for Establishing Payment Rates – Long Term Care: Nursing Home Payment System
Department of Medical Assistance Services

December 18, 2001

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 9-6.14:7.1.G of the Administrative Process Act and Executive Order Number 25 (98). Section 9-6.14:7.1.G requires that such economic impact analyses include, but need not be limited to, 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. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the Proposed Regulation

The proposed regulation replaces the current Patient Intensity Rating System (PIRS) method of classifying nursing facility residents with the Resource Utilization Groups-III (RUGs) methodology, as directed by the 2000 General Assembly (Chapter 1073 of the 2000 Acts of Assembly, Item 319 MM). The proposed regulation also reclassifies nursing staff costs for quality assurance services as direct patient care costs rather than indirect costs and establishes a new method for calculating inflation in the nursing home payment system.

Estimated Economic Impact

Nursing Facility Resident Classification System

Virginia utilizes a case-mix reimbursement method to pay nursing facilities for direct patient care costs.[1] A case-mix system categorizes residents based on their medical condition and expected need of nursing and therapy resources, termed "patient acuity," and adjusts payments made to nursing facilities to account for caseload mix. The object of a case-mix system is to reimburse facilities on the basis of patients served and account for differences in the costs of providing for their needs.

The classification system currently used by Virginia is the Patient Intensity Rating System (PIRS), which categorizes residents into three groups based on an assessment of their ability to perform basic personal care activities (i.e., bathing, dressing, eating, etc.) called Activities of Daily Living (ADL). Using a specific evaluation form,[2] an ADL impairment score of zero (light needs) to 12 (severe or heavy needs) is assigned for each resident: Class A includes residents with an ADL impairment score of 0 to 6; Class B includes those with an ADL impairment score of 7-12; and Class C includes ADL impairment scores of 9 or more combined with specific clinical conditions.

PIRS was innovative when developed in the late 1980s, but is now widely recognized to be outdated. The mix of residents in Virginia's nursing facilities has changed significantly in the past decade. For instance, the statewide case mix norm under the PIRS methodology has increased eight percent, from 1.02 in 1991 to 1.10 in 1999.[3] This indicates that the Medicaid nursing facility resident population is more service intensive than it used to be. The main factors driving this shift are 1) increases in community based services and waivers that allow persons needing less intensive services to remain in community settings with supports rather than being admitted to a nursing facility and 2) shorter inpatient hospital stays that result in residents who,

[1] Virginia's Nursing Home Payment System separates nursing facility reimbursements into three cost categories: direct patient care costs, indirect operating costs, and capital costs. The proposed changes to this regulation apply only to direct patient care costs. Virginia amended its indirect and capital costs in a permanent regulatory action that become effective July 1, 2001.

[2] PIRS requires the completion of a specific resident assessment instrument, the Uniform Assessment Instrument, by providers.

[3] Data verified by DMAS. The case mix score is based on the concept that an average nursing facility resident would have a score of 1.00.

in past years may have remained in the hospital longer, being discharged to a nursing facility while their care needs are still relatively high.

Addressing these concerns, the proposed regulation replaces PIRS with a new case mix methodology, Resource Utilization Groups (RUGs). The RUGs methodology was developed by the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) in the middle to late 1990s for use in the Medicare Prospective Payment System and, since that time, has been implemented by over one-half of the state Medicaid programs in the country. The RUG-III system classifies nursing facility residents into 34 different classes of care and is based on the CMS Minimum Data Set (MDS), a resident assessment data system that is mandated for all Medicare and Medicaid participating facilities. Nursing facilities in Virginia have been electronically submitting the MDS data to the Virginia Department of Health (VDH) on a monthly basis since July 1998. Table 1 provides a comparison of the data used by the PIRS and RUGs methodologies.

Table 1: Comparison of Data Used in PIRS and RUGs Classification Methodologies

	PIRS	RUGS
Assessment Form	Uniform Assessment Instrument	CMS Minimum Data Set
Assessment Variables Used	20	108
Classifications of Care*	3	34
Assessment form used for	Reimbursement only	Reimbursement and Quality of care reporting
Assessment data monitored by	DMAS	DMAS and VDH
Case Mix Indices based on	1987 study	Mid to late 1990s study; Continued development by CMS

*Both methodologies address Specialized Care residents separately.

There are many benefits associated with adoption of the RUGs methodology. First, the MDS is a more sophisticated assessment instrument and is likely to more accurately capture the cost of care for residents served by a particular nursing facility. The CMS data is reviewed by two agencies (DMAS and VDH) and since it is used for reimbursement and quality of care reporting, the potential for fraud or abuse is minimized. Basing the resident classification on data that is already being collected and reported will relieve some of the administrative burden on the part of providers who will no longer have to complete an additional PIRS assessment for

each resident. Second, using the RUGs methodology will require less administrative support and ongoing research than PIRS since DMAS will be able to take advantage of research and development conducted by the federal government. Third, by more accurately and appropriately reimbursing nursing facilities for the patient care costs they incur, the new methodology could potentially increase access for heavy care patients and the quality of care provided.

According to the agency, the costs of converting to the RUGs system, including compilation of the MDS data and programming and development of the new system, were minimal and have already been absorbed by the agency's administrative budget. Aside from implementation costs, transition to the RUGs system is expected to be budget neutral. While total reimbursement may remain the same, there may be some redistribution of payments among providers. Facilities whose levels of service intensity were not fully captured by PIRS will receive higher payments under RUGs; facilities that received payments overstating their level of service intensity will receive lower payments than before.

By adopting a case-mix methodology that appears to be becoming the industry standard and is designed to more accurately reimburse nursing facilities for costs incurred providing services to Medicaid patients, Virginia will likely experience a net economic benefit by replacing its current resident classification system with the RUGs methodology.

Quality Assurance Services

The proposed regulation reclassifies nursing costs related to quality assurance services from indirect to direct care costs. According to DMAS, this change will not have any significant impact on the rates paid for these services, but rather will more appropriately categorize these services which are directly related to resident care.

Inflation Calculation Method

An inflation rate index is used to adjust rate and cost ceilings each year. DMAS currently uses one of four separate quarterly inflation indices depending on the year-end for each individual nursing facility. The proposed regulation simplifies administration by applying the same inflation rate index to all nursing facilities over a given year. The 4th quarter index published in the 2nd quarter of the following year has been selected since 70 percent of nursing facilities in Virginia have a 12/31 year-end. According to DMAS, there is not a wide variance

between the four indices throughout the year and they do not expect this change to have a significant effect aside from making administration far simpler than it is now.

Businesses and Entities Affected

There are 238 nursing facilities currently participating in the Medicaid program in Virginia, serving approximately 27,000 Virginians each year.

Localities Particularly Affected

The proposed regulation will not uniquely affect any particular localities.

Projected Impact on Employment

By more accurately and appropriately reimbursing nursing facilities for patient care costs incurred providing services to Medicaid patients, the proposed regulation may have some impact on employment in these facilities, however there is no data available to provide an estimate of such an impact at this time.

Effects on the Use and Value of Private Property

By more accurately and appropriately reimbursing nursing facilities for patient care costs incurred providing services to Medicaid patients, the proposed regulation may increase the value of private nursing facilities.