Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-90 – Department of Medical Assistance Services
Methods and Standards for Establishing Payment Rates-Nursing Home Payment System
December 27, 2002

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.G of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007.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 Department of Medical Assistance Services proposes to amend the Medicaid cost reimbursement method for indirect costs incurred by long-term care providers. The proposed changes will reduce the indirect care ceiling to 103.9% of the median of facility specific indirect cost per day from 106.9% and eliminate the inflation adjustment for indirect costs in fiscal year 2003. The proposed changes to the reimbursement method have been already in effect since July 2002 under the emergency regulations. Additionally, the proposed changes will establish credit balance reporting requirements for all nursing facilities.

Estimated Economic Impact

These regulations contain rules for nursing home reimbursement methodology. The Department of Medical Assistance Services (the department) reimburses the long-term care costs to Medicaid providers. One of the main cost categories is operating costs. Operating costs are divided into direct operating costs (nurse salaries and benefits, supplies, ancillary services etc.) and indirect operating costs (administrative, general, dietary, house keeping, laundry,

maintenance etc.). Operating cost reimbursements are determined using prospective rates based on the actual costs incurred by the providers, as long as the prospective rates are below the allowable payment ceiling. The determination of reimbursements for the operating costs depends mainly on the payment ceiling and inflation adjustment.

The operating costs payment ceilings are determined for six different peer groups (three direct and three indirect) from base year (every second year) costs incurred by all nursing facilities enrolled with the Virginia Medicaid program. This is accomplished by: (1) calculating the per diem cost figures for all of the facilities in each peer group, (2) finding the median per diem cost figure for each peer group, and (3) applying a percentage factor to the median per diem cost figure. The payment ceilings provide cost containment incentives. Without the payment ceiling, providers would be reimbursed based on the costs they incur subject to specific cost limitations and tests for "reasonableness." With the payment ceilings, each provider's prospective reimbursement rates are established based on either their inflation adjusted actual costs or the ceiling rates whichever is less. Every year the ceilings and each facility's prospective per diem, based on incurred costs, are adjusted by an inflation factor using the Virginia specific DRI-WEFA Skilled Nursing Facility Market Basket Index of routine service costs.

During the base year 2000 the median per diem for indirect costs for all nursing facility providers was $38.09 and the percentage factor was 106.9%. This would have resulted in following peer group rates calculated as of July 2000; $49.47 for the northern Virginia peer group; $45.57 for the rest of state facilities with less than 61 beds; $40.42 for the rest of state facilities with more than 60 beds. The inflation adjustment factors would be applied to these rates to determine the ceilings applicable to each provider. The inflation adjustment factors were 3.9% in 2001 and 6.2% in 2002. Under this payment system, the department paid approximately $244 million to 270 providers in fiscal year (FY) 2001 for indirect operating costs. As of July 2002, there were 17,761 Medicaid patients and 8,934 other patients in Virginia nursing facilities. Thus, the proportion of Medicaid patients at nursing facilities is approximately 66.5%. The department is currently making interim payments based on the proposed methodology under the emergency regulations and will settle the payments at the year-end.

The proposed permanent regulations will reduce the indirect operating cost ceilings by 3% (from 106.9% to 103.9%). The proposed 3% reduction in the ceilings will affect

approximately 131 providers whose per diem costs are higher than the median. These providers will experience a reduction in their reimbursements as compared to the reimbursement they would have received without these changes. Additionally, the inflation adjustment will be eliminated for FY 2003. This change will affect all providers in that their prior year indirect operating costs used to establish their subsequent year prospective rates for periods during the FY 2003 will not be increased by the current 6.2% inflation factor. Also the ceilings will be not be inflated by 6.2% during FY 2003. The impact of the elimination of the inflation adjustment will reduce the reimbursement rates of all providers as compared to what they would have received under the old methodology by an average of approximately $2.98 for the northern Virginia peer group, $2.74 for the rest of state facilities with less than 61 beds, and $2.43 for the rest of state facilities with more than 60 beds.

These changes are proposed to meet the mandate of the 2002 Acts of Assembly.[1] The General Assembly directed these changes to provide an estimated $12 million savings in nursing home payments. Of the expected savings, approximately $5,989,918 will reduce general fund expenditures while about $6,174,822 will reduce federal matching fund expenditures. It should be noted that the $6.2 million reduction in federal matching funds represents an additional loss for the Commonwealth's economy while saving $6 million in general fund expenditures.

Lower reimbursement rates for nursing homes are expected to introduce costs for the providers, as they will not receive as much as otherwise they would have received. Lower reimbursements have the potential to negatively affect Medicaid patients due to a potential decrease in the quality of care stemming from lower funding. There is also a chance that lower funding could increase the pressure on private pay residents through likely higher charges to subsidize Medicaid patients. According to a survey conducted by the Joint Audit and Review Commission, nursing home providers indicated that Medicaid reimbursement rate was one of the reasons for charging more to private pay residents of nursing facilities.[2] Since the proportion of Medicaid patients at nursing facilities is approximately 66.5%, the pressure on non-Medicaid patients to make up for the reduced reimbursements may be significant. Additionally, the proposed changes may introduce financial distress to some marginally profitable nursing homes.

[1] Chapter 899, item 325 HH (1) and (2).
[2] Virginia's Medicaid Reimbursement to Nursing Facilities, Senate Document No. 28, 2000, Joint Legislative Audit and Review Commission of the Virginia General Assembly.

The proposed changes will also establish quarterly credit balance reporting requirements for Medicaid providers. At a given time, providers may have accounts with a positive credit balance, which indicates an excess or overpayment received by the provider due to a claim or billing error. In addition, many times providers are representative payees for benefits the residents receive from social security or other sources and maintain an individual account for each resident's personal funds. From this account, the provider transfers the monies to apply to the recipient's nursing home account receivable and leaves approximately $30 (per month) in the recipient's personal fund account for incidental personal expenses such as purchase of a toothbrush, gum, or candy. Sometimes the providers fail to credit the $30 for incidental expenses. Currently, there is no reporting requirement for credit balances. The department conducts field audits every two years. During the biennial audit, the department identifies credit balances. According to the department, providers have about $2.5 million recoverable credit balances per year.

The proposed regulations will require the providers to report and settle the credit balances on a quarterly basis. Thus, the department and/or the nursing home residents are expected to receive approximately $625,000 per quarter from providers for credit balances. The main benefit of the proposed change to the department and nursing home residents is to have providers timely identify and clear credit balances that occur in their accounts receivables. The department and the nursing home residents will benefit from the additional liquidity it will provide and the time value of receiving overpayments as credit balances are identified and settled quarterly rather than waiting up to two years. The value of additional liquidity and the time value of overpayments are difficult to quantify because the appropriate discount rate that should be applied is uncertain. However, the time value of overpayments can be calculated for various discount rates. The biennial benefit of receiving $625,000 on eight quarterly payments as opposed to receiving $5 million after two years for 2%, 4%, and 6% discount rates are $85,348, $166,531, and $317,194, respectively.

There will be need for some staff time to administer the new quarterly reporting requirement. The administrative costs of reviewing the reports are estimated to be approximately $100,000 biennially. Thus, the net effect on the department will depend on the appropriate discount rate. If the discount rate is 4% or higher, the department will likely experience net benefits. If the value of additional liquidity is about $15,000, then the department may

experience net benefits even at the 2% discount rate. Since the Medicaid recipients at nursing homes will not incur any additional costs, they are likely to experience net benefits in terms of additional liquidity and time value of money.

On the other hand, the proposed changes are likely to introduce net costs to the providers. According to the department, each report should take about three to four hours of provider staff time to prepare and would cost about $100 per facility. Thus, the total biennial administrative costs to 270 providers are expected to be $216,000. In addition, the providers will lose the liquidity and the time value of the $5 million on a biennial basis. Thus, the net economic effect on the providers will likely be negative.

Businesses and Entities Affected

The proposed changes will directly affect nursing home providers. Currently, there are 270 Medicaid participating nursing home facilities in Virginia. Half of these providers will likely experience a reduction in their reimbursements. The Medicaid residents of the facilities will be indirectly affected and may experience some decrease in the quality of care they receive. There are approximately 17,761 Medicaid residents in nursing homes in the Commonwealth. Approximately 8,934 private pay residents at these facilities may also be negatively affected from the proposed changes since they are more likely to subsidize the Medicaid residents. On the other hand residents will likely benefit in terms of additional liquidity and the time value provided by timely credits to their incidental expense accounts.

Localities Particularly Affected

The proposed changes to the regulations apply throughout the Commonwealth.

Projected Impact on Employment

Lower reimbursement rates have the potential to discourage the development of new nursing homes, discourage expansion at current nursing homes, and increase the likelihood of financial distress for marginally profitable nursing homes. This may decrease demand for labor at nursing facilities. It remains to be determined by the department how it will implement the processing and review of these new provider reports, so the potential impact on the departement’s staffing need is not known at this time.

Effects on the Use and Value of Private Property

The value of some nursing homes may decrease as the reimbursements for providing administrative, dietary, house keeping, laundry, maintenance, and other general services decreases. The proposed reduction in reimbursements is about $12 million or about 4.9% of the total indirect cost reimbursements. In addition nursing homes will incur additional costs for quarterly reporting of credit balances and will lose the liquidity and the time value of credit balances they used to enjoy. Lower reimbursements coupled with higher costs and losses in current benefits such as liquidity and the time value of money they currently enjoy will likely reduce the profitability of nursing homes, reduce the future profit streams, and consequently their values.