CASE-MIX REIMBURSEMENT AND RESOURCE UTILIZATION GROUPS (RUGS):

WHAT CONSUMERS SHOULD KNOW

NHCC

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Eighty-five percent of the long-term care provided to New York State's 100,000 nursing home residents is paid for by Medicaid. Long-term care facilities are repaid, or reimbursed, for monies expended for the care of Medicaid residents.

For years, New York's reimbursement system for residential long-term care, which now totals more than $2.5 billion annually, paid facilities a set daily amount, or rate, for each day of care given to Medicaid residents. This rate was derived from past costs with increases to allow for inflation. There were only two classes of rates: one for a skilled nursing facility (SNF) and one for a health-related facility (HRF). Care for Medicaid residents at each SNF was reimbursed at the same rate; care for Medicaid residents at each HRF was reimbursed at the same rate.

On January 1, 1986, a new system — case-mix reimbursement using *Resource Utilization Groups (RUGs)* — went into effect to determine direct patient care costs in New York State. This system attempts to price the amount of resources needed for each resident, e.g., nursing services, activities, social services and therapies, and to

pay facilities a rate based upon the expected cost of these resources.*

WHY THE CHANGE? GOALS OF THE STATE

The State is attempting, through the use of RUGs, to accomplish the following:

1. Relate the reimbursement rate to the resident's present medical needs.
2. Relate the reimbursement rate to individual resident care costs rather than to the type of facility where the care is given. For example, given the same resident, the same direct care costs should apply regardless of whether the resident is in a SNF, HRF, hospital-based, or free-standing facility.
3. Reduce the hospital backlog of patients awaiting nursing home placement by giving facilities a financial incentive to admit residents requiring a high level of care.
4. Minimize facility appeals for more money by paying a rate that adequately covers costs of care.
5. Encourage facilities to be financially efficient by allowing facilities to make a profit.

*Direct care accounts for between 40 percent and 60 percent of the total reimbursement rate. The remainder includes three other cost components: indirect (30 percent to 50 percent, e.g., laundry, security); non-comparable (2-3 percent, e.g., those services not available at all facilities); and capital (5-7 percent, e.g., land, property, furniture). This brochure describes only the part of the new methodology that pertains to the direct care costs.

HOW THE SYSTEM WORKS

There are three steps in this system: (1) Classifying all nursing home residents into one of 16 groups, or RUGs, based upon their medical condition and needs, and upon the staff time they will require; (2) Setting a price for each RUG; and (3) Compiling a facility reimbursement rate.

CLASSIFYING RESIDENTS INTO RESOURCE UTILIZATION GROUPS (RUGs)

Using a new diagnostic tool — the *Patient Review Instrument (PRI)* — a trained registered nurse within each facility will assess the medical and staff time needs of each resident within three months of nursing home admittance. (As of September 1, 1986, the PRI data and a new PRI Screen for nursing home placement have taken the place of the Diagnostic Medical Score [DMS-1] for nursing home placement.)

Residents are first classified into one of five groups according to their medical conditions and needs:

Special Needs – chronic, heavy, or total care (e.g., comatose patients)

Heavy Rehabilitation – therapy five times per week with restorative goals

Clinically Complex – acute, episodic with physician care at least weekly (e.g., terminally ill)

Severe Behavioral Problems – physically aggressive, hallucinations

Reduced Physical Functioning – all other residents – reduced levels of functioning

Each of these medical condition groups requires different care. Residents will then be assessed for needed staff time in terms of their ability to perform three Activities of Daily Living (ADLs): eating, transfer (moving between positions such as from the bed to a chair), and toileting.

Each resident will be given an ADL score based upon his or her independence or dependence in daily living. The higher the score, the more a resident needs help in performing daily tasks, the more he or she will use staff time, and the more money he or she will need for care. For example, with eating, a score of one is given to those residents who feed themselves or require minimal assistance; a score of two is given to those who require continual help; a score of three is given to those totally fed by hand; and a score of four is given to those who are tube fed.

By combining both assessments, 16 groups (RUGs) are formed* — each RUG identifying its members by their medical needs and then by their independence in daily activities. For example, a relatively independent resident who is found to have severe behavioral problems will be in a different RUG than one who is found to be relatively dependent upon staff even though he or she also has severe behavioral problems.

All residents will be reassessed every six months, changing groups if necessary, and all new residents will be assessed within three months of admittance. The State Department of Health will verify all assessments through audits on a sample of residents at each facility.

SETTING THE PRICE FOR EACH RUG

Based upon medical, nursing, and staff time costs, a daily price will be established for each RUG. Each price will be set prospectively, or set in advance. Higher prices will go to those RUGs requiring higher "resource utilization," i.e., medical care and staff time. Prices will be adjusted periodically.

*The medical condition groups are broken up into differing degrees of independence.

COMPILATION OF REIMBURSEMENT RATES PAID TO FACILITIES

To help facilities during the transition from one reimbursement system to another, and to reward financial efficiency, actual monies reimbursed will vary from the price in a number of ways:

1. If a facility spends less than a base price set for each category, it will be allowed to keep the difference between the base and the actual expenditure. This would result in a profit.
2. If a facility spends more than the norm set for each category, it will be given only its actual cost, up to a set ceiling rate. If the cost of care is above the ceiling rate, the facility will face a loss.

A facility's direct care reimbursement rate is based upon the mix of its cases or resource utilization groups (RUGs).

CONSUMER CONCERNS

The case-mix methodology was developed with the aim of creating an efficient and effective care system that related the reimbursement rate to the actual care needed and delivered. While it tries to provide incentives to do this, it cannot ensure that an effective and high quality system will result. It is possible that the opposite may happen. Specifically, consumers are concerned about the following issues:

1. The new system and its set method of reimbursement will enable a cost-effective facility to earn a profit. Some facilities may cut patient care services that will lower quality of care to retain the difference between the base price set and the actual cost of direct patient care. The use of this efficiency incentive should be available only for non-patient care costs or for those facilities which have demonstrated quality care by means of a state inspection.
2. Asking facilities whose costs are above a set ceiling rate to cut costs without careful oversight by state authorities may encourage some to cut patient care costs. Close observation is necessary.
3. Some facilities may be encouraged to keep residents disabled or dependent, because the more care a resident needs, the higher the reimbursement rate. What can be done to reward those facilities which help residents move to a lower paying category?
4. Allowing all facilities to add to their revenue by admitting any resident they want may lead to inappropriate placement of residents needing a high level of care. This could have disastrous results. The State must be sure that facilities are equipped to care for the residents they admit.

5. Encouraging facilities to admit heavy care residents may lead to a backlog of lighter care patients. At this time there are not enough viable alternatives for this group. Where will they go? How will their care be monitored?
6. Residents should have the right to be informed of their RUG group placement. If they do not have access to their own assessment, residents cannot participate in their own care plan.*
7. If facilities reorganize their units or floors around RUG groups, residents should participate in any decision to move from their room or floor. A nursing home is different from a hospital in that a bed or a room or a floor is "home" to a resident. Any forced change in one's home would be very upsetting for a resident.
8. Residents should have the right to appeal their RUG group placement. This placement will affect the level of care given or not given and may even affect which room or floor a resident will reside in.

*As we go to press, it looks as if we may have already won this right. New regulations are about to be voted upon.

FUTURE

The State Health Department has committed itself to working with consumers to monitor the effects of this new system, to develop a crucial link between the reimbursement system and the surveillance/enforcement systems, and to look critically at all of its systems to help make them more effective.

It is important that consumers be vigilant. The State Health Department must be accountable: changes must be made if results prove dangerous to New York State's nursing home residents. We must hold facilities accountable as well. They must deliver the quality care they are being paid for.

If you have experienced any problems relating to this system, please call or write:

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