Adverse impact notification sent to Joint Commission on Administrative Rules, House Committee on Appropriations, and Senate Committee on Finance (COV § 2.2-4007.04.C): Yes[1] ☐ Not Needed ☒

If/when this economic impact analysis (EIA) is published in the *Virginia Register of Regulations*, notification will be sent to each member of the General Assembly (COV § 2.2-4007.04.B).

Virginia Department of Planning and Budget

Economic Impact Analysis

12 VAC 30-70 Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services
12 VAC 30-80 Services that are Reimbursed on a Cost Basis
12 VAC 30-160 Hospital Assessment
Department for Medical Assistance Services
Town Hall Action/Stage: 5100 / 8442
November 21, 2019

Summary of the Proposed Amendments to Regulation

Pursuant to multiple General Assembly mandates, this permanent regulatory action would: (1) authorize the Department of Medical Assistance Services (DMAS) to levy a provider coverage assessment and a payment rate assessment upon private acute care hospitals operating in Virginia, (2) establish new supplemental inpatient and outpatient payments for qualifying private acute care hospitals, and (3) sunset existing supplemental payments made to certain teaching hospitals to avoid overlapping payments.

The proposed permanent changes have already been in effect since October 2018 under emergency regulations.[2] This action would make the emergency regulations permanent.

Background

The three components of this regulatory package listed above were authorized by three budget items in the 2018 Appropriation Act. Items 3-5.15 and 3-5.16 authorized DMAS to expand Medicaid services in Virginia through the use of two types of assessments: a provider

[1] Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined.
[2] https://townhall.virginia.gov/l/ViewStage.cfm?stageid=8352

coverage assessment (coverage assessment) and a provider payment rate assessment (rate assessment). These assessments are required to fund new Medicaid coverage for adults, and were to be implemented on or after October 1, 2018, upon "private acute care hospitals"[3] operating in Virginia. In addition, Item 303.XX 6 c states that supplemental payments for certain teaching hospitals shall sunset after the effective date of the statewide supplemental payment for private acute care hospitals authorized in Item 3-5.16.[4]

These budget items collectively made it possible to expand Medicaid coverage to include an estimated 400,000 adult Virginians. In November 2019, more than 327,000 adults who did not have other forms of medical insurance were covered by Medicaid expansion.

The parameters determining the amounts of the assessments and supplemental payments were set out in the budget items in detail. The proposed regulation closely mirrors those parameters without materially changing those amounts. Instead, the regulation mainly adds definitions for the terminology used in the budget.

Estimated Benefits and Costs

The three components of this regulatory package are required to fund the full cost of expanded Medicaid coverage for adults as well as the new Medicaid hospital supplemental payments required by the legislative mandates. As discussed below, the coverage assessment funds the non-federal share of Medicaid coverage for newly-eligible adults, while the rate assessment funds the non-federal share of an increase in inpatient and outpatient supplemental payments to qualifying private acute care hospitals. The new supplemental payments enhance payments to private hospitals and provide incentives to serve the newly-eligible adults, while the sunset of certain supplemental payments is done to avoid overlapping payments. The analysis herein of these three components is based on several different data sources that may not be directly comparable, but represents the Department of Planning and Budget's best estimate of the benefits and costs.

[3] Public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long-term care hospitals and critical access hospitals are excluded from the definition of "private acute care hospitals".
[4] The 2019 Appropriation Act, Items 3-5.15, 3-5.16, and Item 303.XX 6 c carried forward substantially the same instructions.

Coverage Assessment and Rate Assessment

The two assessments fund the non-federal share of expansion and the new supplemental payments instead of appropriating general funds. Accordingly, no general funds are associated with these assessments. Separate funds have been established; one for the coverage assessment, and one for the rate assessment. More specifically, the coverage assessment generates funds to cover the non-federal share of the full cost of Medicaid coverage for newly eligible individuals, including the administrative costs of collecting the assessment and implementing and operating Medicaid expansion. In addition, the rate assessment generates funds to cover: (a) the increase in inpatient and outpatient rates paid to private acute care hospitals in Virginia up to the private hospital "upper payment limit" and "managed care organization hospital payment gap," and (b) the administrative costs of collecting the assessment and of implementing and operating the associated rate actions.

The detailed mechanics of both assessments are set out in the budget items. Both are levied prospectively, and their magnitudes are determined by the following factors. For the coverage assessment, DMAS calculates each hospital's "coverage assessment amount" by multiplying the "coverage assessment percentage" by the "net patient service revenue." The "coverage assessment percentage" is calculated as (i) 1.08 times the non-federal share of the "full cost of expanded Medicaid coverage" divided by (ii) the total "net patient service revenue" for hospitals subject to the assessment. Similarly, for the rate assessment each hospital's "payment rate assessment amount" is determined by multiplying the "payment rate assessment percentage" by the "net patient service revenue." The "payment rate assessment percentage" for hospitals is calculated as (i) 1.08 times the non-federal share of funding the "private acute care hospitals enhanced payments" divided by (ii) the total "net patient service revenue" for hospitals subject to the assessment.

New Supplemental Inpatient and Outpatient Payments for Qualifying Private Acute Care Hospitals in Virginia

The 2018 Appropriation Act directs DMAS to provide supplemental inpatient and outpatient hospital payments to qualifying acute care hospitals up to the private hospital upper payment limit. The total supplemental payment is based on the difference between (a) the private hospital inpatient or outpatient upper payment limit (in 42 CFR § 447.272, and 42 CFR 447.321,

respectively) as approved by the Centers for Medicare and Medicaid Services and (b) all other Medicaid payments subject to such limit. DMAS has amended the State Plan for Medical Assistance to make supplemental payments to all qualifying hospitals.

Sunsetting Other Supplemental Payments for Private Acute Care Hospitals

In order to avoid overlapping supplemental payments, supplemental payments made to a limited group of private acute care hospitals were terminated on the date the new payments were effective. The supplemental payments that are sunset in this regulatory package were authorized by the 2017 Acts of Assembly, Chapter 836, Item 306.RRR.1. The hospitals affected are Sentara Norfolk General and Carilion Medical Center in Roanoke.

Fiscal Impact

In Fiscal Year (FY) 2019, $87.3 million and $143.7 million were collected from hospitals for coverage and rate assessments, respectively. Based on the most recent official forecast, and assuming $17.4 million in non-medical costs, the coverage assessments for FY 2020 through FY 2022 are estimated to be $278.3 million, $389.8 million, and $422.1 million, respectively. [5] The rate assessment projections for the same time period are $444.7 million, $477.1 million, and $501 million.

While this regulatory action establishes the sole regulatory authority for the two assessments, it applies only to the fee-for-service portion of supplemental payments made to private acute care hospitals. The managed care portion of supplemental payment changes is addressed independently from this action, through amendments to contracts with managed care organizations that include a directed payment for qualifying hospitals. However, since the coverage and rate assessments are based on the total cost of expansion, including the services provided through both the fee-for-service and managed care delivery systems, an accurate assessment of the net impact on affected hospitals requires consideration of both the fee-for-service and managed care portions of the supplemental payments.

Including the managed care portion, the total supplemental payments made to these same hospitals were $292.6 million in FY 2019. This payment exceeds $231 million paid by private

[5] Source: Official Consensus Medicaid Forecast, available at: https://rga.lis.virginia.gov/Published/2019/RD504/PDF.

hospitals as a result of the coverage and rate assessments in FY 2019. Similarly, in FY 2020, affected hospitals are projected to pay an estimated $723 million for the coverage and rate assessments, but are projected to receive approximately $993.2 million in supplemental payments.[6] Thus, it appears that the affected private acute care hospitals are better off with the proposed rules.

The sunset of supplemental payments for the two teaching hospitals would reduce the supplemental payments available specifically to those two hospitals by $101.8 million in FY 2019 and $135.7 million in FY 2020, in order to avoid overlapping with the payments newly available to them. However, according to DMAS, these two teaching hospitals saw the first and the second highest net gain in FY 2019 (i.e. payments received minus assessments paid were $36.6 and $22.9 million for the first and second places, respectively) of all hospitals statewide. Thus, these two hospitals also appear to be better off under the proposed rules despite the sunset of a portion of payments available to them.

Additionally, an intergovernmental transfer from Eastern Virginia Medical School and Virginia Tech was previously required to provide the non-state match for these teaching hospitals. Under the new rules, both hospitals can use the rate assessment funds to draw down the federal match, thereby eliminating the need for the intergovernmental transfer and the resulting dependency on another governmental entity.

Other Effects of Expansion

Generally available research finds that Medicaid expansion in other states is linked to: gains in coverage; improvements in access, financial security, and some measures of health status/outcomes; and economic benefits for states and providers.[7]

In Virginia, according to DMAS, more than 327,000 members are enrolled in expansion as of November 1, 2019, and more than 375,000 members have been enrolled at some point since the beginning of Medicaid expansion. In the year prior to enrolling in Medicaid, two-thirds of new members went without needed medical care such as primary care, prescriptions, mental

[6] The payments in the first four months of FY 2019 are annualized to calculate the $993.2 million (i.e. $331.1 million times three.)

[7] https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/

health care, substance abuse disorder treatment, and dental care; one in four of new members used the emergency room as their primary source of care. After Medicaid expansion, 80 percent of these new members received at least one type of medical care; and the expansion population has been diagnosed with more chronic conditions than the non-expansion population.

The economic benefits of Medicaid expansion in other states include reductions in uncompensated care costs for hospitals and clinics, and also gains in employment as well as growth in the labor market (with a minority of studies showing neutral effects in this area).[8] Also, an increase in labor force productivity could be expected from a healthier population.

One of the most significant statewide economic impacts is due to the net inflow of federal funds into the Commonwealth. Medicaid expansion allows Virginia to draw down federal dollars for the newly covered population and the higher supplemental payments, which avoids an increase in costs to the state. For example, the federal government covered 93 percent of the cost of the expansion in calendar year 2019 and will cover 90 percent thereafter. These new federal funds represent a net injection into the state's economy.[9] In other words, after 2019, Virginia entities would pay for only 10 percent of the full cost of expansion while bringing the remaining 90 percent of federal funds into the Commonwealth, thereby creating new demand for medical services, goods, and labor.

An injection of new demand into the economy creates further expansionary effects beyond the initial increase in spending through what is known as the "multiplier" effect. The multiplier effect refers to the increase in final income arising from any new injection of spending. Further economic expansion occurs because the initial new spending creates extra income, which further boosts spending, which in turn creates more income, and so on. In the end, a dollar of extra spending leads to an increase of more than a dollar of final income. For example, actual expansion expenditures were $866.7 million in FY 2019.[10] Projected expansion expenditures for the current and the next two years are $3.1 billion, $3.7 billion, and $4.1

[8] Ibid.
[9] The federal government may use a variety of strategies to fund the federal portion of the funding some of which may have a contractionary impact at the national level. However, potential nationwide economic effects are not considered in this analysis as the focus is on Virginia's economic activity.
[10] https://www.dmas.virginia.gov/files/links/4167/DMAS%20SFY19%20FM%2012%20June%20Medical%20Accuracy%20Report.pdf

billion.[11] Approximately 90 percent of these amounts represents new spending which is expected to trigger further expansionary effects through the "multiplier" mechanism.

Businesses and Other Entities Affected

There are 69 private acute care hospitals subject to the provider and rate assessments and that are affected by the supplemental payment changes. These hospitals would also experience an increase in demand for their services and goods as well as their administrative costs due to serving a larger population. Similarly, DMAS would see an increase in its administrative costs driven by a larger population.

There are 400,000 Virginians estimated to be eligible under Medicaid expansion. Of these, more than 327,000 members were enrolled in expansion as of November 1, 2019 and more than 375,000 members have enrolled at some point since the beginning of Medicaid expansion.

Localities[12] Affected[13]

Although the expansion is statewide and encompasses all localities, it likely disproportionately affects those localities who have higher percentages of adults lacking health insurance. Medicaid expansion does not impose costs on localities.

Projected Impact on Employment

Medicaid expansion likely increases the size and the productivity of the labor force due to gains in Virginia's health outcomes. The net inflow of funds into the Commonwealth would likely cause an increase in demand for labor due to additional demand for services and goods to cover the expansion population.

Effects on the Use and Value of Private Property

The state's financial responsibility for the expansion population is funded by the private acute care hospitals via the provider assessment. These acute care hospitals also fund the state's share of the funds needed to receive the maximum amount of supplemental payments. The negative effects of the two assessments are offset by the increased demand for their services, their reduced uncompensated care costs, and the increase in supplemental payments they receive.

[11] Source: Official Consensus Medicaid Forecast.
[12] "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.
[13] § 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

Adverse Effect on Small Businesses[14]:

The proposed regulation does not appear to adversely affect small businesses.

Legal Mandates

General: The Department of Planning and Budget has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). Code § 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5)the impact on the use and value of private property.

Adverse impacts: Pursuant to Code § 2.2-4007.04(D): In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance within the 45-day period.

If the proposed regulatory action may have an adverse effect on small businesses, Code § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to Code § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.

[14] Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."