Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-70 and 12 VAC 30-80 – Department of Medical Assistance Services
Methods and Standards for Establishing Payment Rates-Inpatient Hospital Services and Other Types of Care
December 18, 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 proposed changes will 1) modify the Medicaid reimbursement methodology for direct graduate medical education costs for inpatient and outpatient services and 2) clarify the current outpatient reimbursement methodology.

Estimated Economic Impact

These regulations establish the reimbursement methodology for direct graduate medical education costs. Direct medical education costs include salaries and fringe benefits for teaching faculty and resident students and hospital overhead such as rent, maintenance, electricity, and supplies. The costs at teaching hospitals are usually higher than the costs at other hospitals because of the additional costs incurred for educational purposes. The economic rationale for graduate medical education (GME) reimbursement to teaching hospitals largely lies with the public good characteristic of medical education.

Proponents argue that GME not only benefits the medical students in terms of higher future earnings as with any other graduate education, but also the society as a whole in terms of improved health care. According to the Department of Medical Assistance Services (the department), the Commonwealth benefits from supporting GME in two ways: (i) from the medical care provided by licensed physician residents in oftentimes medically underserved areas, and (ii) from recent graduates who remain in the Commonwealth to practice their art. GME cost reimbursement method is designed to compensate for program administrative costs incurred by hospitals with medical teaching responsibilities. Since individuals cannot be excluded from receiving better health care resulting from GME, cost reimbursement for this service is a way that the society participates in the costs for the benefits that spills over to them. Most of the financing comes from public or tax based sources. Virginia Medicaid program is one of these sources.

The current Medicaid reimbursement methodology for direct costs of GME in Virginia relies on two factors: the utilization of the hospital by Medicaid recipients and total direct costs of GME. Based on this methodology, the department makes quarterly lump sum payments to teaching hospitals for the Medicaid share of the direct costs of GME. The quarterly payments are initially based on an estimate and later settled at the hospital's fiscal year end through the cost reporting process. In fiscal year (FY) 1998, 32 hospitals with residency programs incurred $236.6 million in direct GME costs, Medicaid utilization rates ranged from 4.9% to 56.1%, and the total reimbursement was approximately $15.5 million. The two teaching hospitals, MCV and UVA, have relatively large residency programs as compared to others, and consequently incur the majority of reimbursable costs. In 1998, the Medicaid utilization rates for these two hospitals were 18.6% for UVA, 22.3% for MCV, and the total reimbursements to them were approximately $6.5 million and $4.4 million, respectively.

The 2002 Appropriations Act[1] requires the department to reimburse hospitals for GME costs on a prospective methodology and requires the reimbursement amount to be determined on a per resident basis. The statute also requires the department to implement these changes on an emergency basis. To meet its mandate, the department promulgated emergency regulations that were effective July 2002. However, no payments have been made yet under the emergency

[1] Chapter 899, item 325, section U.

regulations. The proposed action will replace the emergency regulations with permanent regulations. The department is currently making estimated GME payments based on the previous payment methodology which will be reconciled to the new prospective per resident methodology at the hospital's fiscal year end.

According to the proposed changes, GME direct costs will be reimbursed based on a hospital specific prospective per resident amount that will be adjusted for inflation. Hospital specific per resident amount will be calculated by dividing the GME direct costs of the hospital by the number of residents and interns working at that hospital. The department proposes FY 1998 as the base year to calculate the per resident reimbursement rate. The reimbursement amounts calculated according to the proposed method are hospital specific and vary from hospital to hospital. For example, per resident amounts for FY 1998 would be $14,110 for UVA and $11,063 for MCV. Once per resident amount for the base year calculated, it will be adjusted for inflation. For example, when accounted for 20.1% inflation between FY 1998 and FY 2003, the reimbursement amounts for UVA and MCV will be $16,947 and $13,287, respectively in FY 2003.[2]

The proposed changes will also provide discretion to the department to change the base year. The department plans to re-base per resident amount when diagnostic related group rates are re-based. Historically, this has been every three years. Once the per resident amount is calculated based on data that will be available in the future, a potential change in GME reimbursements is possible. However, the magnitude of the potential change is unknown at this time.

Under normal circumstances, the current method and the proposed method would yield very little difference in the total payments to hospitals for direct GME costs. This is expected for several reasons. First, the proposed method allows inflation adjustment. The base year per resident amount will be adjusted for inflation over time just as the costs would increase by inflation. So, the inflation effect will be captured. Second, the number of residents at teaching hospitals is expected to be stable over time. The number of residents is relevant because per resident rate includes some fixed direct GME costs such as rent and electricity. If hospitals could increase the number of residents, the hospital's reimbursement for its fixed costs would

[2] Inflation factors between FY 1998 and FY 2003 are 1.039, 1.016, 1.056, 1044, and 1.032, respectively.

increase with each resident as well. However, teaching hospitals do not seem to have much flexibility on their resident count. The department notes that the resident count is determined by the Centers for Medicare and Medicaid Services and the federal approval of the number of residents prevents hospitals from unilaterally increasing the resident count. With these two facts and the assumptions that the FY 1998 data is representative of future direct GME costs and that inflation factors are representative of the relationship between the prices of direct GME costs relative to the DRI-WEFA, Inc. Virginia Specific Hospital Input Price Index, the total payments to hospitals under the both methods would not differ significantly. However, using FY 1998 data will likely particularly benefit UVA.

After 1998, UVA underwent reorganization. It changed its status from being a freestanding clinic to being a provider-based clinic to take advantage of Medicare outpatient reimbursement rates. The effect of this change was to dilute the Medicaid GME payments that would be reimbursed to UVA. Dilution occurred because after the reorganization facility charges were included in the total charges.[3] GME reimbursement is limited to the amount that charges are below costs. By including additional costs on the cost report, the ratio of cost to charges increased, narrowing the gap between cost and charges. Thus, if the current method continued to be applied, the loss in Medicaid GME reimbursement to UVA would be approximately $2 million per year. Of this amount, the Commonwealth would have avoided paying approximately $989,400 and the federal matching share would be about $1,010,600. In short, using the FY 1998 data to calculate the base per resident rate will allow UVA to continue to maintain its current reimbursements from Medicaid program. The Commonwealth and the federal government will continue to pay about $2 million per year that would be saved if these regulations were not promulgated.

The department has argued that this loss of reimbursement from Medicaid could have caused the Commonwealth to underwrite UVA's loss with 100% from the general fund. If the level of GME reimbursement is not held constant for UVA, then UVA would be forced to operate with a deficit. The Commonwealth would then be forced to increase its funding by the full $2 million to eliminate the deficit.

[3] Source: UVA

According to the department, a key point to consider is the extent to which state funds will be used for GME funding. For every dollar in federal funds participation the department accrues through its GME reimbursement methodology, it equates to one more dollar of general funds saved. This equates to $1.01 million dollars that the Commonwealth does not have to budget for GME. The department proposes to use FY 1998 as the base year as a way to maximize Medicaid reimbursements to the state's teaching hospitals pursuant to the 2002 Appropriations Act[4] that directed department to maximize the amount of federal funds participation claimed by the state.

It is worth noting however the department assumes UVA would have maintained the current level of activity without regard to anticipated funding. In contrast, the Commonwealth could choose to let the residency program at UVA shrink. While it is possible that the current funding would have been maintained through some other means, there is no provision in the proposed regulations requiring the department to maintain the current level of GME funding. For the purposes of this analysis, it is not appropriate to assume that current level of GME funding must be maintained. Put simply, the proposed changes do represent about $989,400 in terms of forgone savings the Commonwealth might otherwise enjoy.

The main benefit of the proposed regulations is maintaining the current level of funding to UVA. With these changes UVA will continue to receive the $2 million combined federal and state support and will not be forced to reduce the size of its residency program. This will maintain the potential numbers of physicians coming into the marketplace from Virginia medical schools to practice medicine. Whether maintaining the current number of residents is beneficial for Virginia is not easy to answer as the Commonwealth currently may be under or over investing into its residency program. This requires a thorough investigation of the subject, which is beyond the scope of this analysis.

Maintaining the current UVA funding through these regulations also allows the Commonwealth to save almost half of the GME reimbursements because of federal participation in GME costs. In other words, the proposed method allows the Commonwealth to support UVA GME program at half price.

[4] Chapter 899, item 325, sections Z, AA, and RR.

Additionally, the prospective nature of the proposed methodology has the potential to provide cost containment incentives. Under the current retrospective cost reimbursement method, teaching hospitals do not have incentives to keep their direct costs low, as they are eventually reimbursed for these costs. With the prospective system, the costs incurred above the inflation adjustment will not be reimbursed. Thus, teaching hospitals are expected to be very keen in keeping the growth in direct costs at or below the inflation factor in a given year. This will also contain reimbursement rates in the long run as the rates are re-based using already contained historical costs.

The proposed change in methodology is further expected to improve the predictability and the stability of the GME funding for the teaching hospitals. This is because the resident count is expected to be stable due to the federal approval of the number of residents. A reduction in the volatility of future reimbursement streams is likely to benefit teaching hospitals in terms of financial risk stemming from changing business conditions in the healthcare market. On the other hand, inflation adjustments made according to the proposed method may fail to closely track the changes in GME costs. Thus, there is a chance that reimbursements may not be commensurate with the level of costs the hospitals may incur in practice. However, when the rates are re-based every three years as expected, the potential discrepancies between reimbursements and actual costs will not likely prevail more than a few years.

In addition, there is likely to be some additional administrative costs to department to implement proposed changes. The department will have to calculate per resident reimbursement rates as proposed. This will be done through a consultant and expected to take about two to three weeks. The department does not know the size of these administrative costs.

With another amendment pursuant to the 2002 Appropriations Act[5], the current reimbursement methodology for outpatient hospital services will be clarified. In practice, DMAS had been using the Medicare outpatient cost-based reimbursement methodology. According to this methodology, hospitals are reimbursed for 100% of reasonable outpatient hospital costs less a 10% reduction for capital costs and a 5.8% reduction for operating costs. Starting from August 2000, Medicare changed its outpatient cost reimbursement methodology to another method that relies on Ambulatory Payment Classifications. Because of the statutory

[5] Chapter 899, item 325, section T.

requirement and because of the possibility that the change in Medicare's outpatient reimbursement methodology could create confusion as to whether Medicaid reimbursement methodology would also change, the department outlined in the emergency regulations the same method for Medicaid outpatient reimbursements that had been previously in effect. The proposed regulations are the same as the emergency regulations and they simply establish the same Medicaid outpatient hospital reimbursement methodology that has been previously in effect. Thus, this proposed change is unlikely to create any significant economic effect.

Businesses and Entities Affected

The proposed regulations apply to 32 hospitals with residency programs and 101 outpatient hospitals. By maintaining the current level of funding, UVA will be able to maintain the current number of residents. Thus, residents and interns in teaching hospitals will likely be indirectly affected. Furthermore, the customers of UVA will likely to continue to receive the same services provided through the residency program.

Localities Particularly Affected

The proposed changes apply throughout the Commonwealth.

Projected Impact on Employment

The proposed changes will maintain the current level of funding for UVA GME direct costs and maintain the current number of residents and interns at UVA. Thus, the proposed changes in GME reimbursement methodology will avoid a reduction in UVAs demand for residents and interns that otherwise would occur.

Effects on the Use and Value of Private Property

The proposed regulations are not expected to have a significant effect on the use and value of private property.