Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-80 – Methods and Standards for Establishing Payment Rates; Other Types of Care
Department of Medical Assistance Services
October 10, 2003

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

Pursuant to the 2003 Virginia Appropriations Act (Item 325 KKK), the Board of Medical Assistance Services proposes to limit Type Two (non-teaching) hospitals to 80% of their allowable costs for outpatient operating and capital costs. Type One (teaching) hospitals will continue to be reimbursed at 94.2% of allowable operating costs and 90% of allowable capital costs.

Additionally, Item 325.NNN of the 2003 Appropriation Act directs DMAS to revise the payment methodology for rehabilitation agencies from a retrospective reasonable cost basis to a prospective methodology based on establishing a ceiling at 112 percent of the weighted median cost of all rehabilitation agencies. This legislation exempts rehabilitation agencies operated by the Community Services Boards.

Estimated Economic Impact

Outpatient Reimbursement

Currently at all hospitals, outpatient-operating costs are reimbursed at 94.2% of allowable cost, and capital costs are reimbursed at 90% of allowable cost for Medicaid patients. Pursuant to the 2003 Virginia Appropriations Act (Item 325 KKK), the Board of Medical Assistance Services (board) proposes to limit Type Two (non-teaching) hospitals to 80% of their allowable costs for outpatient operating and capital costs. Type One (teaching) hospitals will continue to be reimbursed at 94.2% of allowable operating costs and 90% of allowable capital costs. As a result, the Department of Medical Assistance Services (department) expects to save approximately $4.25 million in General Funds, and $4.25 million in Non-General Funds.

In response to the reduction in reimbursement rates for Medicaid outpatient services, hospitals could potentially: 1) choose to no longer serve Medicaid outpatients, but continue to serve Medicaid inpatients, 2) choose to no longer serve any Medicaid patients (beyond emergency cases), 3) choose to raise rates to private payers to offset the loss of Medicaid revenue, or 4) scale back services.

The department has not determined whether hospitals may refrain from providing outpatient services to Medicaid patients, while continuing to provide inpatient services for Medicaid recipients. Both the Virginia Hospital and Healthcare Association (VHHA) and the department believe that few, if any, hospitals would choose to serve only inpatient Medicaid patients, even if it is legal. Though the proposed 80% reimbursement rate is substantially lower than the current outpatient reimbursement rates, it is still higher than inpatient reimbursement rates; according to the department, hospitals receive reimbursements for approximately 71% or 72% of their allowable Medicaid inpatient costs.

Currently all Virginia hospitals serve Medicaid patients.[1] According to both the department and VHHA, it is unlikely that any hospital will choose to stop serving all Medicaid patients. VHHA cites the mission of hospitals, both public and private, to serve those in need. The department adds that hospitals would likely consider that the bad will created by refusing Medicaid patients would exceed potential net cost savings of refusing service to those patients.

[1] Source: Virginia Hospital & Healthcare Association

Hospitals could conceivably use the reduced Medicaid revenue as a tool when negotiating service rates with private payers. For example, citing that reduced Medicaid revenue caused an area of care or service to be no longer financially sustainable, a hospital could threaten to stop providing that area of care or service unless private payers pay more. Research by Zwanziger, Melnick, and Bamzai (*Health Economics*: 2000) on California hospitals found that while hospitals increased "their prices to private payers in response to reductions in Medicare rates; they had far smaller and generally insignificant responses to changes in Medicaid reimbursement." The authors attribute part of the failure to raise private payer rates in response to lower Medicaid reimbursement to the competitiveness of California's hospital market. In a less competitive market hospitals may be more able to shift costs. Showalter (*Contemporary Economic Policy*: 1997) in a study using national data also found evidence against cost shifting (raising prices charged to private payers) when Medicaid rates are cut.

Since hospitals are unlikely to choose to no longer serve all Medicaid patients, and in practice hospitals are limited in their ability to successfully shift costs to private payers on a large scale, reduced revenue likely leads to service reductions. For example, Showalter found that "lower Medicaid reimbursements tend to cause physicians to treat relatively fewer Medicaid patients." Reduced physician availability to Medicaid patients causes longer waits for service. People's time has value. Longer waits may discourage some patients from taking the time to make and go to appointments. The quantity and quality of healthcare received may consequently be reduced. Also, lower reimbursement rates may allow for fewer support staff and the elimination of services that are considered beneficial, but non-essential.

Though there are clear costs associated with the reduced reimbursement rates, the estimated $8.5 million saved by reducing the reimbursement rate for hospital outpatient services can be used beneficially through other government expenditure or through lower taxes than would be required to maintain the higher reimbursement rates.

Rehabilitation Agency Reimbursement

Currently, there is no ceiling on the Medicaid payments made to rehabilitation agencies. Pursuant to Item 325.NNN of the 2003 Appropriation Act, the board proposes to reimburse private rehabilitation agencies at a

> rate equal to the lesser of the agency's cost per visit for each type of rehabilitation service (physical therapy, occupational therapy, and speech therapy) or a statewide ceiling established for each type of service. The prospective ceiling for each type of service shall be equal to 112% of the median cost per visit, for such services, of rehabilitation agencies.

Thus rehabilitation agencies will not be reimbursed at a rate more than 12% higher than the median cost. The department expects that this will save approximately $1.5 million in General Funds, and $1.5 million in Non-General Funds. Rehabilitation agencies that charge greater than 12% above the average for services will see their reimbursement cut to 12% above the average. Such agencies could potentially react by reducing the number of Medicaid recipients they see, or to stop serving Medicaid patients altogether. These provisions have been in effect under an emergency regulation since July 1 and the department has not yet seen indications that rehabilitation agencies are reducing the number of Medicaid recipients they see.

Businesses and Entities Affected

The proposed regulations affect the 96 Type II hospitals and the 64 privately operated rehabilitation agencies that provide outpatient services to Medicaid recipients, as well as their staff and patients.

Localities Particularly Affected

The proposed regulations affect all Virginia localities.

Projected Impact on Employment

The proposal to limit non-teaching hospitals to 80% of their allowable costs for operating and capital costs will likely reduce services and some employment at hospitals. The proposal to cap rehabilitation agency reimbursement at 112% of the median cost per visit has the potential to

reduce employment at rehabilitation agencies if pricier agencies choose to see fewer patients in response.

Effects on the Use and Value of Private Property

The lower reimbursement rates will consequently lower the value of hospitals and pricier rehabilitation agencies. Hospitals and their physicians may react by offering fewer services. Pricier rehabilitation agencies may choose to accept fewer Medicaid patients.

References

Showalter, Mark H., "Physicians' Cost Shifting Behavior: Medicaid versus Other Patients," *Contemporary Economic Policy*, v15, n2 (April 1997): 74-84.

Zwanziger, Jack, Melnick, Glenn A., and Anil Bamzai, "Can Cost Shifting Continue in a Price Competitive Environment?" *Health Economics*, v9, n3 (April 2000): 211-25.