Virginia Department of Planning and Budget

Economic Impact Analysis

12 VAC 30-80 – Methods and Standards for Establishing Payment Rates; Other Types of Care
Department of Medical Assistance Services
July 17, 2014

Summary of the Proposed Amendments to Regulation

Pursuant to the 2013 Acts of the Assembly, Chapter 806, Item 307 XX, the proposed changes will implement a permanent prospective payment methodology for Medicaid outpatient hospital services. The proposed payment methodology has been in effect since January 1, 2014 under emergency regulations.

Result of Analysis

The benefits likely exceed the costs for most of the proposed changes. A different design would likely yield the same benefits at lower cost for at least one proposed change.

Estimated Economic Impact

Prior to the emergency regulations, Medicaid reimbursed non-teaching hospitals 76 percent of operating and capital costs for services furnished in an outpatient hospital setting. Teaching hospitals were reimbursed separate percentages of costs for operating and capital costs. Pre-emergency reimbursement methodology was a cost-based methodology. The 2013 Acts of the Assembly, Chapter 806, Item 307 XX has given DMAS authority to implement a prospective reimbursement methodology called Enhanced Ambulatory Patient Group (EAPG) methodology in a budget-neutral manner. DMAS implemented EAPG methodology under emergency

regulations on January 1, 2014.[1] The proposed changes will make permanent the EAPG methodology that has been in effect since January 2014.

EAPG defines a group of outpatient procedures, encounters, or ancillary services that incorporates International Classification of Disease (ICD) diagnosis codes, Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

The new methodology defines EAPGs as allowed outpatient procedures and ancillary services that reflect similar patient characteristics and resource utilization performed by hospitals in an outpatient setting. Each EAPG group is assigned an EAPG relative weight that reflects the relative average cost for each EAPG compared to the relative cost for all other EAPGs. For non-teaching hospitals, a statewide base rate for outpatient hospital visits is calculated using base year cost data inflated to a rate year. The base year costs are adjusted to reflect the Medicaid reimbursement policies for emergency room, laboratory, therapy, and pharmacy services. For teaching hospitals, a separate, budget neutral base rate is calculated.

The statewide base rate is adjusted to be hospital-specific based on the geographic location of the hospital facility. The hospital-specific base rate is determined by adjusting the labor portion of the statewide base rate by the wage index for the hospital's geographic location and adding the non-labor portion of the statewide base rate. The hospital-specific base rate for children's hospitals reflects a five percent additional payment. The total allowable reimbursement per visit is determined by multiplying the hospital-specific base rate times the sum of the EAPG relative weights assigned to an outpatient hospital visit. To maintain budget neutrality, the base rate will be rebased at least every three years.

The EAPG methodology will be transitioned over a three-and-a-half-year period in 25-percent increments. The transition rates will be a blend of cost-based reimbursement and EAPG reimbursement. DMAS will also calculate a budget neutrality adjustment every six months for up to the first six years of implementation.

[1]DMAS converted inpatient hospital services to a similar prospective reimbursement methodology, Diagnosis-Related Groups (DRGs), in the 1990s. Inpatient hospital services are currently reimbursed case rates for DRGs on a prospective basis.

The EAPG relative weights implemented are the weights determined and will be published periodically by DMAS. The weights will be updated at least every three years at rebasing. New outpatient procedures and new relative weights will be added as necessary between the scheduled weight and rate updates.

To maintain reimbursement of drug rebates for outpatient hospital services, each drug administered in the outpatient hospital setting is reimbursed separately to be eligible for drug rebate claiming.

This action will likely increase the efficiency of reimbursement for outpatient hospital services. Under the new system, hospitals will receive a fixed payment for a specific procedure. These payments will be adjusted periodically to account for inflation, for cost of living in certain geographical locations, etc, but will not accommodate individual hospitals. Each hospital will receive the same base payment for the same service adjusted for geographic location. Since the reimbursement rate is calculated using cost data from all hospitals, inefficient hospitals will receive less than what they receive under the cost based methodology and efficient hospitals will receive more than what they receive under the cost based methodology. Thus, all hospitals will have an incentive to keep their costs as low as possible to maximize their profit. Lower costs, in turn, will lead to lower reimbursement rates when the rates are adjusted at least every three years. Over time, inefficient hospitals will be forced to improve their efficiency and reduce costs which in turn will push reimbursement rates down to the lowest possible level on a continuing basis.

By budget-neutral design, the new methodology will not increase or decrease the aggregate reimbursement for outpatient hospital services. In fiscal year (FY) 2011, the total Medicaid reimbursement for outpatient hospital services was approximately $103 million. However, individual hospitals will see changes in their reimbursements. While some hospitals will receive more than what they would have received under the previous methodology, some will receive less. Based on FY 2011 data, of the 96 hospitals, 47 will see a reduction totaling approximately $1.9 million which will be transferred to remaining 49 hospitals. The largest loss to a hospital is estimated to be $201,957 while the largest gain is estimated to be $233,124.

The proposed new methodology also provides an extra five percent reimbursement for children's hospitals. This provision will specifically benefit two children's hospitals which are estimated to receive approximately $204,590 more than what they would receive without the five

percent extra reimbursement. The rationale for providing a higher reimbursement specifically for children's hospitals is not clear.

In order to be paid for all services, providers will have to code in more detail than they may have been used to. Providers may also wish to purchase the EAPG software to monitor reimbursement. Providers' costs associated with these changes are not expected to be significant.

This action will also increase the predictability of reimbursement for outpatient hospital services. Since fixed rates will be paid for services, the total reimbursement will be driven mainly by utilization and no so much by hospital specific cost factors.

The new methodology is also expected to reduce the costs associated with cost settlement of outpatient hospitals services.

Finally, while there is likely to be some administrative costs on DMAS to modify its information technology to incorporate this methodology, the costs of claim system changes are already included in the fiscal agent contract.

Businesses and Entities Affected

The proposed new methodology affects approximately 110 hospitals currently. Some of the hospitals may be small and qualify as small businesses. While some of the 7 managed care organizations may also change their provider reimbursement methodology for outpatient services following this change, this regulation does not require them to do so.

Localities Particularly Affected

The regulations apply throughout the Commonwealth.

Projected Impact on Employment

The new methodology will reduce reimbursement for inefficient hospitals while increasing reimbursement for efficient hospitals. Inefficient hospitals may reduce their demand for labor while efficient hospitals may increase their demand for labor.

Effects on the Use and Value of Private Property

The new methodology will reduce reimbursement for 47 hospitals while increasing reimbursement for 49 hospitals. The asset values of the affected hospitals would be affected depending on the impact on their revenues.

Small Businesses: Costs and Other Effects

Some of the hospitals may be small businesses. The costs and other effects on them would the same as discussed above.

Small Businesses: Alternative Method that Minimizes Adverse Impact

There is no known alternative that would minimize the adverse impact while accomplishing the same goals.

Real Estate Development Costs

The proposed amendments are unlikely to affect real estate development costs.

Legal Mandate

General: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia and Executive Order Number 17 (2014). Section 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:

- the projected number of businesses or other entities to whom the proposed 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.

Small Businesses: If the proposed regulation will have an adverse effect on small businesses, § 2.2-4007.04 requires that such economic impact analyses include:

- an identification and estimate of the number of small businesses subject to the proposed regulation,
- 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,
- a statement of the probable effect of the proposed regulation on affected small businesses, and
- a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

Additionally, pursuant to § 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 (JCAR) is notified at the time the proposed regulation is submitted to the *Virginia Register of Regulations*

for publication. This analysis shall represent DPB's best estimate for the purposes of public review and comment on the proposed regulation.

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