Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-50; 30-60; 30-130 –Amount, Duration and Scope of Medical and Remedial Services; Standards Established and Methods Used to Assure High Quality of Care Services; Amount, Duration and Scope of Selected Services
Department of Medical Assistance Services
December 6, 2004

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 Item 325 QQQ of the 2003 Appropriations Act, the proposed regulations add community-based residential services as covered Medicaid services.

Estimated Economic Impact

Under the proposed regulations, Virginia's Medicaid program will permanently cover community-based residential services as mandated by Item 325 QQQ of the 2003 Appropriations Act. The proposed coverage has been in effect since July 2004 under emergency regulations. The community based-residential services provide therapeutic supervision, structure for daily activities, psychoeducation, and access to psychotherapy to ensure that therapeutic mental goals are attained.

Currently, the state pays 67% of the cost of these services while the rest is paid by the localities. Under the expanded Medicaid coverage, the federal government pays for one half of

the total cost, thus reducing the state and local expenditures by one half. In other words, the state's participation is reduced to approximately 33.5% of the total cost and localities' participation is reduced to approximately 17%. According to most recent estimates, the combined savings to the state and localities is about $2.7 million in FY 2005 ($1.8 million in state savings and $0.9 million in local government savings) and about $4.6 million in FY 2006 ($3.1 million in state savings and $1.5 million in local government savings).

State and localities could choose to use these savings either to reduce tax burden or increase spending on other programs. Given the relatively small size of the savings, they are more likely to be channeled into other programs. Under either circumstance, the additional $2.7 million federal funds in FY 2005 and $4.6 million in FY 2006 could be considered as net injections of money into the state economy. Unlike other sources, federal matching funds do not have an offsetting effect elsewhere in Virginia's economy. The additional funds would initially result in increased demand for goods and services, which would in turn increase total state income. The higher income would trigger other, but less pronounced, increases in demand. Once the economic multiplier process concludes, the increase in total state income would be a multiple of the initial injection of $2.7 million and $4.6 million into the state's economy. The estimated magnitude of the spending multiplier for the first few years for the U.S. economy is usually between 2 to 3 times the initial injection. This means that the $2.7 million injection in FY 2005 could increase Virginia's income (or output) over the next several years by between $5.4 million and $8.1 million and the $4.6 million injection in FY 2006 could increase Virginia's income (or output) over the next several years by between $9.3 million and $14 million.

In addition, the proposed regulations split the new covered services into two levels of care, Level A and Level B. Level A services are medically less demanding than Level B services, and therefore cheaper. Currently, DMAS pays $119 for a Level A service claim and $158 for a Level B service claim. Provided the determination of a service into two different levels does not introduce significant administrative costs to the providers or to DMAS, paying rates commensurate with the medical intensity involved in providing the service is likely to improve the allocation of resources. If the reimbursement rate were the same for all services regardless of their intensity, it may cause more than optimal supply of less intensive services and less than optimal supply of more intensive services. However, this does not mean that creating additional levels of care would indefinitely improve the efficiency in allocation of resources.

Administrative costs of creating additional layers of service would eventually exceed the efficiency gains.

Also, based on an interpretation of the federal law (42 CFR 435.1008 and 42 CFR 435.1009) by the Centers for Medicare and Medicaid Services, Virginia's Medicaid program is not allowed to make payments for community-based residential services to providers with a capacity of more than 16 beds. Because localities have an incentive to reduce their share of the cost of providing services and because they can influence the referral decision, providers with a bed capacity of less than 16 beds are likely to get more referrals than larger providers. Thus, an increase in revenues of small facilities and a corresponding decrease in revenues of large facilities may occur. However, the extent to which localities may actually take action to increase referrals to facilities with a bed capacity of less than 16 beds is not known.

Finally, the proposed regulations establish provider standards. These include staffing ratios and personnel qualifications. According to DMAS, most of the proposed provider standards do not significantly differ from those required under the Interdepartmental Regulation of Residential Care Standards for Level A services and the Department of Mental Health, Mental Retardation and Substance Abuse standards for Level B services, or providers already meet the proposed standards. Thus, providing these services through the Medicaid program should not significantly increase provider costs.

Businesses and Entities Affected

The proposed regulations apply to approximately 50 providers with less than 16 bed capacity. The proposed regulations may also indirectly affect about 75 providers with more than 16 bed capacity.

Localities Particularly Affected

No locality is likely to be affected by the proposed regulations more than others.

Projected Impact on Employment

The proposed financing of one half the expenditures for community-based residential services from federal government is likely to increase Virginia's income (or output). This, in turn, is likely to increase total employment in Virginia. By not being able to reimburse large

providers for services, the proposed regulations could also decrease employment at large providers and increase employment at small providers.

Effects on the Use and Value of Private Property

The proposed regulations are not likely to have a significant effect on the value and use of real property. The asset value of some private businesses involved in providing community-based residential services may be affected. The increase in total spending is likely to have a positive impact on businesses receiving the additional monies. However, total spending is likely to be too dispersed to have a significant effect on any individual business. Also, the asset values of small providers will be subject to a positive effect while the asset values of large providers will be subject to a negative effect due to shifting of some revenues from large to small facilities.