Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30 – 50; 80; 130; - Early and Periodic Screening, Diagnosis, and Treatment; Department of Medical Assistance Services

August 26, 1999

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 9-6.14:7.1.G of the Administrative Process Act and Executive Order Number 25 (98). Section 9-6.14:7.1.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 regulation amends the State Plan for Medical Assistance to expand coverage of inpatient psychiatric services under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) to include services in residential treatment facilities. Under existing regulations, Medicaid only covers inpatient (acute hospital care) and outpatient (therapeutic counseling sessions, home-based services, or day treatment services) psychiatric treatment services for children under age 21. Currently, children receive residential psychiatric services primarily through the Comprehensive Services Act although some other government programs (e.g., Department of Juvenile Justice and Community Service Boards) also place children in residential care.

Background

Residential psychiatric treatment is defined as out-of-home placements in therapeutic group homes where youths receive education, counseling, and physical conditioning on-site. Children in certain mandated populations (foster care, foster care prevention, special education students) can receive residential psychiatric treatment services under the Comprehensive Services Act (CSA). The CSA was established by the 1992 General Assembly as a comprehensive, interagency system of care for at-risk children. In addition to residential care, CSA also provides many other services, such as foster care, specialized education programs, and therapeutic counseling. Services under the CSA are funded by localities and merged state funds from the Department of Education, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, the Department of Social Services, and the Department of Youth and Family Services[1]. In FY 1997, 14,501 children were provided services under the CSA. While the CSA is the primary vehicle for child and adolescent residential treatment services, other government programs (e.g., Department of Juvenile Justice and Community Service Boards) also place children in residential care.

In 1997, the Joint Legislative Audit and Review Commission (JLARC) published a "Review of the Comprehensive Services Act" (Senate Document No. 26). This report made a number of recommendations for improvement of the CSA, including proposing the use of Medicaid funding to serve children for which Medicaid payment could be made. By doing so, federal matching funds could be obtained for services currently paid completely by the state and localities. The 1998 General Assembly acted on the JLARC report and directed the Department of Medical Assistance Services (DMAS) to add coverage of residential treatment for children and adolescents to the State Plan for Medical Assistance effective January 1, 2000.

Estimated Economic Impact

The proposed regulation will implement Medicaid coverage of residential psychiatric treatment and allow Virginia to draw on federal matching funds to pay for services that are now paid for with 100% state and local funds. As of October 1, 1998, the federal participation rate

[1] The Department of Youth and Family Services was the predecessor to the current Department of Juvenile Justice.

for medical assistance services in Virginia is 51.6% but it is estimated that this rate will rise to 51.77% on October 1, 1999.

In its 1997 report, JLARC reported that $56.2 million was spent by the CSA program on residential care for 1,595 Medicaid-eligible children, at an average cost of $35,000 per child.[2,3] If Medicaid funding had been used for each of these children, state and local governments could have saved $29 million[4]. Due to the large number of unknowns associated with implementation of this policy change, it is difficult to project an exact annual fiscal impact. However, any projection would require that the 1997 estimate be adjusted for the following factors:

1. ***Growth in the CSA population:*** JLARC identified 1,595 children in FY1997 whose treatment could potentially be funded by Medicaid. This represented 11% of the total FY1997 CSA population (14,501). CSA caseloads have been growing at 1.5% to 2% per year for the past two years.[5] Assuming that the percentage of children for whom Medicaid funding could be used remains constant, the population eligible for Medicaid coverage is likely to be higher than 1,595. The General Funds for services for CSA-children are to be transferred from CSA to DMAS as funds are expended.

2. ***Services will be available to ALL Medicaid-eligible children:*** As a Medicaid-covered service, coverage of residential treatment facilities will be available for all Medicaid-eligible children, regardless of whether they seek assistance through CSA. DMAS expects to serve about 160 non-CSA children when this program reaches maturity. These 160 non-CSA children are currently receiving residential care through the Department of Juvenile Justice (DJJ) or Community Service Boards. Since these services are now being paid for with State and local money, taking advantage of Medicaid funding will increase total savings to the Commonwealth. However,

[2] Cost estimates reported are in 1995 dollars.
[3] The estimate includes only children that were Medicaid eligible in FY1995, who received CSA funded residential care services, and were assessed to have the risk factors and/or psychiatric symptoms which indicate that they may potentially meet Medicaid's program eligibility criteria. For more details, please refer to Appendix D of the JLARC 1997 "Review of the Comprehensive Services Act" (Senate Document No. 26).
[4] State and local savings estimated here are based on the FY 1997 Medicaid match rate of 51.45 federal, 48.55 State. Using average State and local shares of 62.7% and 37.3%, respectively, the State savings would be $18 million and local savings $11 million.
[5] Unofficial estimates provided by the Office of Comprehensive Services: FY1998 CSA population approximately 14,700 (1.4% growth); FY1999 CSA population approximately 15,000 (2.0% growth).

coverage of these children will result in a shifting of costs from DJJ and the Community Service Boards to DMAS.

JLARC estimated the costs associated with coverage of the 160 non-CSA children would be $5.6 million using the FY1997 average cost of care. The General Assembly appropriated approximately $861,000 total funds for FY2000 ($417,000 General Funds) for coverage of these non-CSA children based on the fact that the program is not expected to be fully operational until the middle of FY2000. DMAS has requested a technical budget adjustment to increase this appropriation by $1.9 million in FY2001 and $3.6 million in FY2002 to adequately provide treatment for the anticipated number of non-CSA children.

There may also be additional Medicaid-eligible children in need of residential care who are currently not receiving treatment. The magnitude of this population is unknown at this time. While coverage of any such children would reduce the aggregate level of savings realized by the Medicaid expansion, the benefits to providing appropriate treatment for these children are probably roughly the same as the benefits of treating children now covered under other state programs.

3. ***Services will be available to VCMSIP children:*** The Virginia Children's Medical Security Insurance Plan (VCMSIP) went into effect in October 1998. At that time, DMAS estimated enrollment of 63,200 children within three years. To date, only 13,869 children have been enrolled,[6] although a major outreach is planned for the start of the school year. Since all services covered under Medicaid EPSDT automatically apply for VCMSIP children, this population will also be eligible for residential treatment services. There is no way at this time to estimate the number of VCMSIP children who may need and qualify for residential care. Coverage of this population is not currently accounted for in DMAS's technical budget request but will be included as the programs (both VCMSIP and EPSDT expansion) mature and the size of this population becomes clear.

[6] Enrollment figure as of 8/23/99.

As with other Medicaid-eligible children not currently receiving needed residential care services, expanding coverage will reduce the aggregate level of savings associated with this policy change. However, the federal match rate for VCMSIP children is approximately 66%, which is higher than the Medicaid match rate of 52%. Therefore, the reduction in savings will be less than that resulting from expanded coverage of additional Medicaid-eligible children while the benefits of providing needed treatment remain the same.

4. ***Cost savings under Medicaid:*** Federal Medicaid matching funds are accompanied by prescriptive provider requirements and utilization management requirements. Although some of these requirements may involve administrative and program changes by localities, they may also reduce the average cost of service paid for each child. Currently, each facility negotiates a rate of reimbursement with each local Community Policy and Management Team. Under the proposed policy, DMAS will set a uniform reimbursement rate. Utilization management under Medicaid may also decrease the average length of stay for some recipients as cases are more actively monitored. The extent of any cost reductions are not known at this time, however, they will only increase the fiscal savings associated with this proposal.

5. ***Responsiveness of localities to proposed policy change:*** The proposed regulation does not require that localities utilize Medicaid funding for eligible children. Although localities would save money, the federal requirements that accompany the federal funds may deter some localities from taking advantage of Medicaid reimbursement. The potential savings of this policy change will depend on the extent it is used by localities, which is not known at this time.

Aside from the expected fiscal savings, this regulatory change will provide a complete continuum of care for Medicaid participants, allowing the most appropriate level of care. Under existing regulations, Medicaid only covers inpatient (acute hospital care) and outpatient (therapeutic counseling sessions, home-based services, or day treatment services) psychiatric treatment services for children under age 21. Providing the most cost effective and least restrictive placement will be beneficial for children in need of residential psychiatric treatment.

The primary disadvantages to the proposed regulation are the federal requirements that accompany federal funding. This will primarily affect service providers, although localities may also have administrative and program requirements to comply with. There are 200 licensed residential service providers in Virginia. Fifteen of those currently qualify to enroll as Medicaid providers and others are seeking the necessary accreditation. It is not known at this time how many providers will qualify and enroll or if there will be any change in the quality of care provided.

Businesses and Entities Affected

The proposed regulation will affect all children in Virginia who receive or are in need of residential psychiatric treatment, estimated to be approximately 1,755.[7] Providers of these services who enroll as Medicaid providers will also be affected by this regulation in addition to localities responsible for placing children in residential care.

Localities Particularly Affected

The proposed regulation should not uniquely affect any particular localities as it applies statewide.

Projected Impact on Employment

The proposed regulation is not anticipated to have any significant impact on employment in Virginia.

[7] This figure reflects 1,595 CSA-children and 160 non-CSA children.

Effects on the Use and Value of Private Property

The proposed regulation is not anticipated to have any significant effects on the use and value of private property in Virginia.

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