Virginia Department of Planning and Budget

Economic Impact Analysis

12 VAC 30-50; 60 – Amount Duration, and Scope of Services for Categorically Needy and Medically Needy Individuals; Standards Established and Methods Used to Assure High Quality of Care
Department of Medical Assistance Services
March 20, 2015

Summary of the Proposed Amendments to Regulation

The proposed changes clarify the intent of Medicaid Mental Health Support Services (MHSS); amend the eligibility criteria, provider and service standards; establish service authorization requirements for certain services; and change limits, unit system, and rate structure used in the reimbursement methodology.

Result of Analysis

Although there is insufficient data to accurately compare the magnitude of the benefits versus the costs, the benefits likely exceed the costs at the aggregate level due to well-known abuses in the provision and utilization of MHSS.

Estimated Economic Impact

These regulations establish eligibility criteria, provider and service standards, and reimbursement rules for MHSS. MHSS are community mental health treatment services with a rehabilitative focus and defined as goal-directed training to enable individuals to achieve and maintain stability and independence in their communities in the most appropriate, least restrictive environments. MHSS include training in or reinforcement of functional skills and appropriate behavior related to the individuals' health and safety; training in the performance of activities of daily living, and use of community resources; training about medication management; and self-monitoring of health, nutrition, and physical conditions.

According to the Department of Medical Assistant Services (DMAS), the intent of this service has always been to provide training to individuals, who have severe, chronic mental

illness or emotional disturbances, so that they can successfully and independently live in their communities in the least restrictive environments possible. DMAS believes that the use of the term “support” in the service definition has contributed to providers' misunderstanding the purpose of this service which has led to the provision of services without the training or rehabilitation focus. In addition, imprecise eligibility criteria have allowed individuals who have not been diagnosed with either a serious mental illness or serious emotional disturbance to access these services. The Department of Behavioral Health and Developmental Services (DBHDS) licensing specialists and DMAS auditors have reported that MHSS have become more like companion care and less like mental health skills training with a rehabilitative and maintenance focus.

Community mental health rehabilitative services are behavioral health interventions. They are intended to provide clinical treatment to those individuals with significant mental illness or children either with, or at risk of developing, serious emotional disturbances. Clinical treatment differs from community social assistance and/or child welfare programs in that behavioral health services are designed to provide treatment to a mental illness rather than assisting with hardships due to socio-economic conditions, age, or physical disabilities.

Although MHSS were not intended to be a stand-alone service, but rather to be coupled with other services that the target population would most likely benefit from, it has been used to provide a wide variety of interventions. According to DMAS, utilization reviews conducted and stakeholder comments noted during the Notice of Intended Regulatory Action comment period indicate that these services have been inappropriately utilized to provide crisis intervention, counseling/therapy, transportation, recreation, and of significant concern, companion-like services, and general supervision. For example, some providers have billed these services for reimbursement when the service actually rendered involved driving the Medicaid recipient to medical appointments (sometimes over long distances) and remaining with the individual to later return him home. Neither transportation nor companion services were ever intended to be covered as part of MHSS. If a MHSS provider is transporting an individual, the provider may only bill for MHSS if skill-building training takes place for the entire time. Direct time spent with the individual is billable to DMAS as long as training in skills related to resolving functional limitations deriving directly from mental illness occurs during the entire time that is

billed. Medicaid already provides transportation to medical appointments via its Logisticare contract.

As a result of misunderstandings about the purpose of these services and imprecise eligibility criteria, the Medicaid expenditures for these services have increased from $46.4 million in fiscal year (FY) 2008 to $224.4 million in FY 2013, a $178 million increase which represents a 384% growth.

Stakeholders' feedback and DMAS observations concluded that without clarifying the service definition and eligibility requirements, MHSS would continue to evolve into a social service level of support rather than a psychiatric treatment service. To address these concerns, the General Assembly directed DMAS to make changes through the 2012 Acts of the Assembly, Chapter 3, Item 307 LL and Item 307 RR (f); and the 2013 Acts of the Assembly, Chapter 806, Item 307 DD. Consistent with these statutory mandates, DMAS promulgated emergency regulations that went into effect on December 1, 2013. The proposed regulations will make the existing emergency regulations permanent.

One of the changes re-names and re-defines MHSS to Mental Health Skill-building Services in order to emphasize the rehabilitative nature that DMAS always intended for this service to have. As explained above, these services were never intended to be interpreted as long-term companion care, or community social assistance.

In order to make sure MHSS services are provided to individuals who have severe, chronic mental illness or emotional disturbances, proposed changes revise the eligibility criteria as follows:

Adults (individuals 21 years of age and older) must (i) have at least one of several listed diagnoses in Diagnostic and Statistical Manual of Mental Disorders (DSM); (ii) shall require individualized training in basic community living skills in order to successfully remain independent in the community; (iii) have a prior history of psychiatric illnesses that required institutionalization or have a history of certain behavioral health treatment, and; (iv) shall have had a prescription for psychotropic medications.

Young people (individuals younger than 21 years of age) must (i) have at least one of the several listed DSM diagnoses; (ii) shall require individualized training in basic community living

skills in order to successfully live in the community; (iii) have a prior history of psychiatric illnesses that required institutionalization or have a history of certain behavioral health treatment; (iv) shall have had a prescription for psychotropic medications; (v) be living independently or actively transitioning (within 6 months) to independent living; (vi) have had completed for them an Independent Clinical Assessment (known as VICAP).

The proposed changes also require providers to document the diagnoses making the individuals eligible for MHSS and provision of services.

The proposed clarification of the service definition, revised eligibility criteria, and documentation requirements are expected make sure correct services are provided for the treatment needs related to an individual's medical/psychiatric condition. Individuals with a qualifying diagnosis will continue to receive appropriate skill building services while individuals who previously received non-skill building interventions via this service will be appropriately directed to resources that can meet those non-skill-building needs; i.e., social services, crisis intervention, case management, etc. In addition, the proposed documentation requirements are expected to reduce the number of adverse audit results and overpayments to providers.

The proposed changes also modify provider qualifications to ensure that appropriately trained/licensed professionals are caring for these individuals with serious mental illness. According to DMAS, when care is rendered by inadequately trained or non-licensed professionals, great harm can be created to these individuals. Supportive in-home licensed providers are now limited to providing non-clinical services under a Medicaid waiver for persons with developmental disabilities. Due to the clinical nature of MHSS, it was decided in conjunction with the DBHDS Office of Licensure to discontinue allowing providers with the supportive in home license to provide MHSS. Also, MHSS is a non-center or home and community based service. The assertive community treatment (ACT) and intensive community treatment (ICT) licenses are restricted to center based service providers. They are not relevant licenses to provide the more flexible community based MHSS.

Under the proposed changes, providers licensed as ACT or ICT would have to update their agency license based on their current staffing patterns. According to DMAS, this update is a formality and the change would easily be accomplished by the provider who employs staff who meet the ICT/ACT credentials. The supportive in-home providers would not be able to make the

switch to the MH Community Support License without hiring clinically licensed staff who meet the licensed mental health professional criteria as defined by DBHDS and also the direct services staff would have to meet a more stringent qualified mental health professional criteria that includes college degrees and one year of clinical service. Supportive in-home providers were able to use staff that did not have a college degree.

DMAS reports that there were 265 providers in December 2013. Currently, there are 316 providers. While the changes in provider qualifications most likely have had some adverse impact on some providers, DMAS does not believe that these changes have prevented any providers continuing to provide MHSS to eligible individuals.

The proposed changes also prohibit overlaps of MHSS with other similar services that would be duplicative and not therapeutically beneficial. MHSS are no longer available under certain conditions and for certain individuals as follows: individuals in group homes and assisted living facilities may no longer receive MHSS from the providers residing in the same facility; individuals who are also receiving in-home residential services or congregate residential services provided through the Intellectual Disability or Individual and Family Developmental Disability Support home and community based waivers; individuals who are receiving services under the Department of Social Services' independent living program, independent living services, or independent living arrangement or any Comprehensive Services Act for At-Risk Youth and Families-funded independent living skills programs; individuals who are receiving treatment foster care; individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities or hospitals; individuals who reside in nursing facilities, except for up to 60 days prior to discharge; individuals who are residents of Residential Treatment Centers-Level C facilities, except for individuals with certain intake codes in the seven days immediately prior to discharge; individuals who receive personal care services or attendant care services; individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, unless their physicians issue signed and dated statements indicating that the individuals can benefit from MHSS. DMAS considers any overlap in these services with MHSS duplicative and clinically ineffective.

The proposed regulations also seek to improve the quality of the services provided by ensuring that MHSS providers communicate important information to other healthcare

professionals who are providing care to the same individuals. According to DMAS, in the past, there has been very little communication with other health care practitioners, and virtually no communication with prescribing physicians. These regulatory changes seek to bridge this gap. For example, if an individual who receives MHSS under the new criteria fails to adhere to his prescribed medication regimen, it could have a significant, negative impact on the individual's mental health. If a paraprofessional providing MHSS to an individual learns of the non-adherence to the prescribed medication regimen, he or she is now required in these regulations to notify his or her supervisory staff of the individual's medication issues. Supervisory staff is also being required to communicate this information to the individual's treating physician, so that he or she is aware of the problem and therefore is enabled to address it at the next visit.

As it should be clear from the description of changes discussed so far, this regulatory action is comprehensive and touches many aspects of MHSS. These changes undoubtedly have a significant economic impact on providers, individuals receiving services, and DMAS. The main economic impact is a decrease in utilization and therefore expenditures reimbursed for MHSS. However, there are serious data limitations and confounding issues making it impossible to produce a precise estimate.

First, the proposed changes discussed so far had become effective in December 2013. In that month, there were prior authorizations that would continue to be valid in the coming months. In addition, due to the comprehensive and complex nature of the changes, there have been likely delays in implementation. Thus, while we can compare expenditure levels before December 2013 and most recent months to get a sense of the economic impact up to this date, the downward trend in expenditures may well continue into the future. If the downward trend continues, the reduction in expenditures so far would underestimate the actual reduction that would be achieved when all changes are fully implemented.

Second, at the time these regulatory changes went into effect, the behavioral services administrator also changed. The change in claims administrator is not a part of this regulatory action and consequently its economic effects cannot be attributed to the change in this action. Thus, some of the reduction in expenditures is attributable to more efficient administration of the claims process. However since the change in regulations and the claims administrator took place

simultaneously, there is no way to isolate the impact of the proposed regulations from the impact of administrator change with the data available.

The average monthly MHSS expenditures from September to November 2013 (over a three month period) were approximately $22 million. The average monthly expenditures from January to March 2015 were $15.5 million. Thus, the average monthly expenditures have decreased by approximately $6.5 million per month (a 30% reduction) which would imply a reduction of $78.7 million per year. The accuracy of this estimate somewhat bolstered by the change in the number of recipients. The number of unduplicated recipient population has decreased from 14,830 in December 2013 to 10,851 in December 2014, a decrease of 27%. However, as discussed above, some of the reduction in expenditures is likely due to change in claims administrator.

These estimates imply that providers of MHSS would see approximately 30% or about $78.7 million per year and perhaps more (if the impact of changes has not been fully materialized yet) reduction in their Medicaid MHSS revenues. Due to federal matching funds, only one half of these savings would be realized by the state and retained in the Commonwealth perhaps for other state expenditures. The other half of the funds is savings to the federal government. The lost federal matching funds would have a net contractionary impact on the Commonwealth's economy.

These changes also represent a negative impact on individuals who used to be receiving these services under previous regulations. Approximately 27% of the number of recipients, or about 4,000 recipients, would no longer be accessing MHSS.

In addition to the changes that have already been implemented, there are some other changes that will go into effect when these regulations are finalized. DMAS reports that as providers have adjusted to recent regulatory requirements implemented, they have begun to expand their businesses into other service areas that they may be able to provide. As a result, there has been an expenditure growth in the two crisis services offered in the community – crisis intervention and crisis stabilization. These services are the only two community mental health rehabilitative services that, to date, have been exempt from service authorization. Thus, DMAS is now seeking to require service authorization for them. DMAS believes this step is necessary to preserve the integrity and quality of these services by ensuring that only individuals who are

truly in crisis receive them. DMAS is ensuring that service authorization does not delay or prevent services to those individuals who truly are in crisis by permitting providers to request authorization within a brief period of time after initiating services.

The recent trend in the data over January 2014 to February 2015 indicates that the total crisis intervention and stabilization expenditures are currently increasing approximately $13,000 per month. The average monthly expenditures for these two services over December 2014 to February 2015 were about $1.37 million. While a $13,000 increase per month for services that range about $1.37 million monthly may seem small, the data confirms that the expenditures are steadily increasing. The proposed service authorization requirements may curtail the trend down, stop growth, or even reverse the trend. Even though there is no data to estimate the magnitude of the impact, it is likely there will be some savings from the proposed service authorization requirement.

Similar to the changes that have already been implemented, the proposed service authorization requirement, would reduce provider revenues, restrict recipient's access to services, and result in loss of federal funds coming into the Commonwealth.

Finally, DMAS proposes limits in utilization in assisted living facilities and in group homes and certain changes in unit and rate structure. However, due to the 2014 Acts of the Assembly, Chapter 5002, Item 301 ZZZ, the changes described below will not be implemented until the General Assembly has reviewed the impact of the proposed regulations.

The number of hours of MHSS provided in an assisted living facility and in group homes will not exceed 4,160 fifteen-minute units per fiscal year, 80 fifteen-minute units per week, and 20 fifteen-minute units per day. This change is proposed to ensure that MHSS is not duplicative of services that are already being provided in residential placements, such as assistance with medication management. DMAS proposes that providers offer half of each week's authorized MHSS hours to assisted living facilities/group home residents outside of their residential setting. This new requirement is intended to assist with training these individuals to achieve and maintain community stability and independence.

Changes in current unit system are also proposed. The current unit value system allows services in hourly ranges as follows: one unit = 1 to 2.99 hours; two units = 3 to 4.99 hours, three units = 5 to 6.99 hours; four units = 7 plus hours. According to DMAS, the current system

creates an incentive to bill for more time than provided because of the imprecise unit value. In addition, there is a 372-units limit per year which yields approximately one unit per day. However, the daily billing allowance is up to four billing units per day with varying time values per unit billed. Thus, providers are permitted to bill seven or more hours of service per day. This creates an imbalance, such that if an individual continued to need this service over the course of a year, he or she would reach his annual limit well before the end of the year.

The proposed regulations would change the unit structure to a 15 minute billing unit and decrease the number of units per day that an individual may receive the service (decreasing from seven hours to up to 5 hours allowable as a maximum of twenty 15 minute billing units per day) to ensure that the service is not over-utilized. The new unit value and new unit allowance would yield a maximum of 5 hours per day, 5 days per week for a total of 5,200 fifteen-minute units per year. The changes in the daily, weekly, and annual limits would stagger services so that they may be provided consistently over the course of a year.

The current reimbursement rate is $91 per unit in urban areas and $83 per unit in rural areas. Under the new system, the rate for one 15-munite unit would be $14.77 in urban areas and $13.47 in rural areas. According to DMAS, under the new unit and rate structure, the total expenditures would increase if the maximum limits are billed. However, with the new daily and weekly limits in the unit structure maximum yearly limit would be more difficult to achieve.

The proposed changes in the limits, units, and rates are designed according to a budget neutral methodology and may not affect total MHSS expenditures. While the new changes may be budget neutral overall, the impact on each provider and individual would certainly be specific and different. However, as mentioned above the changes in the limits, the unit of service, and the rate of reimbursement will not be implemented until the General Assembly has reviewed the impact of the proposed regulations. Thus, no economic impact is expected from these changes until they are implemented.

Businesses and Entities Affected

The proposed regulations primarily effect MHSS providers, recipients, DMAS, and the state and federal government. Per DBHDS Office of Licensing, there were 265 MH Support providers as of July 2013 and there are 316 providers currently. The number of unduplicated recipients was 14,830 in December 2013 and 10,851 in December 2014.

Localities Particularly Affected

The regulations do not affect any particular locality more than others.

Projected Impact on Employment

The proposed changes are estimated to curtail MHSS expenditures by about $78.7 million or more per year. Reduction of this magnitude in revenues of HMSS providers would undoubtedly have a negative impact on their demand for labor and have a negative impact on employment in the Commonwealth.

Effects on the Use and Value of Private Property

Similarly, estimated impact of $78.7 million reduction in revenues would have a negative impact on profitability and therefore the asset value of MHSS providers.

Small Businesses: Costs and Other Effects

The proposed amendments primarily affect MHSS providers. Most of the providers are believed to be small businesses. Thus, the effects discussed above apply to them.

Small Businesses: Alternative Method that Minimizes Adverse Impact

The proposed changes are designed to curtail the abuse in provision and utilization of MHSS. There is no known alternative method that would minimize the adverse impact on providers 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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