Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-50 – Department of Medical Assistance Services
Amount, Duration, and Scope of Services: Methods and Standards to Assure High Quality of Services
January 30, 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

The proposed regulations will i) remove limitations on a pregnant women's access to substance abuse services, ii) eliminate the requirement that a physician must supervise the nurse case manager, iii) delete the prior psychiatric hospitalization requirement for mental health support services eligibility, iv) change the mental health support service limit from a monthly limit to a yearly limit, vi) decrease the minimum number of service hours required for intensive in-home treatment services from at least five hours to three hours per week, and vii) require support and rehabilitation service providers to more frequently review the patients' individual service plans. The proposed changes are intended to improve service delivery and access.

Estimated Economic Impact

These regulations apply to Medicaid reimbursements for community mental health rehabilitation services. These rules are requirements for mental health providers to qualify for reimbursement for the services they provide. The facility standards, licensing requirements, and

some provider employee qualifications, etc. are established elsewhere by other government entities. These rules contain the requirements Medicaid providers must meet to be reimbursed to provide mental health services. Many of the requirements included in these regulations conform the provider qualifications to the licensure requirements set forth by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS).

Although significant revisions are proposed, the majority of the changes are intended to conform the Medicaid requirements to certain federal requirements and the DMHMRSAS regulations. Further, many of these changes clarify the current policy. These proposed changes are not anticipated to have an effect in current practice, but are expected to improve the clarity and enforceability of the requirements, both of which could result in some economic benefits.

Of the remaining changes, several will likely have significant effects on current practice. Among these, the proposal to remove lifetime limitations currently imposed on substance abuse treatment services provided for pregnant women in a residential or outpatient (day treatment) setting appears to be the most significant. Currently, there are lifetime service limitations (330 days for residential and 440 days for outpatient) on substance abuse treatment services provided to pregnant women. Additionally, these services must be received continuously during only one course of treatment. Thus, if the service, once initiated, is interrupted only once, the recipient pregnant woman loses her eligibility. According to the Department of Medical Assistance Services, providers state that this limit is overly restrictive and limits access to the services. In fiscal year (FY) 2001, $101,808 was spent for residential substance abuse treatment for 19 pregnant women and $8,311 was spent for day substance abuse treatment for 11 pregnant women.

The proposed changes will remove the lifetime limit restrictions. Under the proposed regulations, qualified pregnant women will be eligible for up to 300 days of residential treatment and 400 days of outpatient treatment per pregnancy, which could be interrupted without any effect on the ability to access this service. Thus, this change will most likely increase the utilization of these services because the coverage may be provided with more than one pregnancy, because the duration of the service provided under this change may exceed the current life time service limit, and because breaks in the service (dropping out of the treatment program) will not constitute the loss of the coverage for the recipient’s entire life.

The proposed regulations will also expand one of the eligibility criteria for access to residential and outpatient substance abuse treatment services for pregnant women who were in jail or prison. Under current regulations, in order to access such services, the drug use or alcohol use must have occurred within six weeks of referral for this service. As a result, if a woman was incarcerated for longer than six-weeks prior to the referral, and was not in a substance abuse treatment program in the jail or prison, she would not qualify for services. Under the proposed rules, the time frame allowed will start from six weeks prior to incarceration rather than six weeks prior to the referral. Thus, a number of additional pregnant women who abused drugs or alcohol prior to their imprisonment would qualify for these services, which will increase the number of Medicaid recipients that will be approved to receive this service.

These changes are directed toward reducing substance abuse among pregnant women by increasing access to services. The prevalence of substance abuse is significant among pregnant women reaching about 5% nationally.[1] The research shows that, this prevalence is associated with significant adverse health effects for newborns and mothers and has adverse implications on employment outcomes, education expenditures, and criminal activity. The research also shows that although no significant differences could be found between residential and outpatient substance abuse treatment outcomes, both types of these services are generally effective in treating these women. Despite the fact that the cost of residential treatment is typically higher than outpatient treatment (by a magnitude of almost six times in the referenced study), every dollar spent on residential treatment is found to save about $4 in other medical costs.[2] Other research in this area lends support to the finding that the medical benefits of substance abuse treatment services significantly exceed the costs of providing these services.[3] Finally, available research indicates that the benefits from reduced criminal activity alone are sufficient to pay for

[1] Howell, Heiser, Harrington, 1998, "A Review of Recent Findings on Substance Abuse Treatment for Pregnant Women," Journal of Substance Abuse Treatment, v. 6, no. 3, pp. 195-219.
[2] French, Salome, Carney, 2002, "Using the DATCAP and ASI to Estimate the Costs and Benefits of Residential Addiction Treatment in the State of Washington," Social Science & Medicine, v. 55, pp. 2267-2282.
[3] Svikis, et al, 1997, "Cost-Effectiveness of Treatment for Drug-Abusing Pregnant Women," Drug and Alcohol Dependence, v. 45, pp. 105-113.
French, McCollister, Cacciola, Durell, Stephens, 2002, "Benefit-Cost Analysis of Addiction Treatment in Arkansas: Specialty and Standard Residential Programs for Pregnant and Parenting Women," Substance Abuse, v. 23, no. 1, pp. 31-51.
Barnett and Swindle, 1997, "Cost-Effectiveness of Inpatient Substance Abuse Treatment," v. 32, no. 5, pp. 615-629.

the costs of treatment programs in several settings including residential only, outpatient only, and residential and outpatient combined.[4]

The expected increase in utilization of residential and outpatient substance abuse treatment services due to the proposed changes will certainly increase the Medicaid payments to substance abuse providers, almost half of which (49%) will be financed by the Commonwealth. The source of the remainder of the necessary funds will be the federal funding agency. However, as discussed, the benefits of these services are significant and include potential cost savings in future inpatient and outpatient hospital care for the mother, in prenatal and newborn care for the children, and in care for the children with developmental delays. Thus, the net fiscal effect will likely be a reduction in overall Medicaid expenditures. According to the federal Substance Abuse and Mental Services Administration, residential substance abuse treatment reduces the risk of premature delivery by 70%, the risk of low birth-weight by 84%, and the risk of infant mortality by 67% relative to the risks among untreated abusers. Studies also report a significant reduction in alcohol and drug use, in criminal activity, as well as improvements in economic well-being and improvements in parental status during the six months following treatment compared to six months prior to the substance abuse; all of which represent additional benefits of the treatment services. Given the available research findings, it appears that the benefits of expanded substance abuse services would easily outweigh the costs associated with providing these services.

Another change related to residential and outpatient substance abuse treatment services is the removal of the requirement that a physician supervise the nurse case manager while performing her/his substance abuse treatment tasks. In Virginia, nurses are licensed and in addition, may be certified to perform substance abuse treatment case management services. However, to qualify for Medicaid reimbursement, currently, a physician must medically supervise the provision of services. Given that the nurses are licensed by the Virginia State Board of Nursing and qualified to independently provide case management services, no significant change in the quality of case management services provided to patients is expected by removing the physician supervision requirement. A benefit of this proposed change is eliminating some administrative costs in terms of less productive physician time needed to

[4] Daley, et al., 2000, "The Costs of Crime and the Benefits of Substance Abuse Treatment for Pregnant Women,"

provide the required supervision. Also, because of the reduction in required physician supervision time, physicians will be provided incentives to treat Medicaid patients. Thus, more doctors may be willing to provide services to Medicaid recipients and the proposed regulations may increase access to substance abuse services.

Another proposed change for the receipt of mental health support services removes the requirement that the recipient must have a history of psychiatric hospitalization. Mental health support services include assistance and monitoring with activities of daily living for people with severe mental disorders. For example, the support services include help with maintaining personal hygiene, maintaining adequate nutrition and hydration, taking prescribed medication as ordered, or managing finances provided to people with severe depression, schizophrenia, and bipolar disorders. Also, the current Medicaid payment limit is 31 hours of support services per month. In FY 2001, Medicaid paid $5.3 million to providers for these support services. The main goal of these in-home support services is to avert potential hospitalizations and to keep these recipients in their communities.

The removal of the prior psychiatric hospitalization requirement will expand the eligible population for the mental health support services and will increase the number of recipients who could receive this service. Thus, the Medicaid expenditures for these services are most likely to increase. This potential increase in spending represents the additional costs of this change. The main benefit, however, is averting potential hospitalizations. Availability of the support services to an expanded population will likely reduce the number of psychiatric hospitalizations that would likely have occurred. Thus, future Medicaid expenditures for psychiatric hospitalizations will probably decrease. Additionally, among the potential benefits is the economic value to the society and the affected recipients associated with keeping these individuals in their homes and communities. In short, the net economic effect of this change will depend on whether every additional dollar spent on mental health support services would produce more than a dollar benefit in terms of lower hospital costs and keeping recipients in their homes and communities.

The proposed regulations will also re-establish the mental health support service limitation in terms of 372 hours per year rather than 31 hours per month. Note that the net annual service limit will remain the same. However, this change will increase the flexibility in

the timing of the provision of these services. This change is to address possible needs of a recipient whose medical condition requires more intensive services in the early stages of providing this service. With this change, the recipient will be able to use the service as the medical condition warrants. While this change will afford the flexibility to provide more than 31 hours of support services in a month in the early stages of treatment, it will also expose recipients with continued extensive need to the risk of not receiving any support services in later months of treatment. For example, there exists a chance for a recipient to reach the annual limit in the first nine months of the year and not qualify for any services during the last quarter of the year. In short, the net effect of providing a uniformly distributed service throughout the year compared to providing the same service clustered at times within the same year is not clear. Services rendered must be medically necessary, but there could be an increase in utilization of this service since this change will preserve unused hours in a month to be used later

The proposed changes will also reduce the minimum number of hours required to provide intensive in-home treatment services for children from at least five hours a week to three hours a week. In FY 2001, Medicaid paid approximately $7.2 million for in-home treatment of 1,620 children. Currently, providers are not allowed to provide in-home treatment services to children if the service need is less than five hours a week. With this change, children with a minimum need of three hours weekly for in-home services will qualify for Medicaid reimbursement. Thus, an increase in the number of children utilizing these services and a corresponding increase in Medicaid expenditures for in-home services are expected. On the other hand, these services will also likely divert some of the children from more costly potential hospitalizations and residential treatment and keep them in their homes and communities. Thus, the net economic effect of this change will also depend on whether every additional dollar spent on in-home treatment services for children produces more than a dollar benefit in terms of lower hospital costs plus the economic value of keeping children in their homes and communities.

With another change, more frequent re-authorization of mental health support services and psychological rehabilitation services will be required. Currently, providers may authorize mental health support services for a recipient up to six-consecutive months and may authorize psychological rehabilitations up to a year, which in effect allows providers to review the individual service plans only once in every six months and once every year, respectively. The proposed amendments will reduce the maximum authorization period to three months for support

services and to six months for psychological rehabilitation services. As a result, the providers will have to review the individual service plans at least once every three months for support services and every six months for rehabilitation services, and based on the review, re-authorize services as needed.

More frequent review of individual service plans will likely introduce additional costs to the providers in terms of staff time and possibly in terms of other administrative costs to create and maintain additional data elements or paperwork. However, more frequent reviews will necessitate that the provider stay current about the patient's status and more closely track the changes in patient's medical condition. As a result, changing service needs may be identified earlier. Dispensing more appropriate services early on may improve the treatment success, which would benefit the patient and increase the efficiency of every dollar spent for treatment in terms of improved health outcomes.

Businesses and Entities Affected

The proposed regulations apply to approximately 90 community mental health service providers and approximately 27,600 Medicaid recipients.

Localities Particularly Affected

The proposed regulations apply through out the Commonwealth.

Projected Impact on Employment

We can expect to see an increase in labor demand in the areas of substance abuse treatment, mental health support, intensive in-home services while the labor demand in inpatient hospital services area will probably decrease.

Effects on the Use and Value of Private Property

The proposed changes will likely positively affect the value of privately owned substance abuse treatment, mental health support, intensive in-home service businesses while there is likely to be a negative effect on private inpatient hospital services care businesses.