REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Reimbursement of Educational Services within the Medicaid Residential Treatment Rate

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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EXECUTIVE SUMMARY

Coverage of educational services delivered as part of an approved treatment plan involving residential placement under the Medicaid program could result in two outcomes to the Commonwealth's programs for children in need of these services. First, the utilization of federal funding for educational services would serve to relieve some fiscal stress at the local level. As the Comprehensive Services Act for At-Risk Children and Youth (CSA) program is currently the only venue for state funding of educational treatment for these children, localities must provide approximately one-third of the necessary funding. With federal money utilized for these services, the amount of local funding required would be reduced.

Secondly, the inclusion of educational services as a Medicaid-covered service would allow more children in need of educational services, and residential treatment, to access these services by a determination of Medical eligibility rather than through local decision-making, the outcomes of which may vary from locality to locality. While increased access at a reduced price (due to the use of federal funding) is a benefit to the Commonwealth, the state portion of the costs of increased utilization will most likely offset any general fund savings that would otherwise be achieved through the use of federal funds for education and residential services.

These outcomes, however, also have policy challenges. The challenges are that Medicaid funding could drive placement decisions, more localities may circumvent the CSA process to avoid paying the local share, and local control over education would be diminished as the state assumes a larger role. The Secretary of Health and Human Resources and the State Executive Council will need to carefully monitor the Medicaid funding of educational services in order to reduce the unintended consequences of the change.

INTRODUCTION

Item 326 GGG of the 2004 Appropriations Act directs the Department of Medical Assistance Services (DMAS) to modify the State Plan for Medical Assistance to include reimbursement for required tuition payments in the agency's reimbursement methodology for Medicaid-eligible residential services. DMAS is further directed to report on the regulatory changes necessary to implement this methodological change and any fiscal impact associated with this new approach. A copy of Item 326 GGG is included as Attachment A to this report.

This report is in response to the requirement under 326 GGG to provide more information on this reimbursement methodology change.

BACKGROUND

Residential treatment encompasses a wide array of services to alleviate or manage mental/behavioral health issues impacting the well being of recipients in need of this care. As the name indicates, residential treatment involves the placement of a child in an institutional setting of varying levels. Because the child is placed outside of the home, residential treatment represents a fairly restrictive environment relative to alternative community-based placements. Residential treatment is often the last resort, barring acute-psychiatric hospital placement, after other treatment approaches have failed to have the desired therapeutic effect.

Residential treatment services are often provided to children and adolescents through the CSA program. The CSA program and DMAS have worked closely on CSA-related services that are also covered under Virginia's Medicaid program in order to provide funding, to the extent possible, through the Medicaid program. The Medicaid program is funded jointly with state and federal funding; to the extent Medicaid is able to cover CSA services, federal funding is available to match state and/or local funding, rather than having the service paid for entirely with state and local funds under CSA. In other words, any cost coverage by the Medicaid program for CSA children replaces some state or local funding with federal funds (currently, the federal match rate is 50 percent, meaning that for every state/local dollar expended under Medicaid, a federal dollar is expended as well).

The Virginia Medicaid program has been covering residential treatment services for children and adolescents under the State Plan for Medical Assistance (hereafter, State Plan) since January 2000. Medicaid funding has been used to cover these services for both CSA and non-CSA children since that time. DMAS determines the CSA or non-CSA status of the recipient based on whether or not the CSA program provides and pays for any CSA services for that individual, including education services. If a recipient is considered a CSA child, the portion of funding for residential services required to generate the federal match is the responsibility of the CSA program through its general fund appropriation and required local match. If the recipient is determined to have non-CSA status, the state match is generated by the general fund appropriations to DMAS.

Under the current State Plan, Medicaid does not cover educational costs for recipients in residential care, regardless of CSA status. If a child is receiving educational services currently, they are either being paid for by the CSA program or by some other means. Federal regulations generally prohibit federal financial participation (FFP) under Medicaid for payment of formal educational services. However, DMAS received guidance from the Centers for Medicare and Medicaid Services (CMS) that stated that Federal regulations at 42 CFR 441.13(b) make an exception for individuals under age 21 receiving inpatient psychiatric services as prescribed in an active treatment plan. It is under this guidance that DMAS will submit a state plan amendment to CMS requesting approval of payments for educational services that are part of the treatment plan. The following discussion analyzes the potential impact of Medicaid coverage for educational services provided as part of an approved treatment plan including residential services, and outlines the regulatory changes necessary to implement such an approach.

DISCUSSION

Because educational services for residential care recipients are currently non-covered services in the Medicaid program, most children in residential treatment receiving educational services would be determined to have CSA status, with the CSA program paying for the both the entire cost of the educational services (a state/local fund mix) and the state/local portion of the residential treatment services cost (with 50 percent from federal funds). If Medicaid changed the State Plan to include educational services for recipients of residential treatment, some of these children would no longer be in receipt of CSA-funded services (since educational services would be covered under Medicaid), and these children would therefore have their status change from CSA to non-CSA in the eyes of the Medicaid program.

This shift in status would therefore cause a budget shift as well, with the Medicaid program increasingly responsible for both the state portion of the residential services cost and the state portion of the cost of educational services. For the CSA program, there would be a concomitant decrease in the liability of the program for these services (absent any change in budget allocations).

Medicaid coverage of educational services already provided as part of a CSA residential treatment plan would result in a savings to the Commonwealth of roughly half the existing cost, as payment though Medicaid would generate a 50 percent federal match, thus allowing Virginia to reduce state and local expenditures for the existing recipients. While the DMAS appropriation would have to increase (either through general fund increases or some type of shift of general and local funds from the CSA program), the state's responsibility for services already being provided to CSA children would decrease through savings to the CSA program due to the ability to utilize federal funding.

However, coverage of educational services would most likely result in some added cost relative to current spending overall, as existing non-CSA children would now have coverage for educational services. If Medicaid covers services, they will most likely be included in treatment plans with greater incidence. Additionally, it is likely that a population exists that has been denied CSA-funded services and has therefore not pursued residential treatment under Medicaid because Medicaid does not currently cover the educational component of the treatment. If Medicaid begins to cover the educational services, this population would represent additional costs for both the educational services and the more expensive residential treatment itself.

Current utilization data from both the CSA and Medicaid programs show that in state fiscal year (SFY) 2004, and average of 430 children were receiving residential treatment per month. Of the 430 children, 400 had CSA status and the remaining 30 were non-CSA (pure Medicaid). There is no basis to estimate the size of the population that may have been denied CSA-services and did not pursue any service under Medicaid.

Estimated Fiscal Impact

Calculating the state's fiscal impact of covering educational services delivered as part of a residential treatment plan is difficult to accomplish due to the uncertainty surrounding the amount of the recipients that would shift from CSA to non-CSA status, and the potential increase in total recipients due to expanded coverage under Medicaid. For this analysis, DMAS is projecting a 16 percent shift from CSA status to non-CSA status. This represents what the Department believes to be toward the high-end of the potential shift, but appears to be a realistic assumption based on locality input.

Regarding the addition of recipients due to Medicaid coverage, there is some additional cost to the state related to current Medicaid children who would most likely begin receiving educational services once Medicaid began covering them. The number of current Medicaid-only children (the current non-CSA tally) in residential services is available for estimating a fiscal impact of this coverage change. However, the population that may be waiting in the wings who currently do not receive residential or educational services under CSA or Medicaid, but will once educational services are included in Medicaid, is difficult to estimate. Given the average cost per recipient (discussed below), it will not take too many additional recipients to negate any general fund savings from this coverage initiative.

For this analysis, DMAS has assumed an educational cost of $105 per day, for an average of 20 days per month. This translates into a 240 day "school year" which is different from the 180 day year provided in primary and secondary public education, however, the agency believes that the longer "school year" is consistent with the treatment needs of the population in residential treatment. In terms of cost, these assumptions result in a monthly cost of $2,100. Under Medicaid coverage of these services, federal funds would cover half of this cost, or $1,050 per month.

Based on expenditures for SFY 2004, DMAS determined that the average monthly cost of residential treatment (under current Medicaid and CSA reimbursement methods) equals $10,192 per recipient.

Fiscal Impact Analysis. With these limitations to the analysis stated, the following fiscal impact analysis presents the agency's best estimate of the fiscal impact of covering educational services based on the assumed percentage shift of recipients from the CSA program to the Medicaid program. The impacts calculated below basically assume that localities and the CSA program would no longer be responsible for their portion of funding for children that move from CSA-status to non-CSA status as a result of providing coverage under Medicaid for educational services. Clearly the general fund savings from the CSA program should be transferred to DMAS under this approach. However, a policy choice remains as to whether any maintenance of effort or identification of prior CSA status should be built in to continue to generate a local match for these services.

DMAS is estimating that a 16 percent shift from CSA to non-CSA status will result in a general fund savings of $1.3 million ($6.4 million savings to CSA; $5.1 million cost to DMAS) based on the current known count of recipients of these services. This general fund figure includes an estimated $756,000 in additional costs to DMAS due to additional pure-Medicaid recipients (identifiable) receiving this newly covered service. *However, the general fund savings would likely be offset through an influx of additional recipients into these services. Under this scenario, an additional* ***19 recipients per month receiving residential and educational services would erase the general fund savings.*** Assuming localities are no longer responsible for a match for those children moving from CSA status to Non-CSA status, we estimate a local savings of $3.3 million. Federal funding would be increased by $5.4 million. The table below presents this information.

Educational Services & Residential Services (assumed 16% Shift form CSA to Non-CSA)					
	GF	NGF (local)	Total		
CSA Budget (current)	$ 22,797,213	$ 11,744,019	$ 34,541,231		
CSA Budget (new)	$ 16,355,483	$ 8,425,552	$ 24,781,034		
Net Effect on CSA Budget	$ (6,441,730)	$ (3,318,467)	$ (9,760,197)		
	GF	NGF (federal)	Total		
DMAS Budget (current)	$ 1,834,592	$ 26,295,824	$ 28,130,416		
DMAS Budget (new)	$ 6,932,789	$ 31,713,824	$ 38,646,613		
Net Effect on DMAS Budget	$ 5,098,197	$ 5,418,000	$ 10,516,197		
	GF	NGF (local)	State + Local	NGF (Federal)	Total
Combined Budget (current)	$ 24,631,805	$ 11,744,019	$ 36,375,824	$ 26,295,824	$ 62,671,648
Combined Budget (new)	$ 23,288,272	$ 8,425,552	$ 31,713,824	$ 31,713,824	$ 63,427,648
Net Effect on Combined Budget	$ (1,343,533)	$ (3,318,467)	$ (4,662,000)	$ 5,418,000	$ 756,000
Annual GF Cost per Additional Recipient	$73,753				
Number of Additional Recipients to Negate GF Savings	19	per month			

Next Steps Toward Implementation

Development of Implementing Regulations. DMAS currently pays for residential treatment services under a per day payment rate. This per diem is determined by DMAS based on information submitted by enrolled residential psychiatric treatment facilities. This rate does not currently cover the costs of professional services (such as services rendered by a psychiatrist), nor does it cover the costs of educational services delivered in the residential treatment facility. Regulations and the State Plan would need to be modified to provide Medicaid coverage for educational services, and the regulations regarding the development of the per diem rates may need to be modified to incorporate an addition to the rate for the cost of educational services.

In order for this change to be effective July 1, 2005, DMAS may need emergency regulatory authority language added to the Appropriations Act this year. It is still possible for the agency to promulgate regulations in time for a July 1, 2005 implementation date through the Fast Track process, which can take approximately six months. However, this process would need to begin immediately, and feedback from legislators, and the providers themselves, regarding this report may require modification to the draft regulations and potentially delay the process. In addition to the regulatory change necessary, DMAS will need to obtain approval of the State Plan Amendment (SPA) from the Centers for Medicare and Medicaid Services (CMS).

Modifications to DMAS Claims Processing Systems. In addition, inclusion of education as an add-on to the residential treatment rate may require some DMAS claims processing systems changes. It may be necessary to develop two sets of per diems for residential treatment providers, one with educational services and one without. Another possibility is acceptance of the educational component based on inclusion in the residential claim, which would require the development of new revenue codes and system edits.

DMAS is also in the process of examining the potential inclusion of professional services that are currently paid separately from the residential per diem within the per diem based on additional CMS guidance. The agency would like to incorporate both modifications to the per diem rate concurrently, however, additional system edits will be necessary for this potential change as well, not to mention additional regulatory changes associated with this separate modification.

Implementation Timeline. The agency's goal for implementation of this coverage initiative is July 1, 2005. However, the regulatory and systems changes, as well as provider input on the approach and assumptions, make implementation by July 1, 2005 under the Fast Track regulatory process difficult, however not impossible. Emergency regulatory authority granted under the Appropriations Act would potentially allow implementation for SFY 2006 under a much more accelerated process, while at the same time allowing for further development of the approach both internally and with the input of other interested parties. Going forward with the Fast Track process as the only option for implementation by July 1, 2005 may be unwise, as the Fast Track process only moves on a fast track if interested parties do not have comments regarding the regulatory changes. Given the magnitude of this change, it may be unlikely that no comments will be received.

ATTACHMENT A

Item 326 GGG of the 2004 Appropriations Act. "Effective July 1, 2005, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to include reimbursement for required tuition payments for children receiving Medicaid-eligible residential services, provided such educational services are part of the treatment plan. The Department, in cooperation with the Office of Comprehensive Services, shall report by January 1, 2005, on the regulatory changes necessary to effect the inclusion of these new services under Medicaid and the related fiscal savings to the Comprehensive Service Act for At-risk Children and Youth program."