Department of Behavioral Health and Developmental Services
2014 Fiscal Impact Statement

1. **Bill Number:** HB574

House of Origin	☐	Introduced	☐	Substitute	☐ Engrossed
Second House	☐	In Committee	☐	Substitute	☒ Enrolled

2. **Patron:** Yost

3. **Committee:** Passed Both Houses

4. **Title:** Mandatory outpatient treatment

5. **Summary:** Extends the period that a person may be held pursuant to a temporary detention order (TDO) from 48 hours to 72 hours. The bill also provides that the community services board required to monitor a person who is the subject of a mandatory outpatient treatment order shall acknowledge receipt of the order within five business days. If the person's case is transferred to another jurisdiction, the community services board serving that jurisdiction shall acknowledge the transfer and receipt of the order within five business days.

6. **Budget Amendment Necessary**: No. The introduced budget (HB/SB30) included funding of $1,418,880 GF in FY 2015 and $1,721,788 GF in FY 2016 in order to fund the impact of the changes to the maximum period of temporary detention. The introduced budget, however, also assumed a minimum TDO period of 24 hours, which added additional costs. A budget amendment would be required in order to recoup the difference between the assumptions in the introduced budget and the implications of this bill.

7. **Fiscal Impact Estimates:** See item 8 below.

8. **Fiscal Implications:** This bill provides that a person held pursuant to a temporary detention order may be held no more than 72 hours. Currently, a person may be held pursuant to a temporary detention order for up to 48 hours.

The legislation would extend some of the inpatient hospital stays that are associated with the Temporary Detention Order (TDO) program and paid for by the Involuntary Commitment Fund, administered by the Department of Medical Assistance Services (DMAS). TDOs can start any day of the week and while some discharge dates do occur on weekend days most occur during the week, with added emphasis on Mondays, Wednesdays and Fridays. DMAS analyzed the current discharge dates of those TDOs that are lasting for approximately 48 hours and made the following assumptions. Seventy-five percent of those starting on a Saturday and ending on a Monday will receive an extra day. Ninety percent of those starting on a Sunday and ending on a Tuesday will be admitted an extra day. Seventy-five percent of those ending on a Wednesday will get an extra day. Ninety percent of those ending on a Thursday will get an extra day, and finally 10 percent of those TDOs ending on a Friday will get an extra three days, over the weekend. TDOs that currently have admission dates and discharge dates the same day, the following day, or longer than 48 hours due to a weekend or holiday are assumed not to receive

any extra days due to the extension to 72 hours. With these assumptions DMAS calculates an additional 12.5 percent increase in inpatient hospital bed days and uses that as an estimate of 12.5 percent in additional costs.

TDO payments have longer lags between service dates and claims payments than typical claims. DMAS has assumed the full effect of the extension to 72 hours would not be reached until five months after the start date of the proposed legislation. This lag is included in the FY 2015 fiscal impact. The fiscal impact for the extension to 72 hours is calculated at $956,254 GF in FY 2015 and $1,560,554 GF in FY 2016. The out-years beyond FY 2016 assume no growth.

Expenditure Impact:

Fiscal Year	*Dollars*	*Positions*	*Fund*
2014	-	-	-
2015	$956,254	-	General Fund
2016	$1,560,554	-	General Fund
2017	$1,560,554	-	General Fund
2018	$1,560,554	-	General Fund
2019	$1,560,554	-	General Fund
2020	$1,560,554	-	General Fund

The fiscal impact estimate for FY 2015 and FY 2016 is less than the funding included in the introduced budget. This is due to the fact that the bill does not include a 24-hour minimum for TDOs. No budget amendment is necessary because the introduced budget include sufficient funding to cover the cost of this bill; however a budget amendment is necessary in order to capture the savings.

The Involuntary Commitment Fund is responsible for reimbursing payments for acute care services for persons who have been involuntary detained under a TDO. TDOs are also paid for Medicaid members who receive the TDO at a facility that can bill Medicaid for that service. These TDOs are paid out of the Medicaid program but are not able to be distinguished as TDO initiated expenditures. While there would likely be some increase in Medicaid expenditures it would be minimal, difficult to estimate and is not included in this estimate. Likewise studies have shown that subsequent care is reduced due to extended TDO care. DMAS cannot identify any reduction in subsequent Medicaid expenditures and this effect has not been included in this estimate.

<u>Potential Savings</u>

Studies have shown that subsequent care, post-TDO, is reduced by extending the length of time individuals are subject to a TDO. It is thought that longer periods of time in a TDO allow for individuals to have the time to stabilize and be properly evaluated to determine the best treatment options for them. Therefore, post-TDO it is less likely that an individual would require inpatient hospitalization and more likely would receive outpatient treatment or services in the community. The primary study conducted on Virginia's TDO program was prepared for the Commission on Mental Health Law Reform in 2009. The study basically indicated that for FY 2010, extending

TDOs by 24-hours would result in 26,288 additional TDO days and a decrease of 24,506 hospitalization days for a net increase of 1,782 days.

The main issue with determining any potential savings is figuring out what payer would incur the savings. The state would only experience savings through its Medicaid program, which covers only about 12 percent of the state population. The fiscal impact in Section 7a on the Involuntary Commitment Fund utilizes different assumptions than the TDO study. The potential savings estimate uses the same data for the TDO costs and assumes Medicaid represents 20 percent of post-TDO hospitalization costs. Extrapolating the same impact from the TDO study results in the potential for 2,616 less post-TDO days paid for by Medicaid. Assuming a cost per day of $531.84 would generate total Medicaid savings of $1,391,449, of which half or $695,725 would be savings to the general fund, which is reflected in the table in Section 7b (the FY 2015 amount factors in the typical payment lag). It should be noted that these estimates could be higher or lower, but are presented to provide some idea of the savings impact.

Potential Savings*:

Fiscal Year	*Dollars*	*Positions*	*Fund*
2014	-	-	-
2015	$475,875	-	General Fund
2016	$695,725	-	General Fund
2017	$695,725	-	General Fund
2018	$695,725	-	General Fund
2019	$695,725	-	General Fund
2020	$695,725	-	General Fund

** Note that these savings estimates to the Medicaid program are based on several fairly general assumptions, and are included in this fiscal impact statement to provide a general idea of savings that might accrue to the Medicaid program from this bill. The cost of the bill is still expected to be greater than the savings presented in the table.*

9. **Specific Agency or Political Subdivisions Affected:** Courts, Community Service Boards, DBHDS

10. **Technical Amendment Necessary:** No.

11. **Other Comments:** This bill is identical to SB 439.