



Overview of Governor's Health & Human Resources Budget

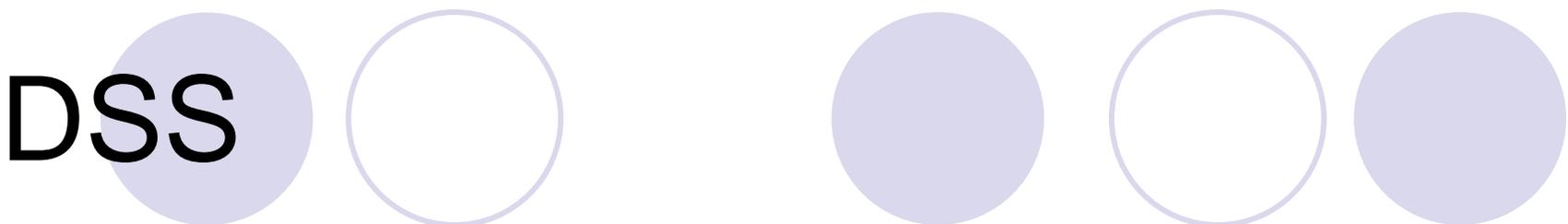
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Total HHR Budget Reductions

	FY 2009	FY 2010
General Fund Reduction	(\$201,526,122)	(\$316,717,087)
General Fund Revenue/Transfers	\$60,504,637	\$4,655,000
Total General Fund Impact	\$262,030,759	\$321,372,087
Total Position Level Changes	(220.00)	(804.00)
Total Layoffs	57	530

HHR Policy Principles

- Minimizing impact on direct services
- Priority on reducing central office and administrative positions vs. field staff whenever possible
- Decrease usage of contracts and P-14s
- Providing funding for initiatives critical to maintaining services, retaining accreditation, or supporting the healthcare workforce



DSS

- Initiatives

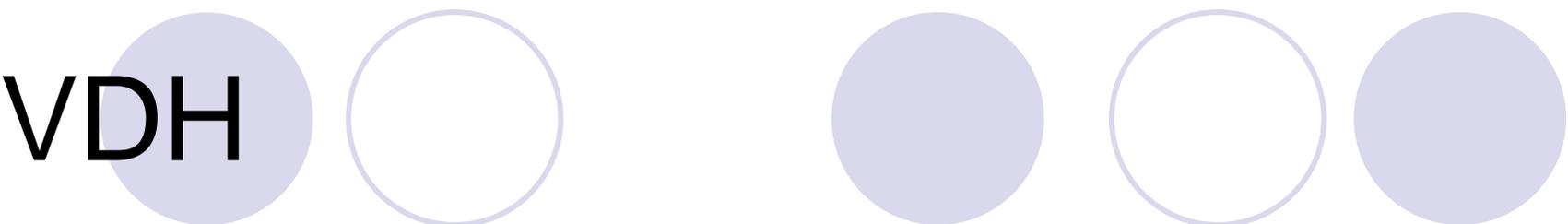
- Funding for Virginia Food Banks
- Language to modernize and web-enable eligibility determination system
- Budget neutral portable auxiliary grant pilot

- Reductions

- Eliminate vacant positions and reduce staffing levels
- Reduce foster care rate increase from 8% to 6%
- Use TANF funds to supplant GF—maintains funding for CAAs, Healthy Families, and child care programs

- Utilization of NGF Balances

- Title IV-E revenue surplus (\$16.8M)
- TANF child support collections—increase due to stimulus checks (\$19.6M)
- Food Stamp high performance bonus award (\$1.4M)
- Balance in CPS Registry Fund (\$500K)



VDH

- Central Office

- Eliminate vacant positions and reduce staffing levels
- Reduce discretionary spending
- Reduce aid to non-state entities
- Balances from Vital Statistics Automation Fund (\$2.0M)
- Balances from Water Supply Assistance Grant Fund (\$3.1M)

- Local Health Departments

- Eliminate vacant positions
- Reduce operating expenses
- Reduce allocation to two locally administered health departments



DMHMRSAS: Serving People with Intellectual and Developmental Disabilities

- Virginia has the opportunity to make a firm commitment to a community-based system of services and supports
- Closure of the most aged residential buildings and redeployment of capital funds into community housing is more cost effective and consistent with national trends, advocacy and individuals' rights
- Capital outlays for residential facilities will be limited to critical health and safety issues

DMHMRSAS Training Centers

- Large state-operated facilities are aging and need repair
- Costly to operate:
 - National Average - \$167,000 annually
 - Virginia Average - \$143,000 annually
 - Waiver with residential services - \$90,000 annually
- Virginia has high utilization of large state-operated facilities compared to other states
 - By 2010, 140 state facilities in the USA will have closed since 1970
 - By 2009, 9 states and D.C. will not operate large state-operated facilities – 11 other states have fewer than 200 people living in large state facilities. Virginia serves 1,276 in training centers
- Difficult to meet federal quality of care requirements in these large institutions

Training Center Actions

- Virginia moves from 5 to 4 MR facilities with the closure of SEVTC
 - Statewide census from 1,276 to 1,116
- Redirect \$23M capital bond at SEVTC and \$18.5M (\$43M allocated) capital bond at CVTC
 - Renovate 4-6 bed homes to be operated by CSBs or private contractors
- Access Money Follows the Person dollars (3:1 match)
- Serve People in the Most Integrated Setting:
 1. Reduce the number of people served in state facilities
 2. Cease the admission of children and all long-term admissions into state facilities
 3. Implement Money Follows the Person demonstration
 4. Increase system efficiency and improve quality of life

DMHMRSAS: Serving People with Mental Illness

- Need for public inpatient adult mental health beds not likely to decrease soon
 - Driven by forensics and complex adult cases
 - Virginia serves 1,439 in mental health hospitals
- Updating mental health hospitals (first ESH and WSH) is critical
 - Need to maximize efficiency/staffing in WSH design
- The private sector is a valuable partner in providing mental health services
 - Need to stimulate private services
- The state has been exiting child and adolescent care for the past 10 years

DMAS

- Minimize impact on direct services
- Maintain eligibility
- Protect physician and dentist and reimbursement
- Capture administrative savings
- Eliminate new services and waiver slots that have not been utilized
- Place cap on EDCD waiver
- Eliminate funds where there is no federal match