

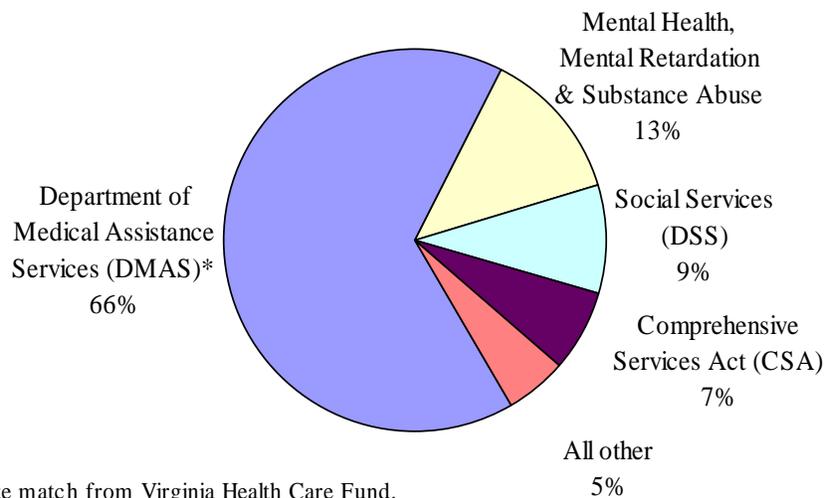
# Overview of HHR Spending

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- During the 2008-10 biennium, \$9.2 billion in state spending is budgeted for Health and Human Resources (HHR) programs.
  - HHR accounts for 26 percent of the Commonwealth's state spending.
- Four state agencies account for 95 percent of spending within Health and Human Resources.

## 2008-10 State Spending on HHR Agencies

(\$9.2 billion from the general fund)



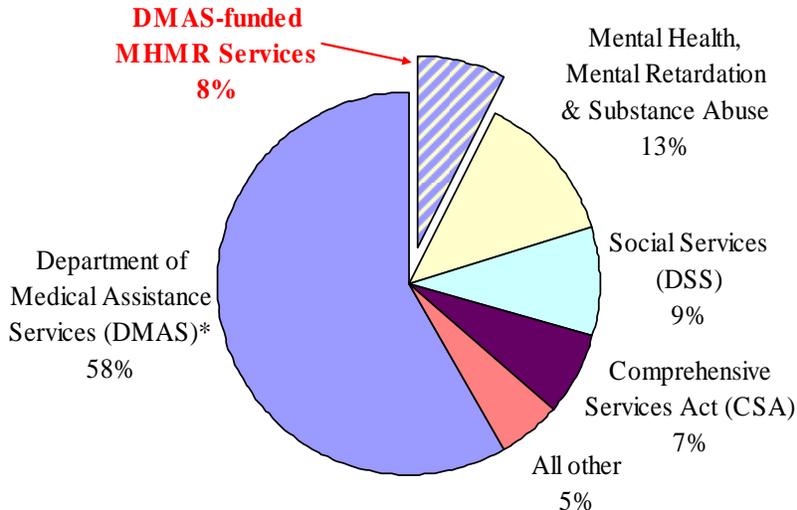
- The Department of Medical Assistance Services accounts for two-thirds of every state dollar spent in HHR.

# Medicaid Funding for Mental Health and Mental Retardation Services is Significant

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## 2008-10 State Spending on HHR Agencies

(\$9.2 billion from the general fund)



\* Includes state match from Virginia Health Care Fund.

- Payments made on behalf of individuals with mental illness and mental retardation make up a significant share of DMAS' spending.
- Medicaid-funded mental health and mental retardation (MHMR) services account for eight percent of HHR spending.
  - MHMR services are among the fastest growing expenditures within Medicaid.

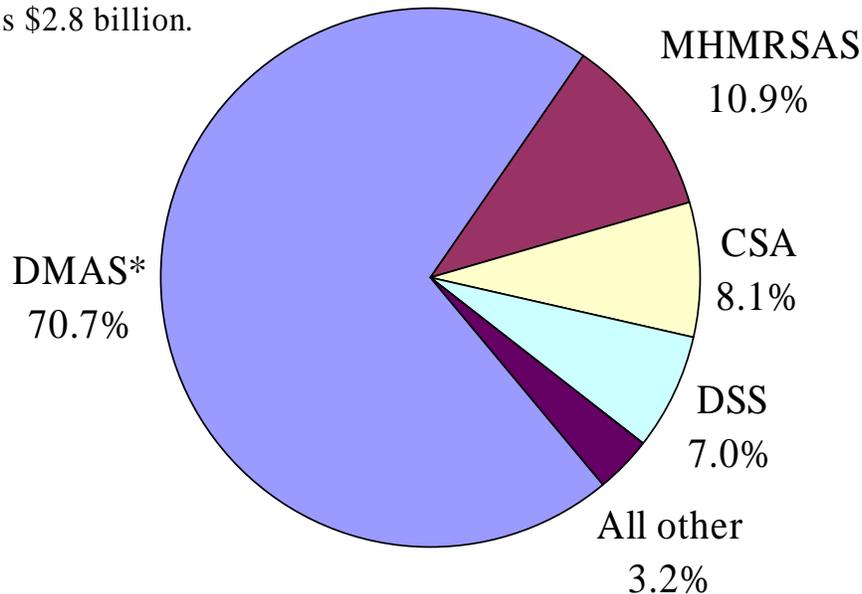
# Four Agencies Account for Growth in HHR

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- Four agencies explain virtually all (96.8 percent) of the growth in state spending in HHR since FY 1998.

## HHR Agencies Contributing to Growth since FY 1998

Increase in state spending equals \$2.8 billion.



\* Includes state match from Virginia Health Care Fund.

- Medicaid explains 71 percent of spending growth within HHR during this period.
- While spending at DMAS has increased 8.5 percent each year since FY 1998, it is not the fastest growing program.

# CSA is the Fastest Growing Program in HHR

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- General fund spending on the Comprehensive Services Act for At-Risk Youth and Families (CSA) increased from \$101 million in FY 1998 to \$324 million in FY 2010.

Comparison of HHR Agency Growth Rates



\* Includes state match from the Virginia Health Care Fund.

- Per capita spending in CSA has nearly doubled since 1998 at the same time caseloads grew by 62 percent; increasingly complex cases and expensive residential placements explain much of the growth.
  - Enrollment has been relatively flat until recently.
- Unprecedented fiscal policy actions were taken last session to facilitate placements in less expensive, community-based settings.

## Policy Choices Also Contribute To Rising Spending

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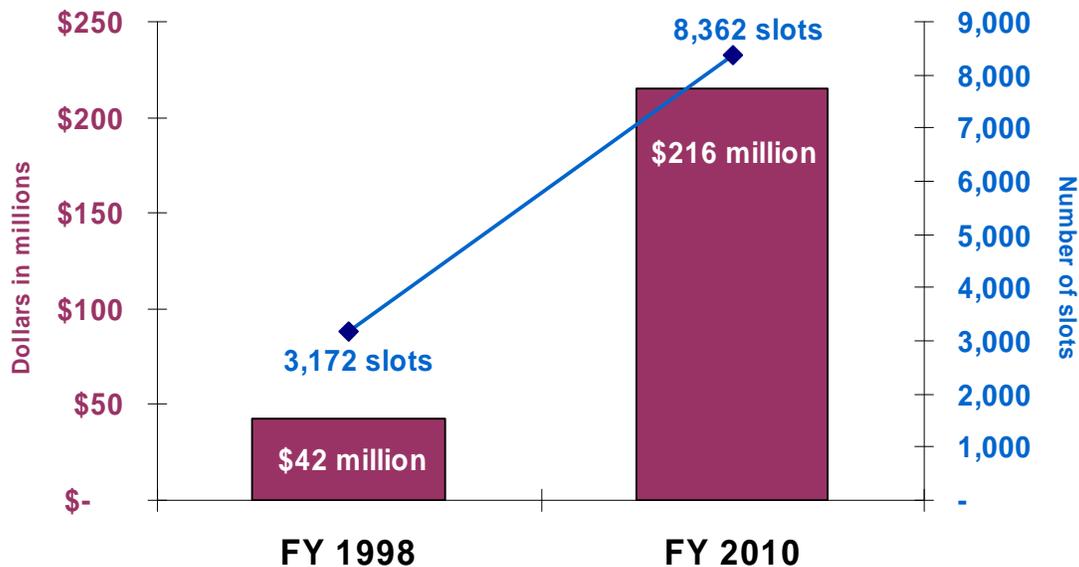
- Current law -- state and federal -- dictate many fiscal policy decisions in health and human resources.
- In Medicaid, the “forecast” recognizes the cost of continuing services based on anticipated changes in enrollment and per capita spending, which is a function of price, volume, and intensity.
- Last week, a new Medicaid forecast was issued indicating that increased enrollment and rising costs will require an additional \$325 million GF during the current biennium.
  - Last session, the General Assembly appropriated \$352.3 million from the general fund to accommodate anticipated Medicaid growth.
- Discretionary decisions reflect choices made to address ongoing or emerging policy issues.
  - Last session \$41.6 million GF was appropriated to improve the Commonwealth’s civil commitment process and strengthen the community-based mental health system in the wake of the tragedy at Virginia Tech in April 2007.

# Discretionary Spending on the Mental Retardation Waiver Program

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- Last year \$41.6 million GF was appropriated to expand the mental retardation (MR) waiver program by:
  - Adding 600 mental retardation waiver slots;
  - Increasing provider rates by 3.6 percent; and
  - Allocating start-up funding for new waiver slots.
- Since 1998, enrollment in the MR waiver program has more than doubled from 3,172 to 8,362 at a cost to the general fund of \$172 million – a five-fold increase.

**General Fund Growth in the  
Mental Retardation Waiver Program**



## HHR Spending Will Likely Continue To Rise

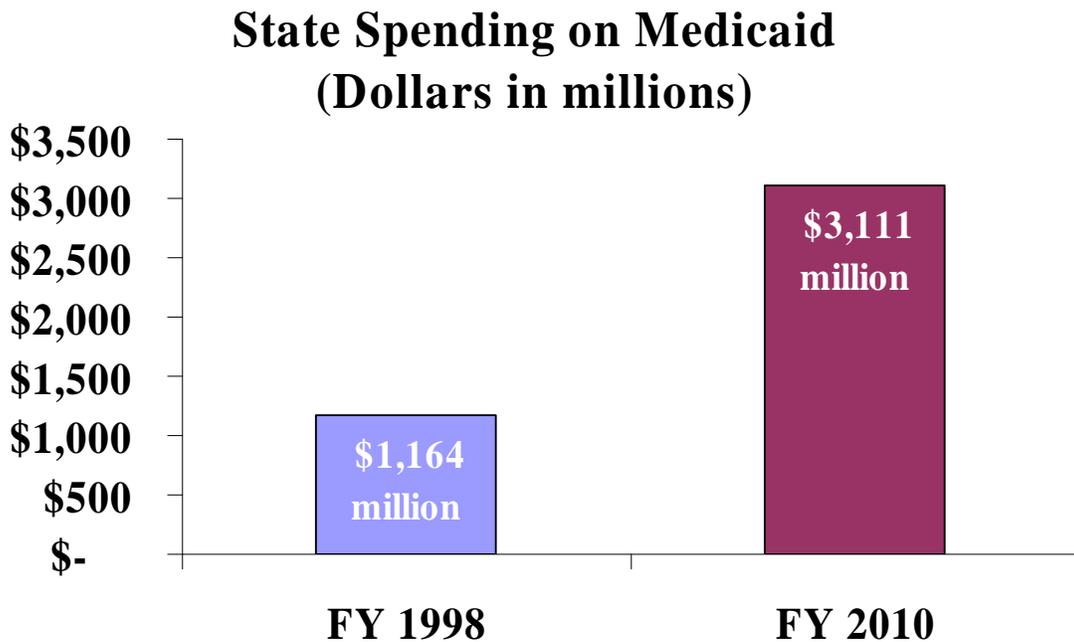
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- Medicaid is projected to grow 8.0 percent annually during the next ten years due to a combination of increasing enrollment, especially among the elderly and disabled, and rising per capita spending.
  - Because enrollment in Medicaid is counter-cyclical with the economy, caseloads are rising as the Commonwealth's economic conditions worsen.
- The cost of providing CSA services for children and youth is also expected to rise, exceeding 10 percent each year of the current biennium.
- Higher spending on Medicaid and CSA combined with lower revenues will place additional financial pressure on other state programs.
- As the largest program within HHR, Medicaid will likely be targeted for budget reductions.
  - What is Medicaid?
  - Who is enrolled and what services do enrollees receive?
  - How much has Medicaid grown and why?
  - What options are available to control rising costs?

## Medicaid: Three Programs in One

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- Medicaid provides health and long-term care services to low-income Virginians. It is a:
  - 1) Health insurance program for low-income families, primarily children and pregnant women;
  - 2) Funding source for individuals with significant disabilities; and
  - 3) Long-term care program for the elderly.

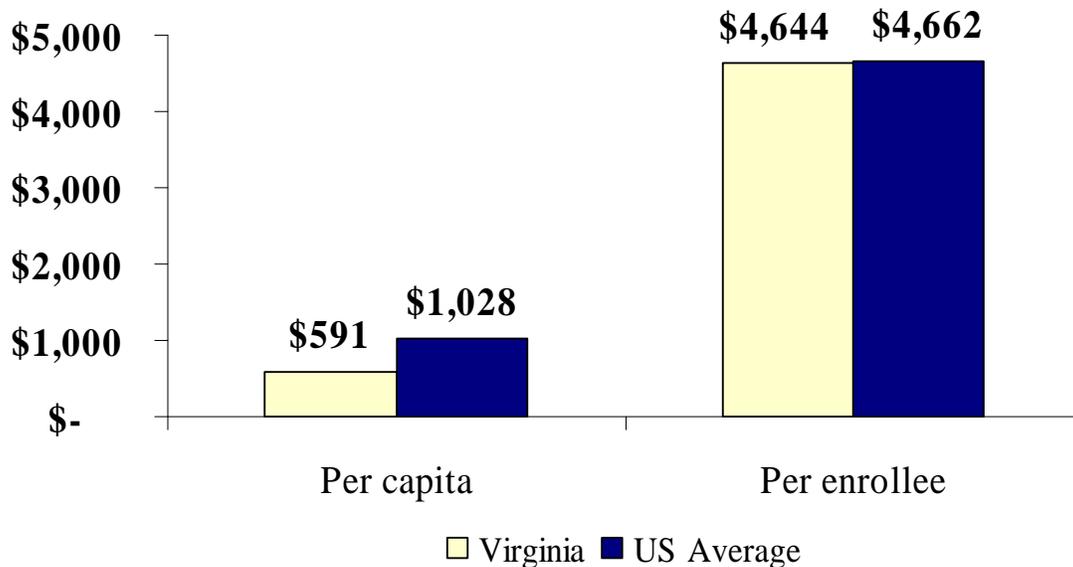


- Medicaid spending growth trailed the national average from 1990 through 2004 but exceeded it from 2004 through 2006.

# Virginia Spends Less on Medicaid Than Other States

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**Medicaid Spending Compared to U.S. Average**



- Virginia ranks 48<sup>th</sup> among its peers in terms of per capita Medicaid spending.
  - Fewer residents are enrolled in Medicaid (8.9 percent) compared to the U.S. average (15.0 percent).
- Virginia ranks 31<sup>st</sup> in Medicaid spending per enrollee, slightly less than the national average.

## Who receives Medicaid?

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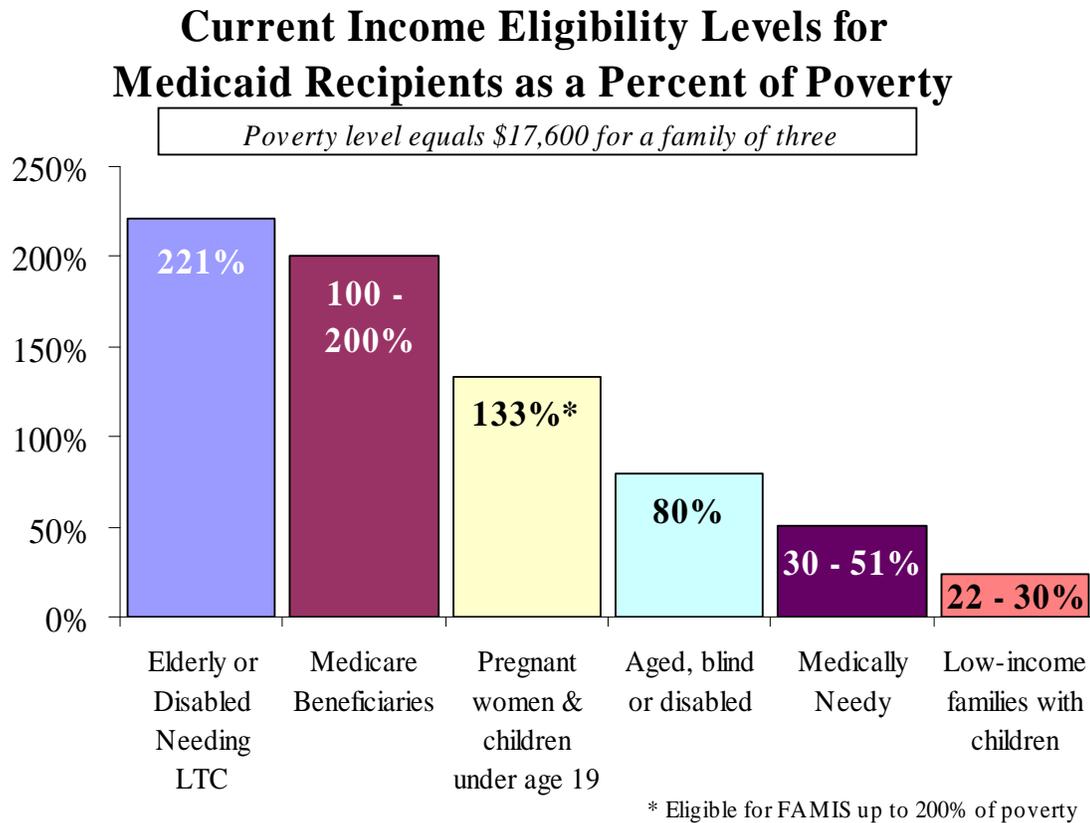
- The federal government requires states to serve certain mandated populations to receive matching funds.
  - A national survey found that 71 percent of Medicaid enrollees are mandatory.

<b>Mandatory Population Groups</b>
Aged, blind, or disabled
Member of a family with children
Low-income children and pregnant women
Certain Medicare beneficiaries with incomes less than 135% of federal poverty guidelines (FPG)

- Mandatory groups must also meet financial criteria (e.g., income and resource) to be eligible for Medicaid.
- States that choose to expand coverage beyond “mandatory population groups” are eligible for federal Medicaid matching funds.

<b>Optional Population Groups</b>
“Medically needy” individuals whose income exceeds Medicaid limits but who are impoverished by medical bills
Individuals who are at-risk of needing nursing home or an ICF-MR level of care without home- and community-based waiver services
Aged, blind, or disabled with income under 80% of FPG
Nursing home residents with income under 300% of SSI (221% of FPG)
Children under 21 in foster homes, private institutions, or subsidized adoptions
Women screened and diagnosed with breast or cervical cancer

# Income Eligibility Levels Vary Considerably



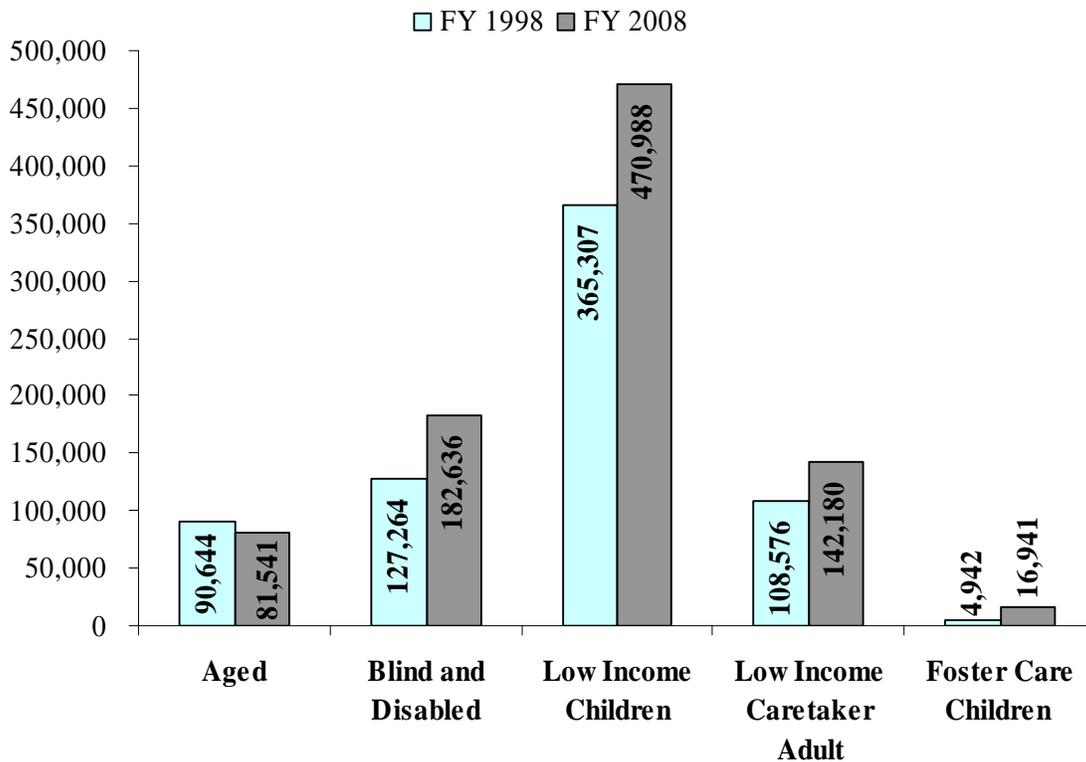
- Income eligibility levels range from:
  - 221 percent of federal poverty guidelines or \$1,911 per month for an individual who is aged, blind or disabled needing long-term care services;
  - 22 to 30 percent of poverty for low-income families with children based on historic Aid to Families with Dependent Children (AFDC) standards from 1996 that vary from \$325 to \$434 per month for a family of three.

# Individuals Who Are Blind and Disabled Are Driving Caseload Growth in Medicaid

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- In 2008, 894,286 individuals were eligible for Medicaid services, an increase of 197,553 or 28 percent since 1998.
- Children represent the largest group in Medicaid, but caseloads have increased more rapidly among the blind and disabled -- 44 percent compared to 29 percent.

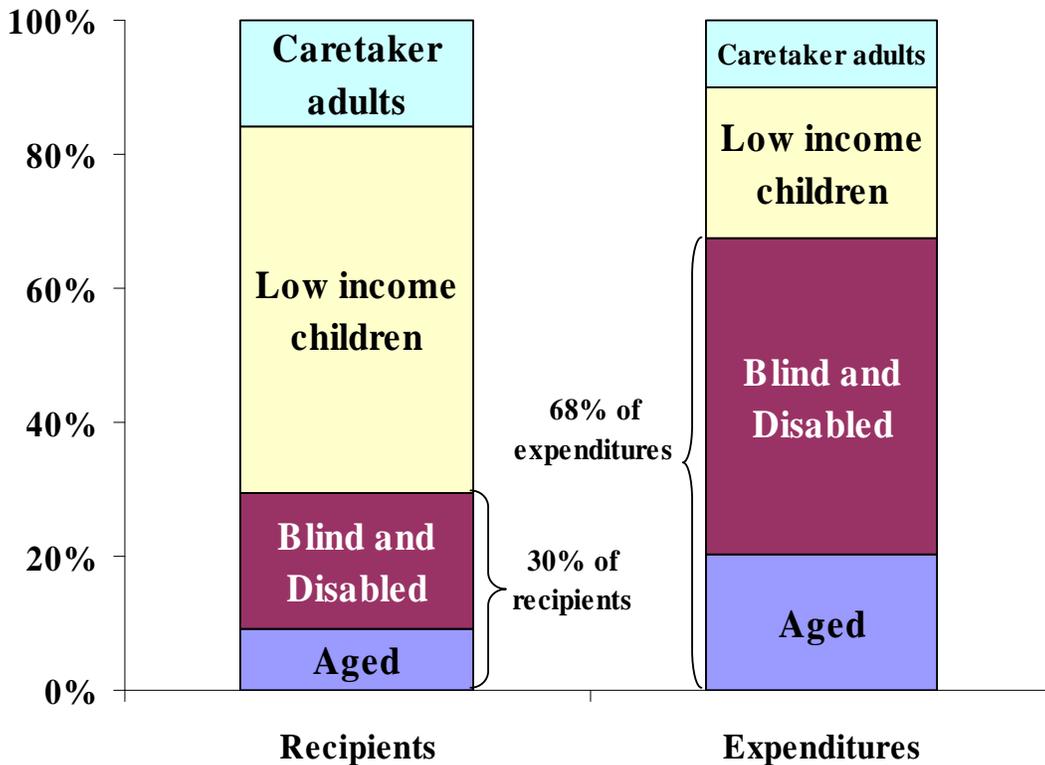
**Medicaid Enrollment by Population Group**



# Medicaid Spending Is Heavily Weighted Toward the Aged, Blind and Disabled

- Low-income children make up 53 percent of recipients but only 21 percent of expenditures.
- The aged, blind and disabled, on the other hand, account for only 30 percent of recipients but more than two-thirds of expenditures.

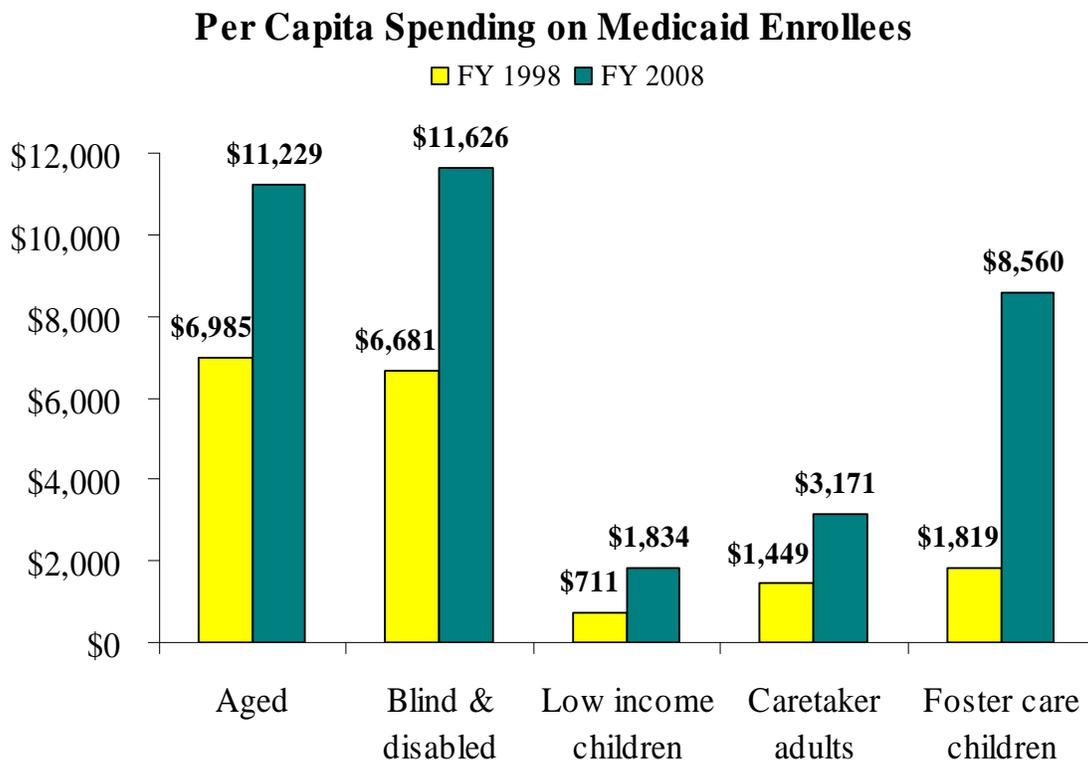
Medicaid Recipients and Expenditures (FY 2008)



## Per Capita Spending Is Highest for Recipients Who Are Elderly and Disabled

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- Medicaid services for the aged, blind, and disabled are 3 to 6 times higher than low-income children and caretaker adults.
  - The aged, blind and disabled typically require more intensive and expensive services, over a longer period of time, than families and children.
- Per capita spending on children in foster care increased almost five-fold since 1998 as the cost and utilization of residential treatment services has risen.



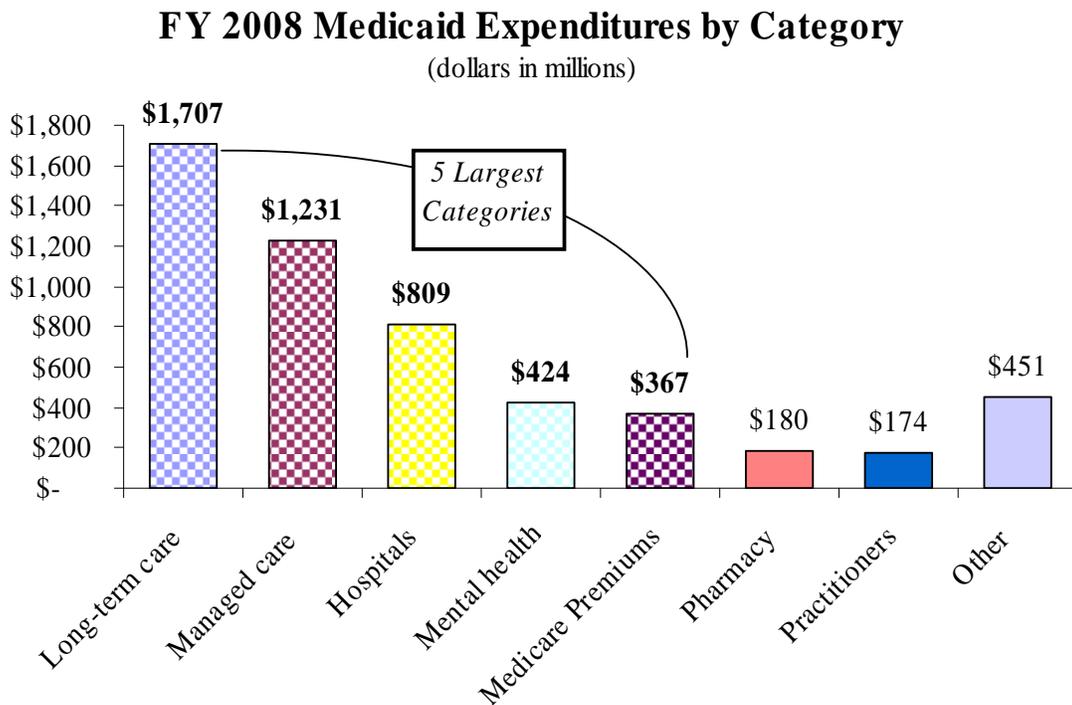
# What Services Does Medicaid Provide?

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- Federal law requires states to provide certain mandatory services to Medicaid beneficiaries.
  - It is estimated that 60 percent of Medicaid expenditures are “optional.”

<i>Mandatory Services</i>
<b>Hospital services</b>
<b>Nursing facility services</b>
<b>Physician services</b>
<b>Medicare premiums, copays and deductibles (Part A and B)</b>
Certified Pediatric Nurse & Family Nurse Practitioner Services
Early & periodic screening, diagnostic, and treatment (EPSDT)
Certain home health services (nurse, aide, supplies and treatment services)
Laboratory and X-ray services
Nurse midwife services
Rural health clinics and federal qualified health center clinic
Family planning services and supplies
Transportation
<i>Optional Services</i>
<b>Prescribed drugs</b>
<b>Mental health and mental retardation services</b>
<b>Home &amp; community-based waivers</b>
<b>Medicare premiums, copays, and deductibles (Part B - medically needy)</b>
Dental and skilled nursing facility care for persons under age 21
Clinical psychologist
Services provided by certified pediatric nurse and family nurse practitioner
<b>Intermediate Care Facilities for the Mentally Retarded (ICF/MRs)</b>
Optometry, podiatry, and home health services (PT, OT, and speech therapy)
Certified pediatric nurse and family nurse practitioner services
<b>Case management services</b>
Prosthetic devices
Other clinic services
Substance abuse treatment
Hospice
<b>* Bold denotes one of 10 largest Medicaid service expenditures.</b>

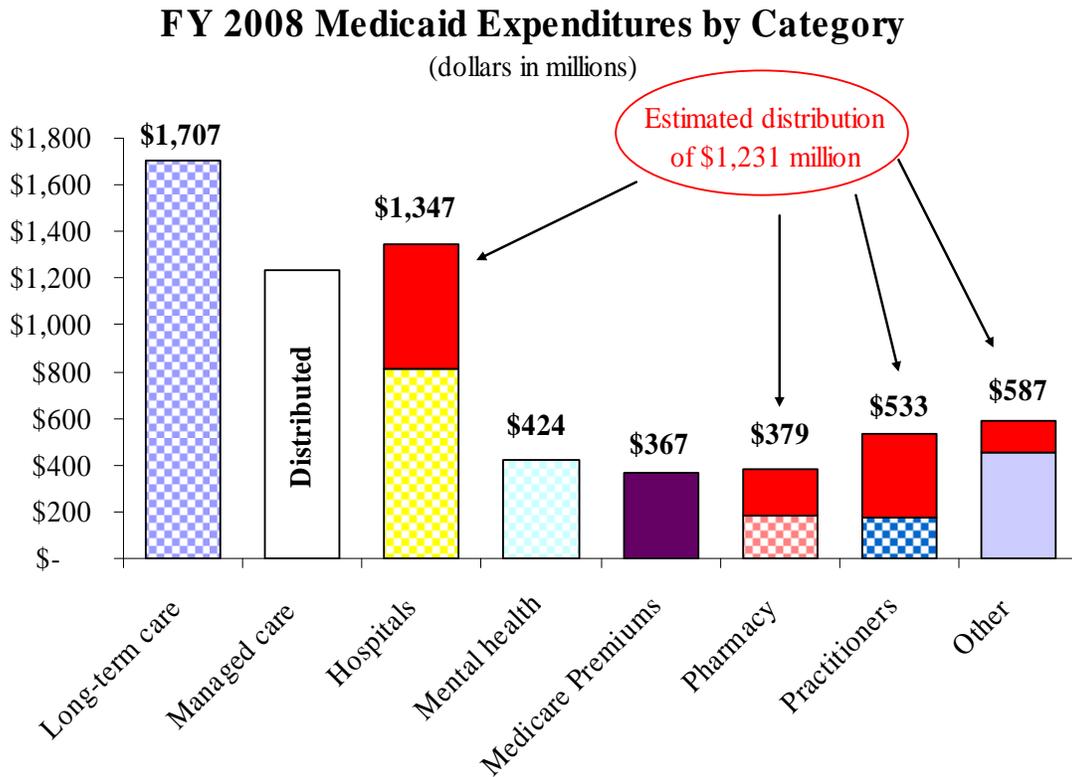
## Five Medicaid Service Categories Accounted for 85 Percent of Spending in FY 2008



- **Long-term care services** such as nursing home care, intermediate care facilities for persons with mental retardation (ICF-MR), and community-based waiver services account for 32 percent of overall spending.
- Capitated or fixed payments to **managed care** companies comprise 23 percent of spending.
- Inpatient, outpatient, and emergency **hospital services** make up 15 percent of Medicaid expenditures.
- **Mental health** services and **Medicare premiums** make up an additional 15 percent of spending combined.

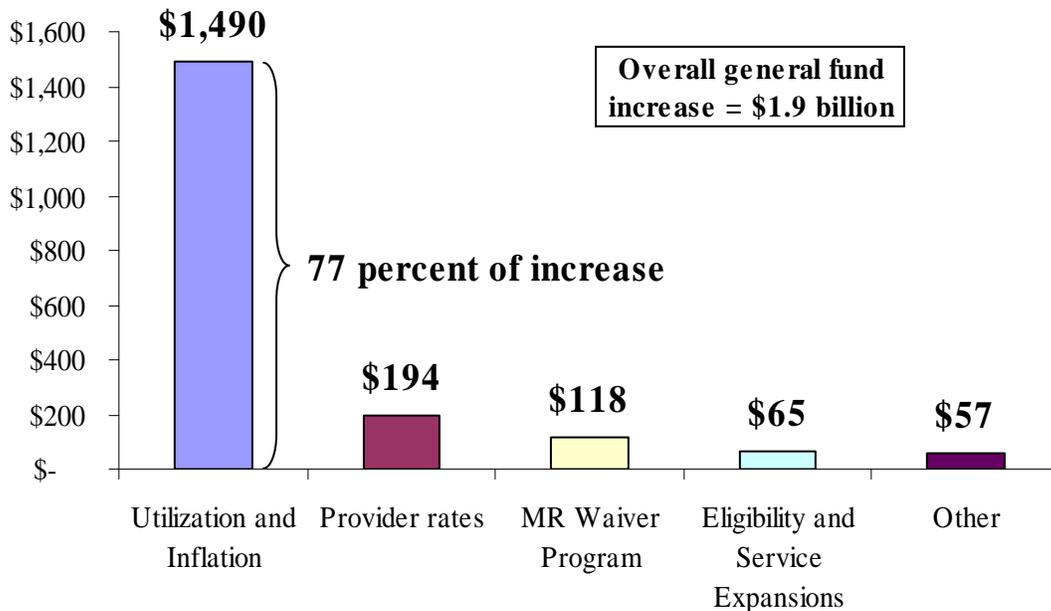
# Managed Care Pays for Hospital Services, Physician Visits and Prescription Drugs

- Payments to managed care companies are distributed across service categories including hospital services (44%), provider payments (29%), prescribed drugs (16%) and other services (11%).



# Utilization and Inflation Explain Most New Spending in Medicaid

Medicaid Spending Growth since FY 1998

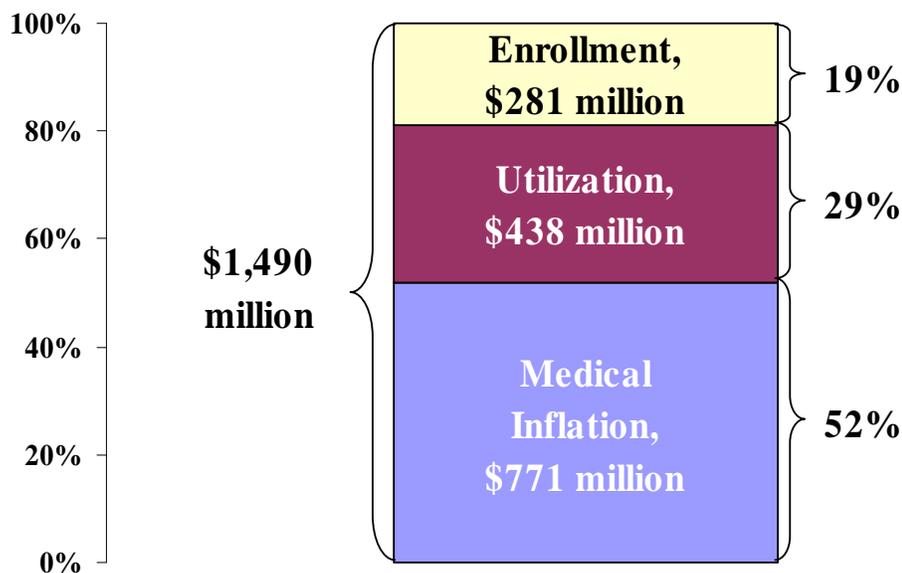


- Utilization and inflation or “the forecast” updates projected spending based on trends in enrollment and per capita costs but also prior-year policy decisions.
  - In 2005, dental service rates increased 30 percent at a cost to the general fund of \$7.8 million but spending on dental services is expected to grow by \$36.3 million through FY 2010.
  - Additional general fund appropriations for the MR waiver program (\$118 million) far exceeds the difference in projected expenditures from 1998 to 2010 (\$177 million), primarily reflecting increases in per capita spending.

# Medical Inflation Explains Most of the Growth in Forecasted Medicaid Spending

- The General Accounting Office indicates that health care spending per capita, a function of medical price inflation and utilization, increased 6.9 percent annually from 2000 through 2005.
  - Medical price inflation has increased, on average, 4.4 percent a year.
  - Utilization, the volume and intensity of health care services consumed, increased 2.5 percent a year.
- Applying these factors to Virginia’s Medicaid program suggests that medical inflation accounts for 52 percent of spending since 1998.

**Explanation of Medicaid Utilization and Inflation**



# Advances in Medical Technology Are Driving Health Care Spending

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- Health economists and policymakers agree that medical advances are driving utilization and costs in health care.
- Increasingly, medicine is available to treat the rising prevalence of chronic disease such as asthma, diabetes and heart disease, contributing to higher health care costs.
  - Spending on statins to treat high cholesterol increased 156 percent between 2000 and 2005.
  - Spending on diabetes drugs doubled in six years, despite the lack of strong evidence that the new drugs are superior to older generation medications.
- As medical advances are diffused and incorporated into clinical practice, more individuals receive “state of the art treatment”, raising overall health care costs.
- Managed care entities indicate that outpatient services, physician payments and pharmacy services have increased between 10 and 18 percent in recent years.
- Virginia hospitals note that the acuity of patients discharged increased 39 percent from 2001 to 2006.

## Policy Decisions Account for Twenty-Three Percent of Recent Medicaid Growth

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- At least, twenty-three percent of the growth in Medicaid since 1998 can be attributed to policy decisions.
  - Payments to providers, such as hospitals, nursing homes, physicians, dentists and personal care attendants, account for \$194 million of Medicaid growth.
  - Additional mental retardation (MR) waiver slots as well as payments to MR waiver providers account for \$118 million of the general fund growth in Medicaid spending.
  - Eligibility and service expansions accounted for \$65 million of Medicaid growth since 1998 including:
    - Providing services to children in residential facilities;
    - Expanding coverage for children with developmental disabilities;
    - Increasing access to the elderly and disabled up to 80 percent of poverty; and
    - Including substance abuse treatment, organ and bone marrow transplants and cancer treatment.

# Growth in Medicaid Spending Has Not Gone Unnoticed

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- As Medicaid spending has risen, repeated attention has been paid to cost-containment measures.
- Cost-savings strategies have been implemented in recent years to “bend the curve” in Medicaid including:
  - The integration of acute and long-term care for seniors and individuals with disabilities to improve care coordination and reduce hospitalizations;
  - The allocation of enhanced federal funding to create community-based services for up to 290 individuals residing in long-term care settings;
  - The creation of disease management programs to better manage chronic conditions such as asthma, diabetes, and heart disease; and
  - The establishment of various strategies to control the rising cost of prescription drugs including: a) drug utilization review, b) preferred drug list, c) specialty drug program, and d) maximum allowable cost program.

# No Single Bullet Will Limit the Growth of Medicaid Spending

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- A combination of short- and long-term strategies will be needed to help balance the current budget and restrain the rising cost of Medicaid in future years.
  - **Immediate savings strategies** typically involve changes to provider payments, eligibility levels, or benefits to recipients.

<b>Possible Medicaid Savings Strategies</b>
<b>Freeze or reduce provider rates</b> <ul style="list-style-type: none"><li>- Eliminate inflationary increases</li><li>- Analyze current rates to ensure payment levels are appropriate</li><li>- Create incentives for providers to meet certain policy goals/withhold funding if benchmarks are not met</li></ul>
<b>Restrict or eliminate access to certain services</b> <ul style="list-style-type: none"><li>- Require prior approval for high-cost services</li><li>- Assess recent trends in service utilization to eliminate possibility of improper billing and monitor use of high-cost services</li></ul>
<b>Tighten or eliminate eligibility for optional populations</b> <ul style="list-style-type: none"><li>- Pare back coverage for the medically needy</li><li>- Reduce eligibility for the elderly and disabled with income under 80 percent of poverty</li><li>- Freeze enrollment for community-based waivers</li></ul>
<b>Increase cost-sharing to encourage/discourage behavior</b> <ul style="list-style-type: none"><li>- Impose co-pays for non-emergent ER visits</li></ul>

# Longer-term Medicaid Savings Strategies

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- Longer term savings strategies may require up-front investments.
  - “Structural” cost-savings are frequently uncertain and difficult to reflect in the current budget.

<b>Possible Medicaid Savings Strategies</b>
<p><b>More effectively manage high cost patients</b></p> <ul style="list-style-type: none"> <li>- Ensure compliance with disease management programs</li> <li>- Enroll foster care children into managed care</li> <li>- Review utilization for mental health services</li> </ul>
<p><b>Reduce reliance on institutional settings for long-term care</b></p> <ul style="list-style-type: none"> <li>- Construct smaller, community-based mental health facilities to generate federal Medicaid funds</li> </ul>
<p><b>Emphasize personal responsibility in health care decisions</b></p> <ul style="list-style-type: none"> <li>- Expand benefits for compliance with policy goals/ restrict benefits for non-compliance</li> </ul>
<p><b>Encourage use of Health Information Technology (IT)</b></p> <ul style="list-style-type: none"> <li>- Reward providers for adopting Health IT/ withhold payments for non-compliance</li> </ul>
<p><b>Create a public-private partnership to evaluate the cost-effectiveness of new medical technology - “What treatment’s work best, and how do you use them?”</b></p> <ul style="list-style-type: none"> <li>- Develop clinical guidelines for providers to follow</li> <li>- Limit or eliminate payments for certain services</li> </ul>

## Conclusion

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- Four agencies within the Health and Human Resources Secretariat account for 95 percent of current spending and virtually all of the recent growth.
- Medicaid is not only the largest program within HHR but also one of the fastest growing.
  - Medicaid provides health insurance for low-income families and children and long-term, chronic care for the elderly and disabled.
- The elderly and disabled make up less than one-third of the Medicaid population but 68 percent of the cost.
- Compared to other states, Virginia covers fewer individuals and spends slightly less per enrollee.
- As the largest program within HHR, Medicaid will likely be targeted for budget reductions.
- Demand for Medicaid services tends to rise, especially among low-income families and children, during periods of economic instability.
- Balancing the current budget will likely involve short-term strategies, but “bending the curve” in the future will necessitate thoughtful consideration of longer-term options.