Health and Human Resources

Senate Finance Committee
November 19-20, 2009

Introduction

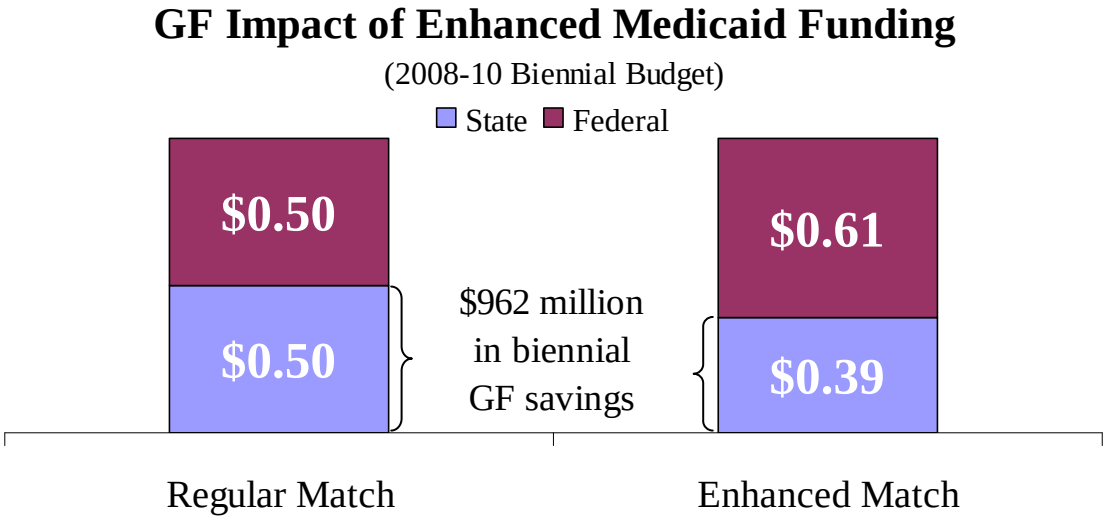
- When the 2008-10 biennial budget was signed into law in May 2008, state spending for Health and Human Resources (HHR) totaled $9.2 billion.

- A year later, general fund spending was reduced by $833 million to $8.4 billion. Net reductions included:

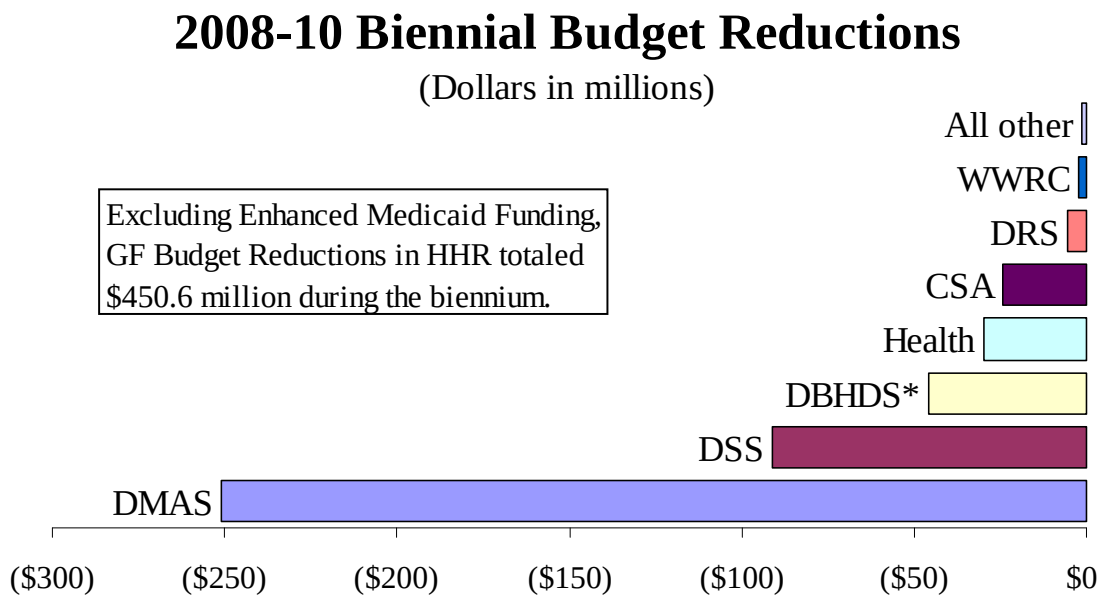
  – Decreases across HHR totaling $1.3 billion; and

  – Increases of $484 million for forecasted growth in Medicaid and FAMIS and several modest spending initiatives.

- The federal government temporarily increased its share of Medicaid spending from 50 to 61 cents, allowing the Commonwealth to reduce its share of spending from 50 to 39 cents, resulting in general fund savings to offset rising Medicaid costs and declining GF revenues.



Increased Federal Funding and Delayed Payments Minimized Reductions in HHR



* Formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services.

- More than one-half of the biennial GF reductions at the Department of Medical Assistance Services and the Department of Social Services were achieved through the use of federal funds or delayed payments.

- Substantive reductions have occurred in HHR.

  – Funding was eliminated for the Indigent Health Care Trust Fund and the State and Local Hospitalization Program; and

  – Resources provided to Community Services Boards were reduced by 5 percent and 43 central office staff laid off in DBHDS' Central Office.

HHR Dodged A Bullet in 2009

- The infusion of nearly one billion dollars from enhanced federal Medicaid funding – even though all of it did not stay within HHR – minimized the need for deeper cuts during the 2009 Session.

  – Federal funding was designed to help states deal with rising Medicaid caseloads at the same time general fund revenues were becoming scarcer.

- Swapping out general fund appropriations with federal Medicaid dollars in FY 2010 created a structural GF gap for the program in the FY 2010-12 budget.

  – The "cliff effect" for Medicaid, reflecting the reduction to the general fund base in FY 2010, only gets steeper with increased enrollment in health care programs that serve low income Virginians.

- This funding gap will require:

  – An examination of the investments made in HHR in recent years;

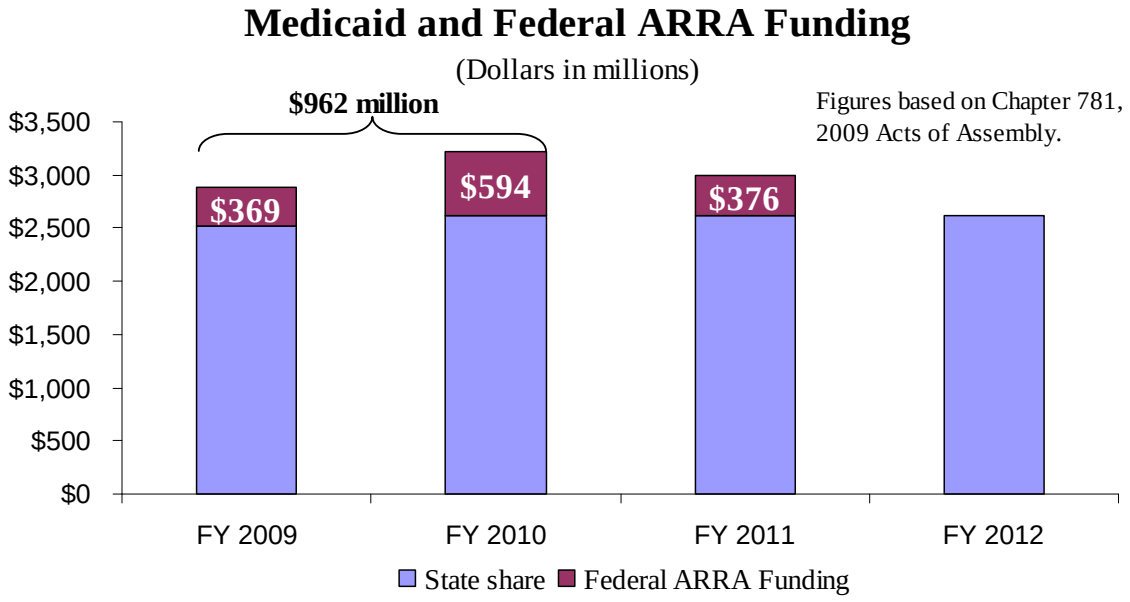
  – A review of budget cuts that have already been enacted; and

  – New reductions when the demand for health care and social services is at historic levels.

Enhanced Medicaid Funding, the "Cliff Effect," and the Forecast

Enhanced Federal Medicaid Funding

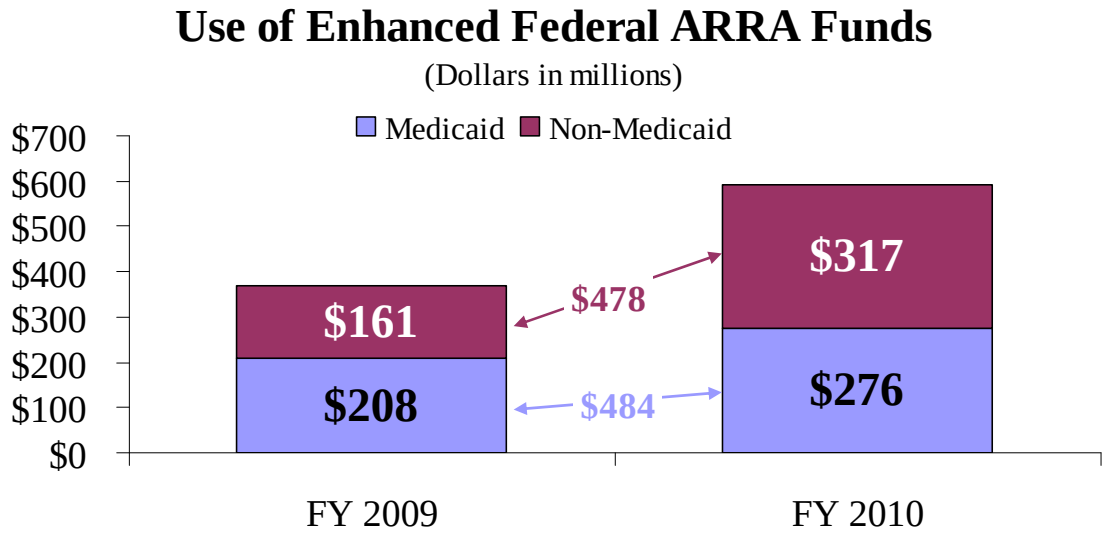
- The American Recovery and Reinvestment Act of 2009 boosted the federal share of Medicaid spending while reducing the state's share, resulting in general fund savings of $962 million this biennium.



- As the nation's economy stagnated last winter, the federal government temporarily increased its share of Medicaid spending, as it had in 2003, in effect reducing the Commonwealth's obligation to the program.
  - Enrollment in Medicaid is "counter-cyclical" – caseloads tend to rise as unemployment increases.
  - Federal dollars were also substituted for state general fund spending in other areas including foster care and child support.

Enhanced Federal Medicaid Funding and Maintenance of Effort Requirement

- Enhanced federal funding freed up state general funds that were used primarily for forecast-related expenditures of $463 million in Medicaid and FAMIS but also $21 million to provide a few modest increases.

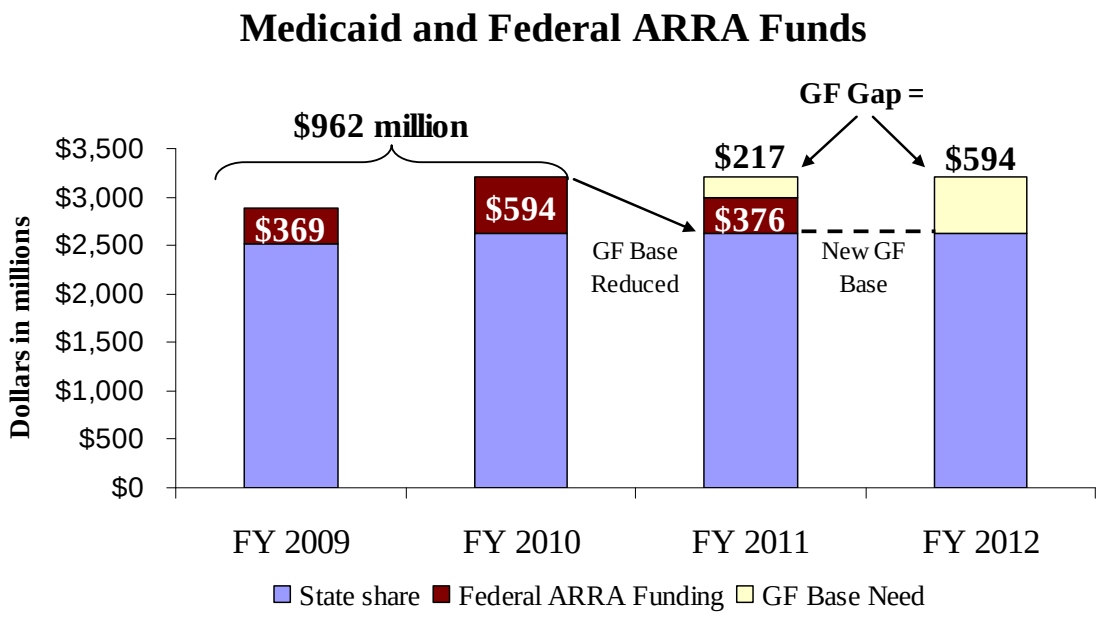


- The balance of $478 million was used to backfill the loss of general fund revenues from the revised February 2009 forecast and forestall further reductions.

- Increased federal funding and the imposition of a maintenance of effort requirement prohibiting reductions to eligibility through December 31, 2010 immunized Medicaid from further budget reductions.

Medicaid Funding's "Cliff Effect"

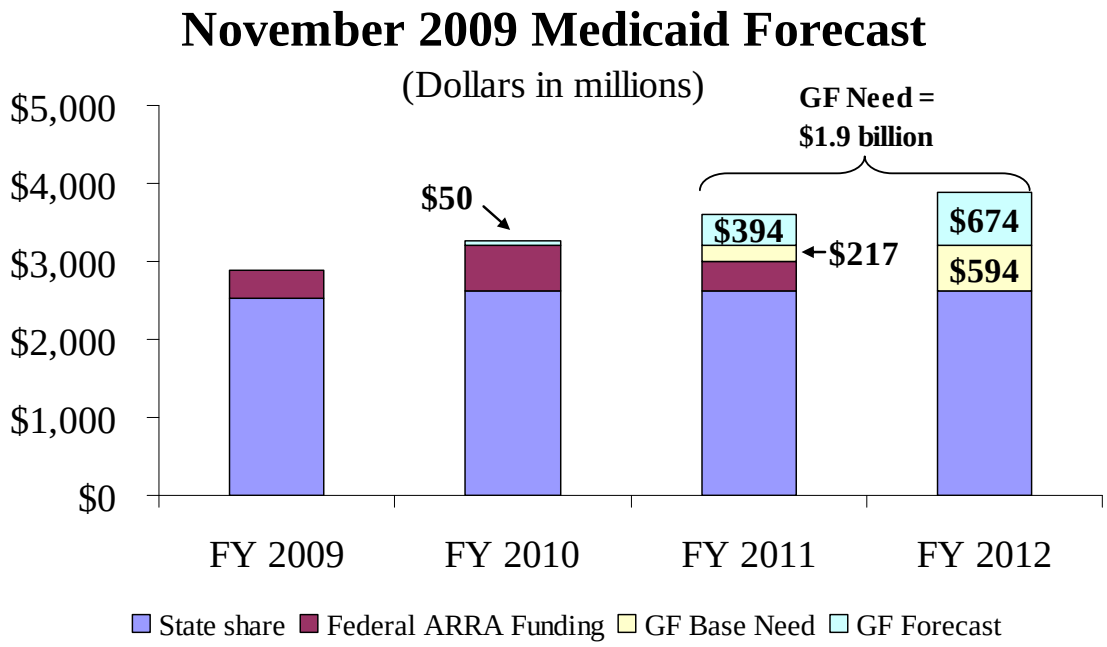
- Enhanced federal funding allowed the Commonwealth to reduce its general fund commitment to Medicaid by $594 million in FY 2010.



- Based on current law, a minimum of $811 million GF must be restored during the FY 2010-12 biennium to maintain funding for the Medicaid program.
  - Providing less than $811 million will require legislation or budget amendments to achieve savings within Medicaid.
- These figures **do not** reflect projected increases in Medicaid enrollment due to the current recession.

Projected Increases in Medicaid Will Require $1.1 Billion from the General Fund

- In addition to restoring $811 million GF, the recently released Medicaid forecast will require the addition of $1.1 billion to address rising caseloads and costs.



- Double-digit Medicaid expenditure growth in FY 2010 is expected to continue in FY 2011 (11 percent) and moderate somewhat in FY 2012 (8 percent).
  - Average monthly caseload growth has nearly tripled from 0.4 percent in FY 2008 to 1.1 percent in FY 2010 for non-disabled adults and children.
- Capitated payments to Medicaid managed care organizations are expected to rise 12 percent in FY 2011.

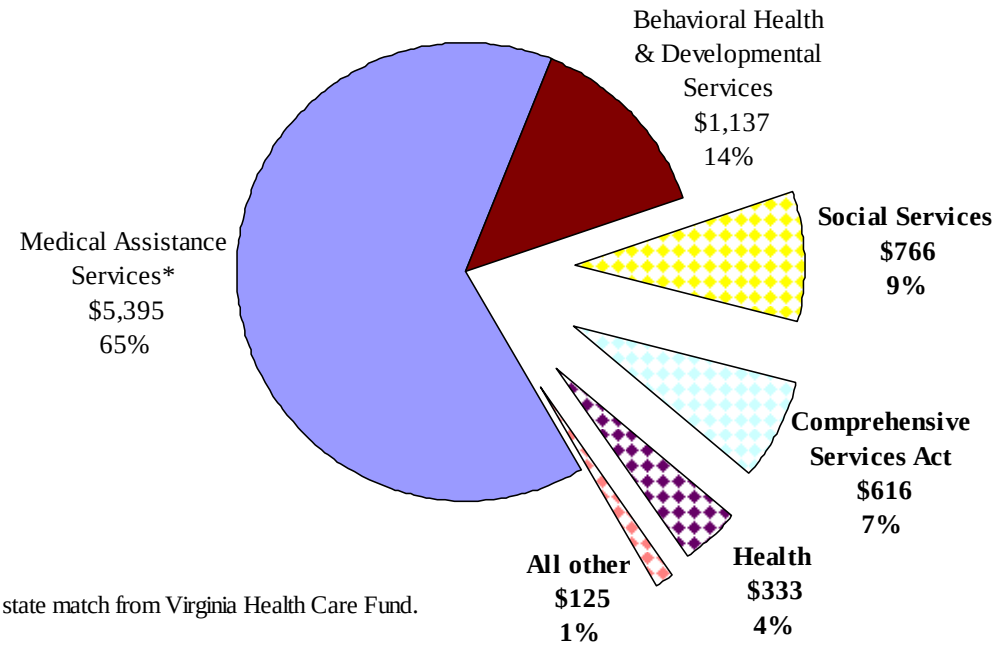
Fiscal Implications of Disappearing Federal Support and November Medicaid Forecast

- The combined effect of federal support that is drying up and projected increases in Medicaid make it highly unlikely that HHR alone can absorb the reductions necessary to close the funding gap.

  – For example, you would have to eliminate funding for all HHR agencies except DMAS and DBHDS to save approximately $1.9 billion.

2008-10 State Spending on HHR Agencies

(Dollars in millions)



* Includes state match from Virginia Health Care Fund.

- More likely, this gap in funding will need to be distributed across all state agencies.

Current HHR Spending and Explanation of Recent Increases

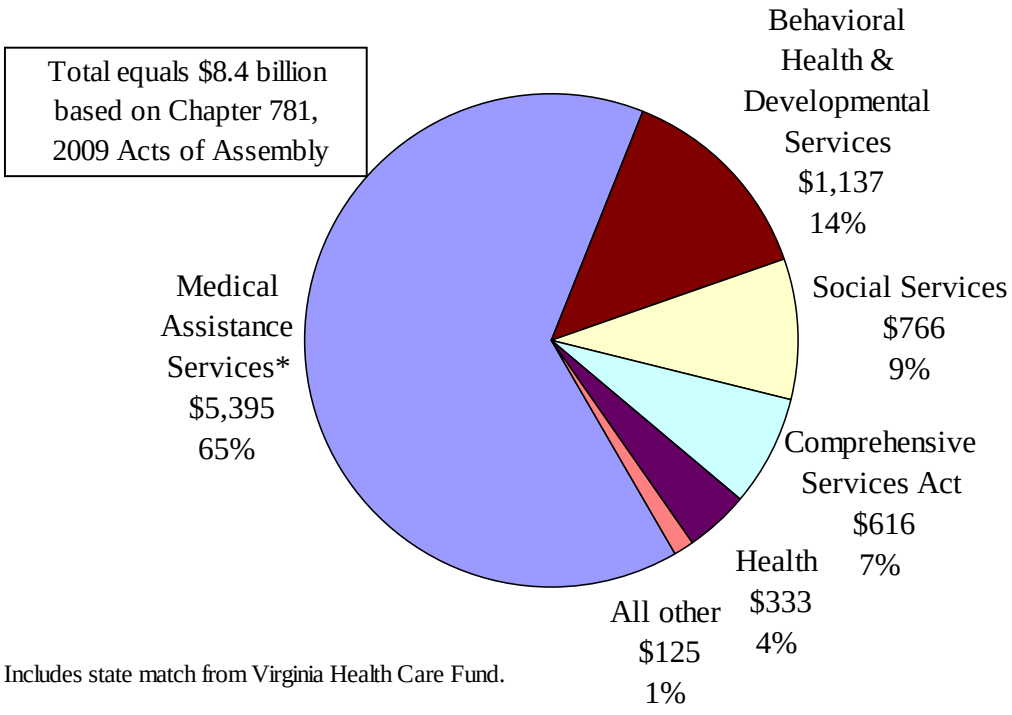
Current Snapshot of HHR Budget

- After beginning the biennium with a $9.2 billion budget, HHR spending was trimmed to $8.4 billion.

- Four agencies account for 95 percent of state spending within the HHR budget.

2008-10 State Spending on HHR Agencies

(Dollars in millions)

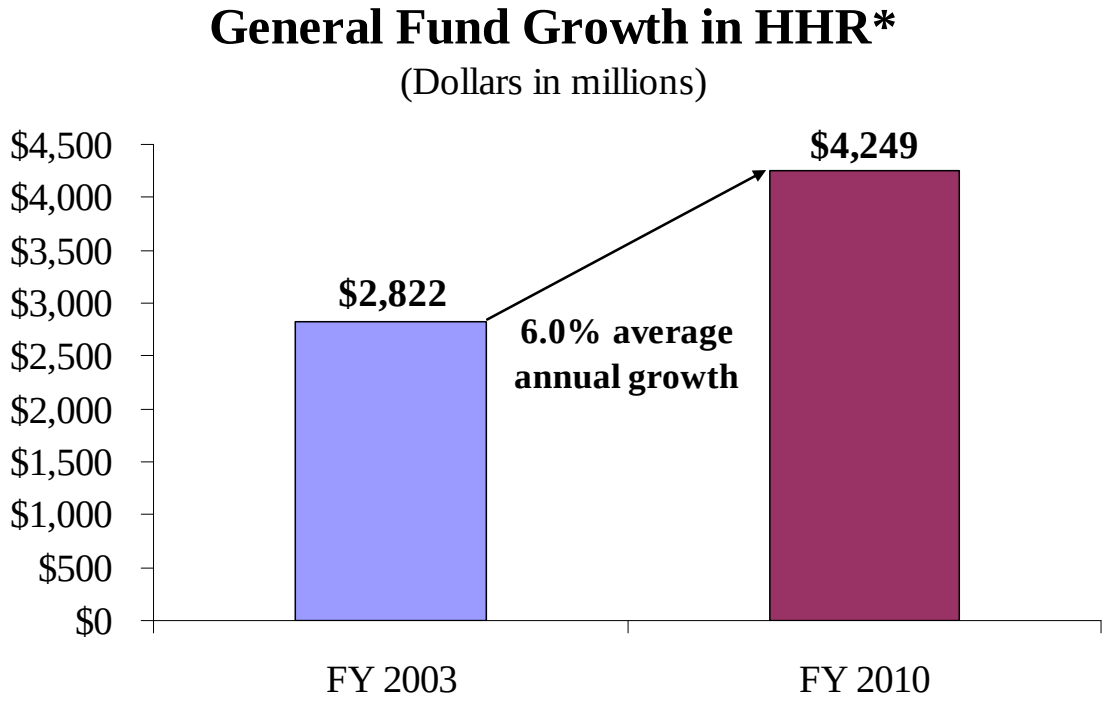


* Includes state match from Virginia Health Care Fund.

- The totals above do not reflect $212 million in additional general fund reductions in HHR announced by the Governor in September 2009.

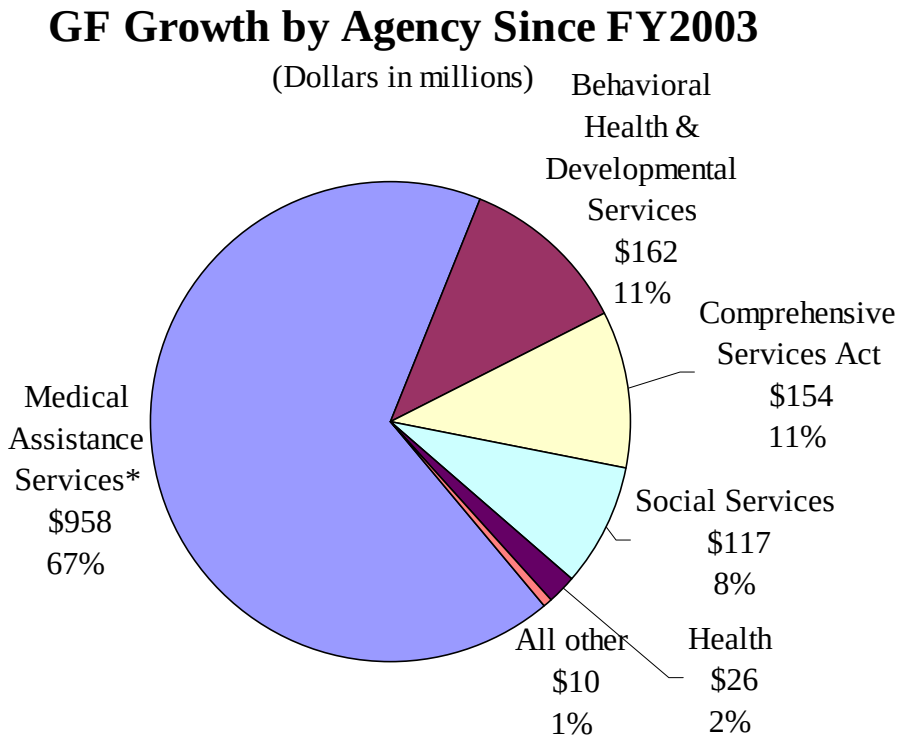
HHR Spending Since the Last Recession

- General fund spending on HHR programs has grown by $1.4 billion since the Commonwealth began to emerge from the 2001 recession.



* Includes state match from VHCF.

Four Agencies Account For Most HHR Spending Growth

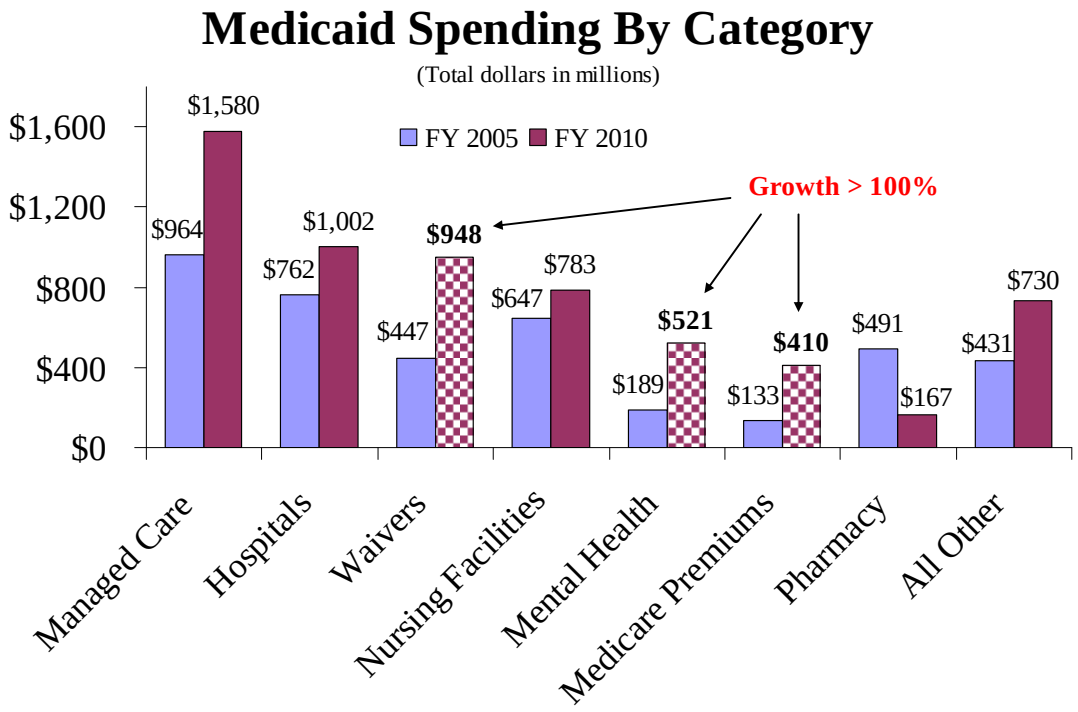


- Spending within HHR has been driven by:
  - Mandatory spending on Medicaid, CSA and child welfare services; and
  - Policy choices related to these same programs as well as efforts to improve the Commonwealth's community-based mental health service system and support state facilities that serve individuals with mental illness and intellectual disabilities.

Profile of Current Spending at DMAS

- Two-thirds of general fund growth or $958 million is attributable to the Department of Medical Assistance Services (DMAS), which is responsible for Medicaid.

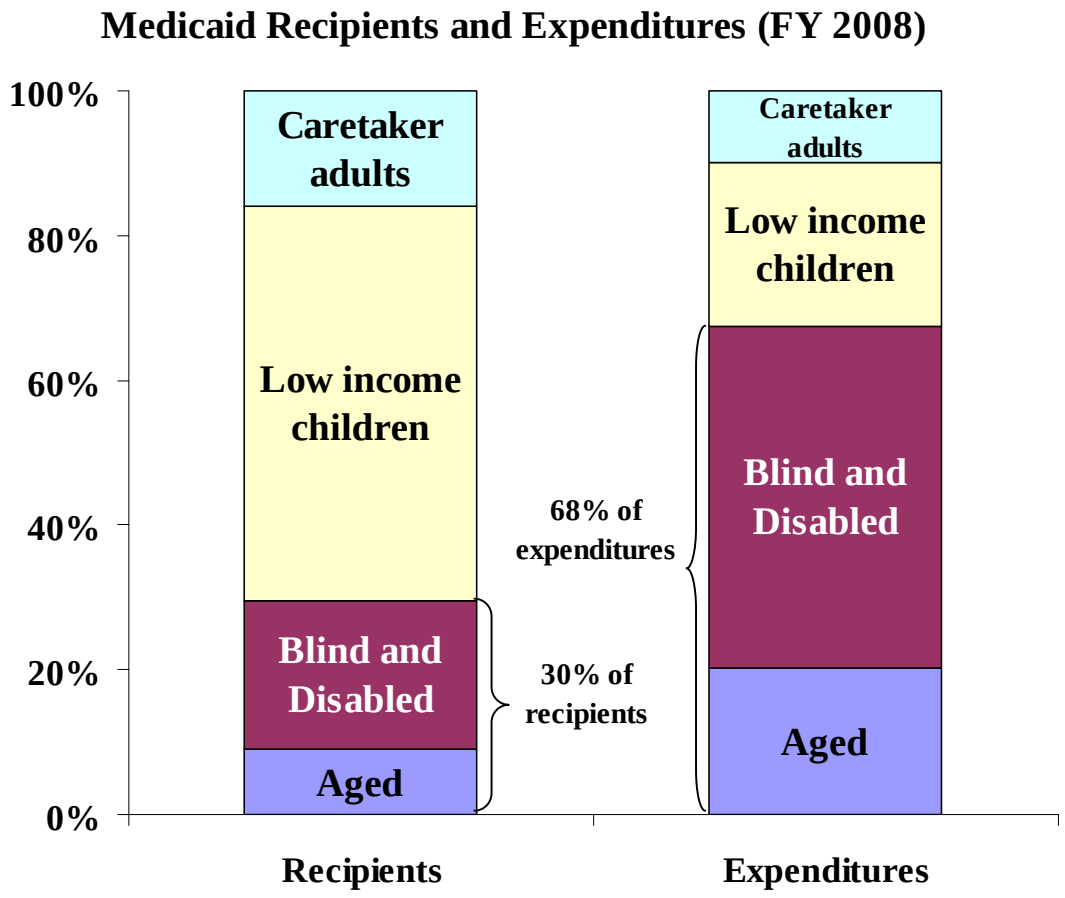
- Most Medicaid resources are spent on **a) acute care** provided by managed care companies and hospitals and **b) long-term care** delivered through both nursing homes and home and community-based waivers.



- More than three-quarters of DMAS' expenditure growth is attributable to the underlying cost of providing health and long-term care services to the elderly, disabled, and low-income families and children.

The Aged, Blind, and Disabled Account for A Disproportionate Share of Spending

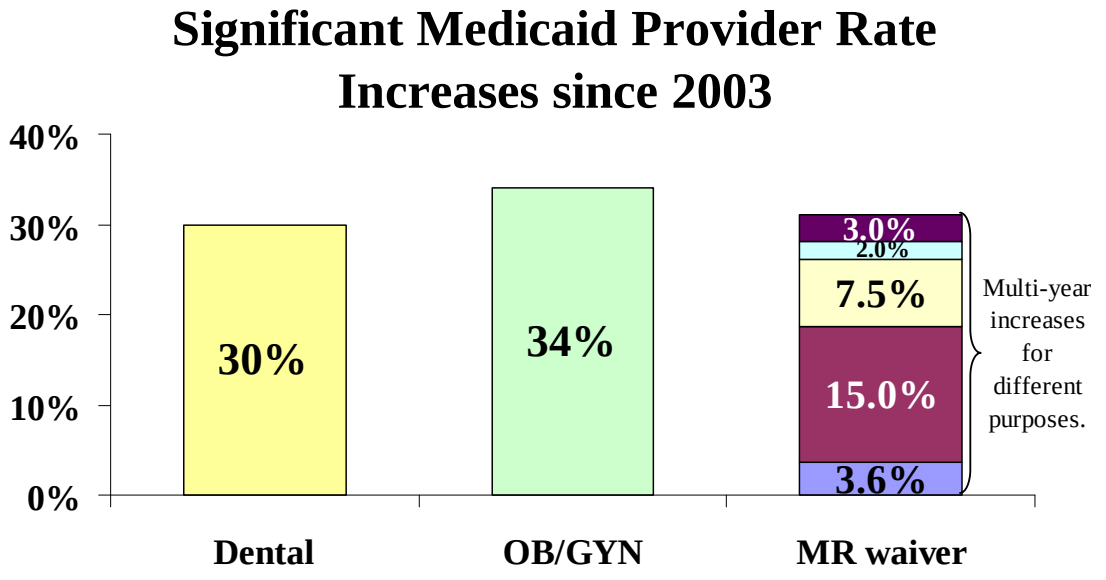
- A minority of recipients -- the aged, blind and disabled -- account for the vast majority of Medicaid spending due to their chronic health and long-term care needs.



Medicaid Provider Rate Increases

- Excluding costs related to utilization and inflation, two areas of spending account for most of the growth within Medicaid – provider rates and the MR/ID (Intellectual Disabilities) waiver program.

- In response to concerns about the inability of recipients to access Medicaid-funded dental, OB/GYN and MR waiver services, significant provider rate increases occurred in recent years.

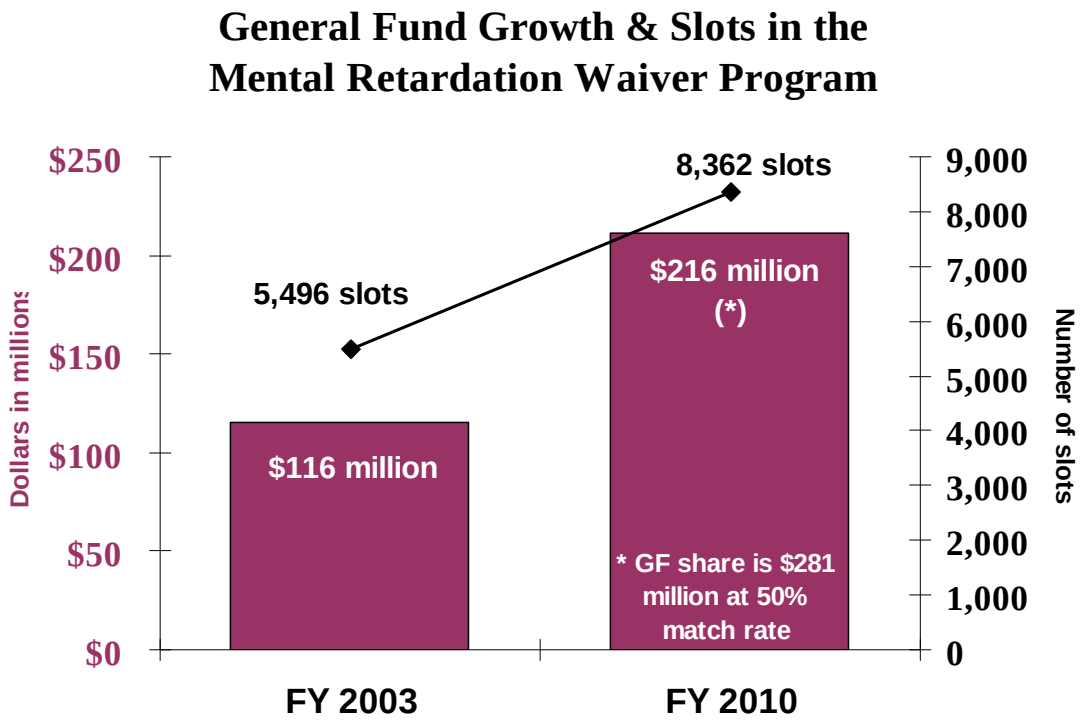


- It is well-known that adequate rates are necessary to attract and retain qualified providers to deliver Medicaid's array of health and long-term care services.

Recent Medicaid Provider Rate Increases

Medicaid Service	Percent Increase	GF Share (in millions)
2009 Session		
Personal care	5.0	$5.1
2008 Session		
MR waiver – Residential services	3.6	$5.0
2007 Session		
MR waiver - NOVA differential	15.0	$5.3
Inpatient psychiatric	7.7	$3.3
Physician	2.0	$2.2
Pediatric	2.0	$1.5
2006 Session		
MR, DD, and DS waiver	5.0/10.0	$17.4
Inpatient hospital (*)	2.6	$8.4
Pediatric	5.0	$6.7
Nursing facilities (*)	4.5/0.8	$4.0
Physician	3.0	$6.9
Personal care	3.0	$2.6
* These providers receive an automatic inflationary increase each year.		
2005 Session		
Obstetrical & gynecological	34.0	$9.1
Dental	30.0	$7.8
Inpatient hospital	1.3	$3.6
MR & DD waiver	2.0	$3.3
2004 Session		
Nursing facilities	n/a	$9.7
Inpatient hospitals	4.2	$9.1
MR waiver	3.0	$4.7
Personal care	5.0	$3.0

Mental Retardation Waiver Program



- Even as funding for other Medicaid providers or programs has been reduced or eliminated, the commitment to the MR/ID waiver program has not waned.

- During the current biennium, 800 new MR/ID waivers were added at an average cost of $72,000 per slot.

  – In addition, legislation passed last year that requires the addition of 400 waiver slots each year for the next 10 years to eliminate the waiting list for individuals with intellectual disabilities.

Perspective on Medicaid Reduction Strategies

- The three pillars of Medicaid are recipients, benefits, and providers.

- Because most spending is made on behalf of the aged, blind and disabled, it will be nearly impossible to shield these groups from budget reductions.

- There is a growing consensus that fundamental health care reforms are needed to slow rising costs including:

  - Stronger incentives for patients and providers to control costs;

  - Modified payment systems to reward positive health outcomes not volume of care delivered; and

  - Better data on the effectiveness of different treatments.

- There are few proven strategies that will result in measurable budget savings this biennium.

  - Time and effort is needed to develop the expertise necessary to create innovative strategies that can address rising health and long-term care costs.

- Short-term strategies will resolve current funding gap.

Recent Medicaid Reduction Strategies Adopted by Other States

FY 2010 Medicaid Budget Reduction Strategies	# of states
Recipients*	
Enacted or expanded care or disease management	14
Adopted managed long-term care strategies	8
Initiated a medical home model	7
Imposed new or higher copayments	3
Benefits	
Eliminated or reduced current benefits	15
Restricted access to home and community-based services	7
Providers	
Froze or reduced payments to nursing homes and/or hospitals	39
Enacted a variety of prescription drug cost-containment measures	35
Created "pay for performance" strategies	34
Imposed (16) or increased (17) provider tax	33
Reduced payments to physicians	13
Reduced payments to hospitals	12
Imposed cost controls for institutional placements	7
Reduced payments to managed care organizations	5

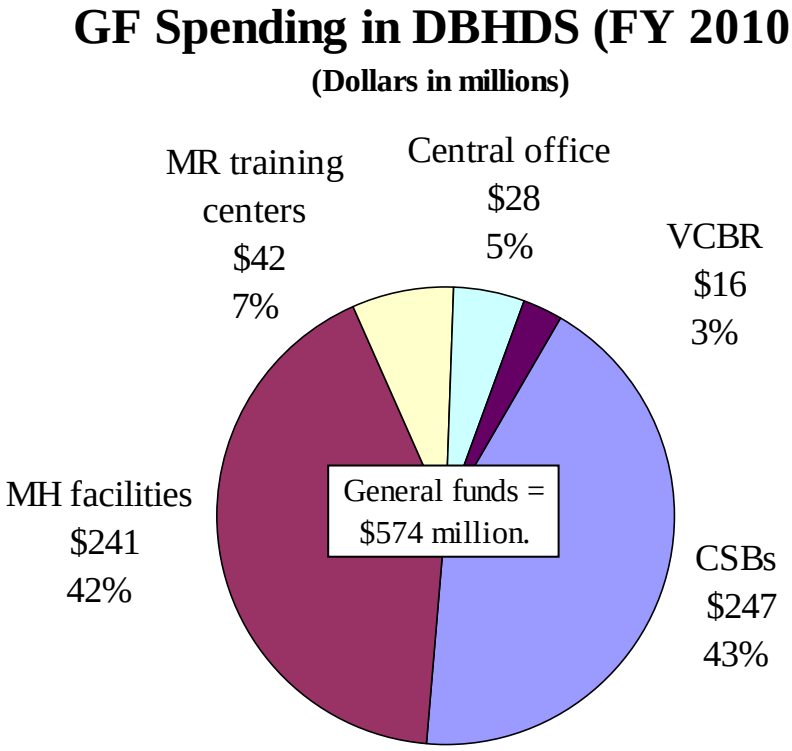
Source: "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession," Kaiser Family Foundation, September 2009.

* To qualify for enhanced federal Medicaid matching funds between October 1, 2008 and December 31, 2010, states cannot reduce eligibility levels below those in effect on July 1, 2008.

Medicaid Budget Reduction Strategies the General Assembly May Need to Consider

Medicaid Budget Reduction Strategies
Recipients*
Expand managed care to: - The elderly and disabled; - Foster care children; or - Unserved areas.
Create intensive managed/coordinated care model for highest cost populations
Reduce eligibility for optional populations (e.g., medically needy, elderly/disabled with income under 80% of poverty)
Freeze enrollment for community-based waivers
Impose additional cost-sharing requirements
Benefits**
Review, reduce and/or eliminate certain optional benefits
Evaluate cost-effectiveness of optional benefits
Providers
Eliminate inflation adjustments and rebasing for hospitals and nursing home
Reduce provider rates
Impose a provider tax
Withhold a portion of provider payment and require that the remaining portion of payment be earned
Create incentives for nursing homes and state intellectual disability training centers reduce their size
* Federal law requires states to cover certain populations. ** Federal law requires states to provide certain services.

Profile of Current Spending at DBHDS



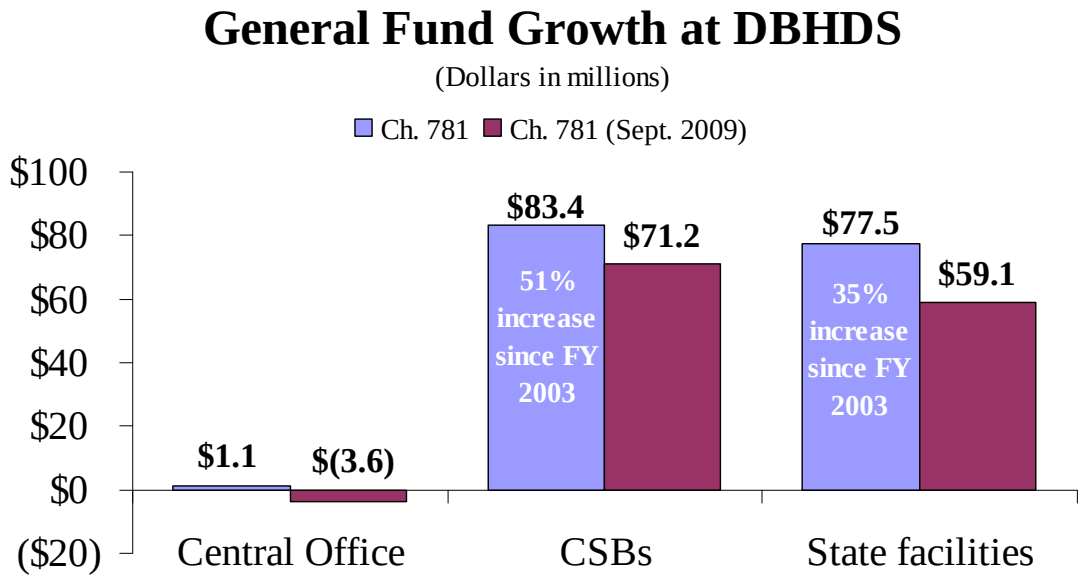
- Most of the $574 million GF spent within DBHDS is targeted toward nine mental health facilities and 40 Community Services Boards.

- More than $100 million GF annually is appropriated to DMAS for Medicaid-eligible services provided in state facilities, primarily for individuals with intellectual disabilities.

  – Overall, eight percent of Medicaid spending is for individuals with behavioral or developmental disabilities.

Community Services Boards and State Facilities Account for Most New Spending

- DBHDS is responsible for 11.4 percent of overall growth in HHR, totaling $161.9 million since FY 2003.



- Recent budget strategies resulted in a five percent reduction to CSBs and additional layoffs within the Central Office and state facilities.

Anticipated Layoffs Based on September Reductions		
	Direct Care	Admin.
Central Office	0	40
Mental health facilities	13	70
Intellectual Disability Training Centers	0	22

Changes in Response to Virginia Tech

- In the wake of the tragic events that took place at Virginia Tech in April 2007, the 2008 General Assembly:
  - Revised mental health civil commitment laws,
  - Enhanced funding for emergency mental health services; and
  - Provided additional support for community-based mental health services.

2008 General Assembly	
Mental health service	**GF Share (in millions)**
Emergency, crisis stabilization, case management, inpatient and outpatient hospital services	$18.0
Divert individuals with mental illness from criminal justice system*	3.0
Outpatient mental health services for children	3.0
Crisis intervention training	0.3
TOTAL	**$24.3**
* NOTE: Funding was reduced by 11 percent during 2009 Session.	

Expanded Community-based Mental Health Services Was Also a Priority in 2006

- The 2006 General Assembly approved funding to:
  - Enhance community-based mental health services through locally-administered funds;
  - Divert individuals from placement in state mental health facilities; and
  - Increase access for children and adolescents.

2006 General Assembly	
Mental health service	**GF Share (in millions)**
Community-based services* designed to divert individuals from ESH, WSH, and NVMHI	$13.5
Community-based services for all other state facilities	6.6
Statewide crisis intervention services	4.7
Child and adolescent mental health services	1.0
Treatment in juvenile detention centers	1.0
Opiate addiction pilot project	0.5
Divert individuals from jails	0.5
TOTAL	**$26.8**
Community-based services may include discharge assistance planning, inpatient mental health treatment, in-home residential support, jail-based hospital diversion projects, psychiatric evaluation, crisis counseling and expanded case management.	

Possible DBHDS Reduction Strategies

- The cost-effectiveness of facility- and community-based services needs to be reviewed.

- Community-based alternatives to more expensive institutional placements must continuously be discussed for all populations.

  – Investments in evidence-based, mental health services may allow for further bed reductions;

  – Expanded housing options are essential for further census reductions at state training centers; and

  – Alternatives to inpatient treatment at the Center for Behavioral Rehabilitation must be explored.

- Long-term solutions will need to be creative and the role of state facilities constantly evaluated.

- Three issues will militate against these efforts:

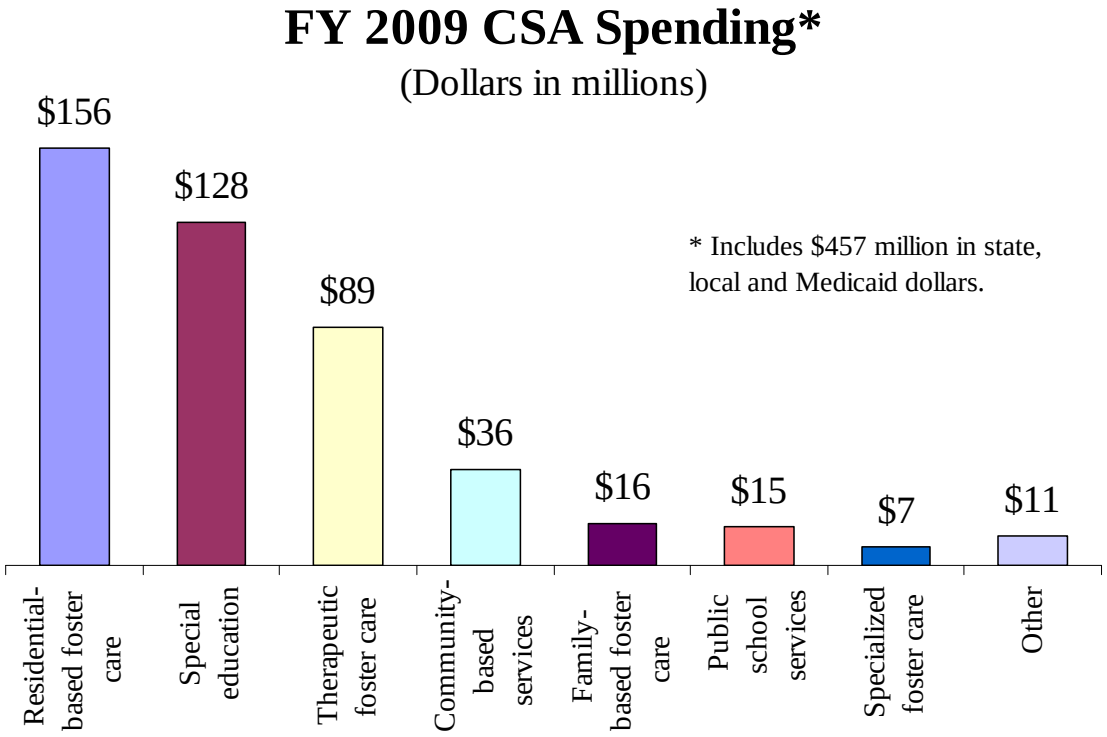
  – State facility beds are increasingly occupied by long-stay, forensic or court-ordered, cases.

  – Sex offender population at Burkeville is growing.

  – Funding for CSBs has been reduced by more than ten percent during the current biennium.

CSA Spending Grew the Fastest Since 2003

- General fund spending on the Comprehensive Services Act for At-Risk Youth and Families (CSA) nearly doubled from $162 million in FY 2003 to $316 million in FY 2010.



- In FY 2009, CSA spent most of its resources for:
  - A continuum of foster care interventions from less-intensive family-based care to more-intensive residential treatment (59 percent); and
  - Instructional costs, residential care and ancillary special education services (31 percent).

Unprecedented Growth at CSA Led to Historic Changes

- In 2008, CSA officials forecast double-digit spending increases requiring an additional $159 million GF during the 2008-10 budget.

- The 2008 General Assembly used "carrots and sticks" to restrain spending and get costs under control.

  – The local share of community-based services was reduced by 50 percent to encourage localities to create services closer to children and families; and

  – The local share of more expensive, residential placements was increased by 25 percent.

- Enrollment growth and costs appear to have flattened for the first time in almost two decades.

- Child welfare outcomes have also improved.

  – Family-based placements are up 10.7 percent;

  – Permanent placements increased 6.5 percent and fewer children are "aging out" of foster care; and

  – Placements in congregate care have fallen by a third.

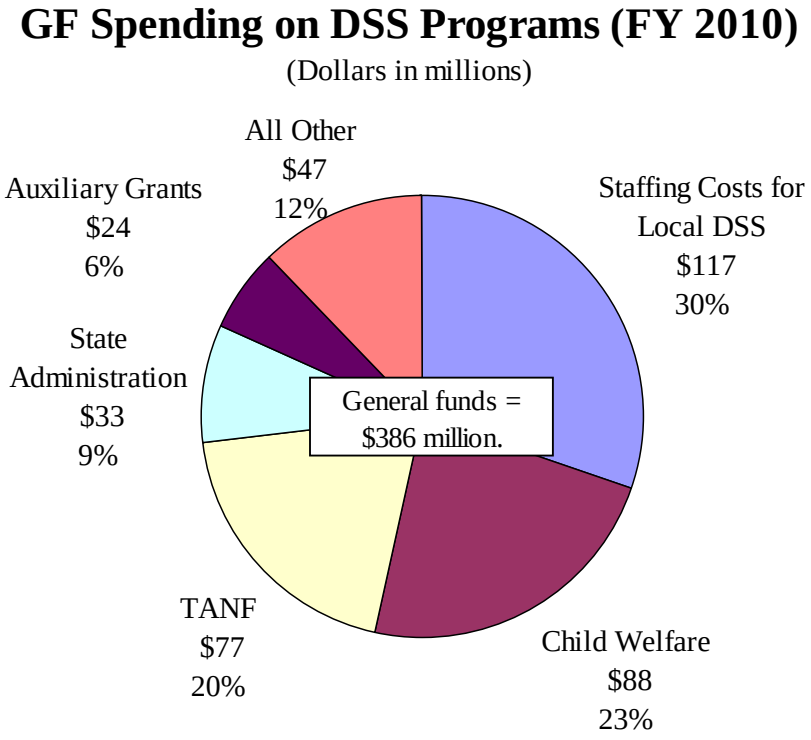
- Available data is encouraging but preliminary.

Possible CSA Reduction Strategies

- CSA spending has actually declined in FY 2009 compared to FY 2008.
  - In September 2009, the Governor reduced projected spending in FY 2010 by $31.6 million or ten percent.
  - Projected spending in the next biennium may be level.
- Because of the magnitude of the reductions announced in September, additional budget strategies involving CSA should be targeted and possibly include:
  - Refining payment strategies to reward providers that document tangible progress in youth behavior and assessing financial sanctions for providers that cannot demonstrate progress; and
  - Rewarding localities that are able to "bend the cost curve" by allowing them to retain a portion of the savings achieved through community-based initiatives.

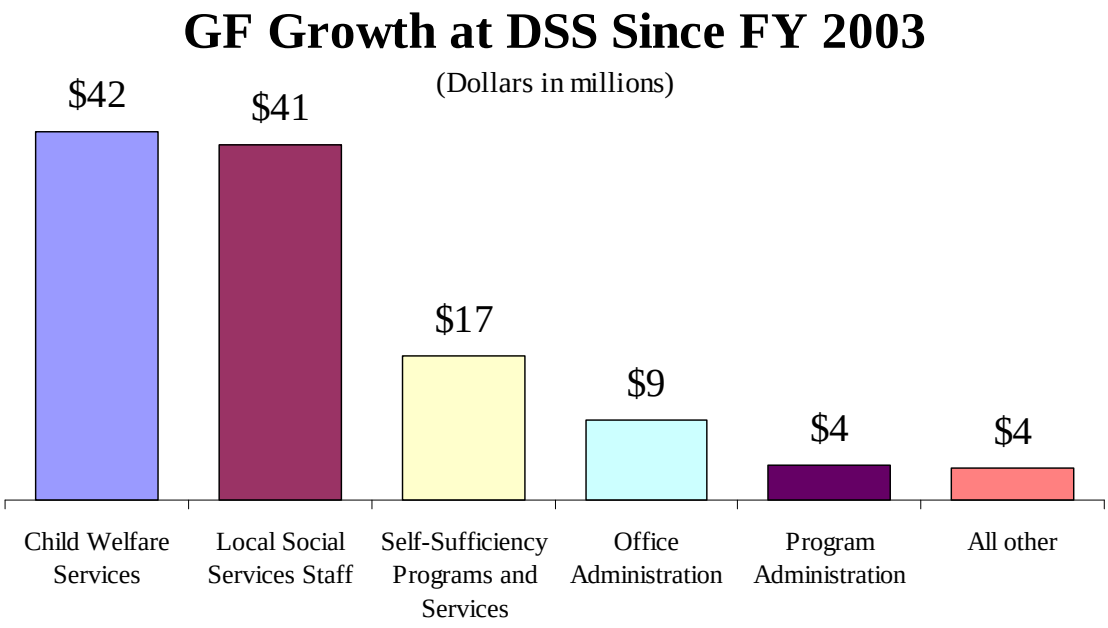
Current GF Spending on DSS Programs and Recent Growth

- Almost three-quarters of general fund spending at DSS is for local DSS offices that employ eligibility staff and social workers who manage state and federal programs, child welfare services, and the Temporary Assistance for Needy Families (TANF) program.



- Funding for services provided by DSS increased by $117 million to $386 million since FY 2003, accounting for eight percent of HHR growth.

Mandated Spending Explains Most of the Growth Within DSS



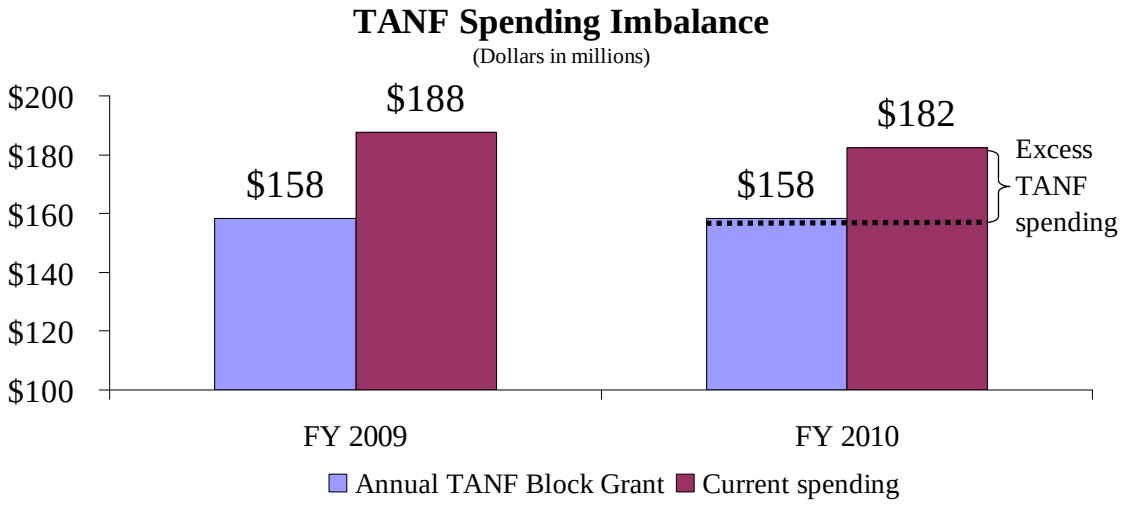
- Mandatory increases in the cost of serving children in foster care or receiving adoption subsidies account for most of the recent growth in spending.

- Funding for local social services staff has increased to offset the loss of federal Title IV-E funding and recognize higher costs related to salary and benefits.

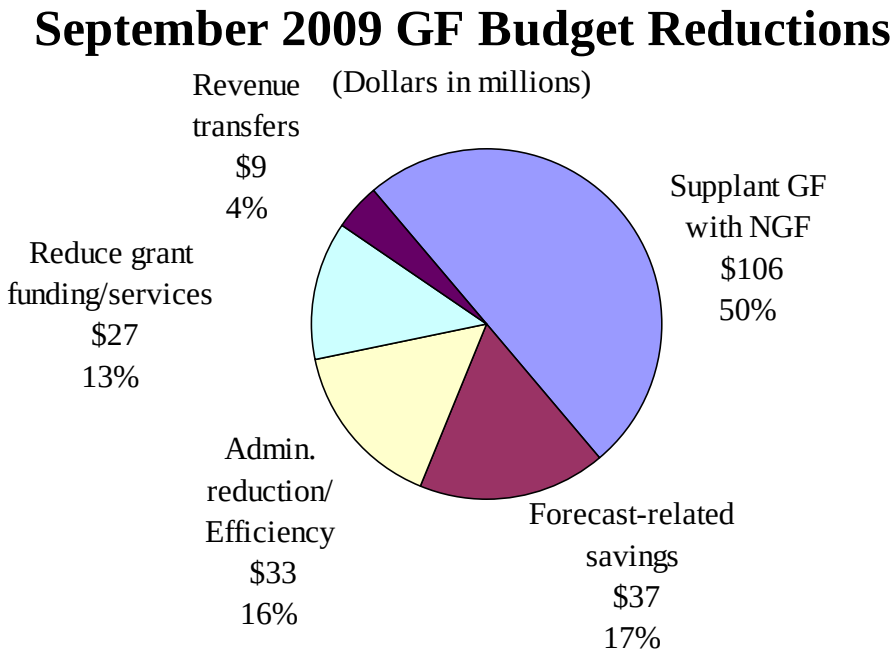
- Changes in federal law (e.g., TANF reauthorization) and federal funding reductions for child support and child welfare services have also contributed to increased spending.

Possible DSS Reduction Strategies

- Federal law will complicate efforts to reduce funding for child welfare and TANF.
- Strategies that may need to be considered include:
  - Regionalizing services provided by local Departments of Social Services;
  - Eliminating programs or services that are not required by state or federal law;
  - Rolling back recent increases provided to foster and adoptive families; or
  - Reducing payment rates to TANF recipients.
- Federal TANF reserve funding will not be available to bail out the Commonwealth this year.



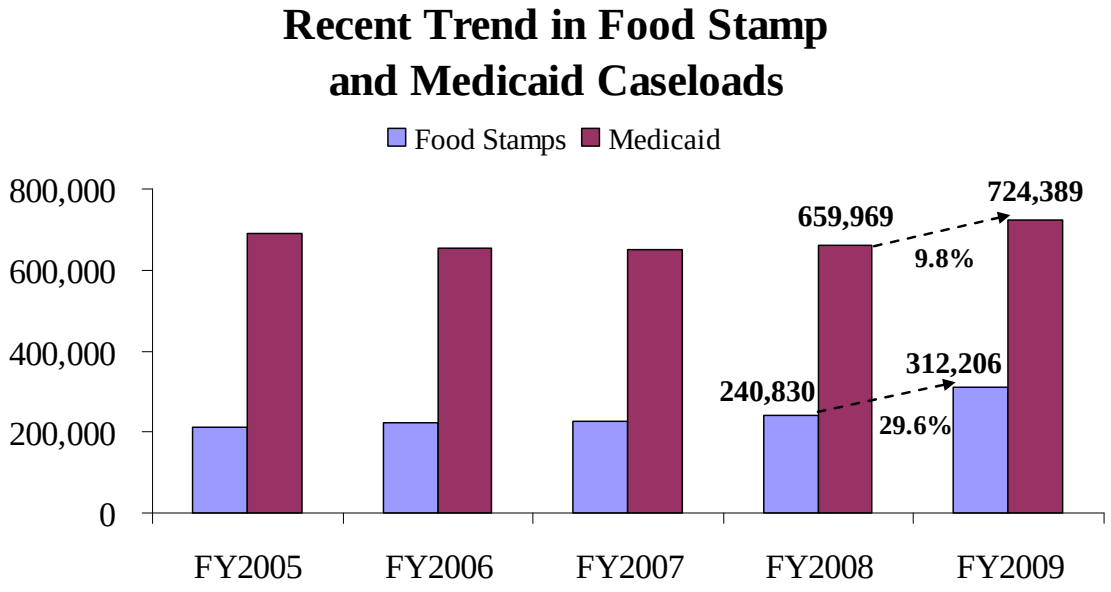
September 2009 Budget Reductions
Total $212 million in HHR



- Substantive reductions in HHR included:
  - A three percent decrease in funding for indigent health care costs at the state's teaching hospitals;
  - A five percent reduction in CSB services;
  - The elimination of direct care staff at state mental health facilities; and
  - A five percent reduction for free clinics and community health centers.

Additional Budget Reductions Will Occur As Demand for Services is Growing

- Another round of budget reductions in HHR will occur against a backdrop of rising demand for health and social services.



- Food stamp and Medicaid caseloads increased by 29.6 percent and 9.8 percent, respectively, in the last year.
  - At the same time, TANF caseloads are up 11.1 percent.
- Local DSS offices that process applications and manage caseloads for food stamps and Medicaid report serving families they have never seen before.

Conclusion

- Enhanced federal funding for Medicaid helped to soften but not solve the fiscal problems facing the Commonwealth.

- Vanishing federal support exposed a gap in funding for Medicaid that must be addressed at the 2010 Session.

- Most spending within HHR is targeted toward:

  - Health and long-term care services for the aged, blind, and disabled and low-income families;

  - Acute and chronic treatment services for persons with a mental illness, intellectual disability or substance abuse disorder;

  - Individually-tailored interventions for children and adolescents in foster care or special education; and

  - Basic assistance for low-income families.

- There are no silver bullets to painlessly address the funding gap faced by the Commonwealth.

- Further reductions will take place as localities face unprecedented demands for health care and social services.

Appendix I

Mandatory Population Groups
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.

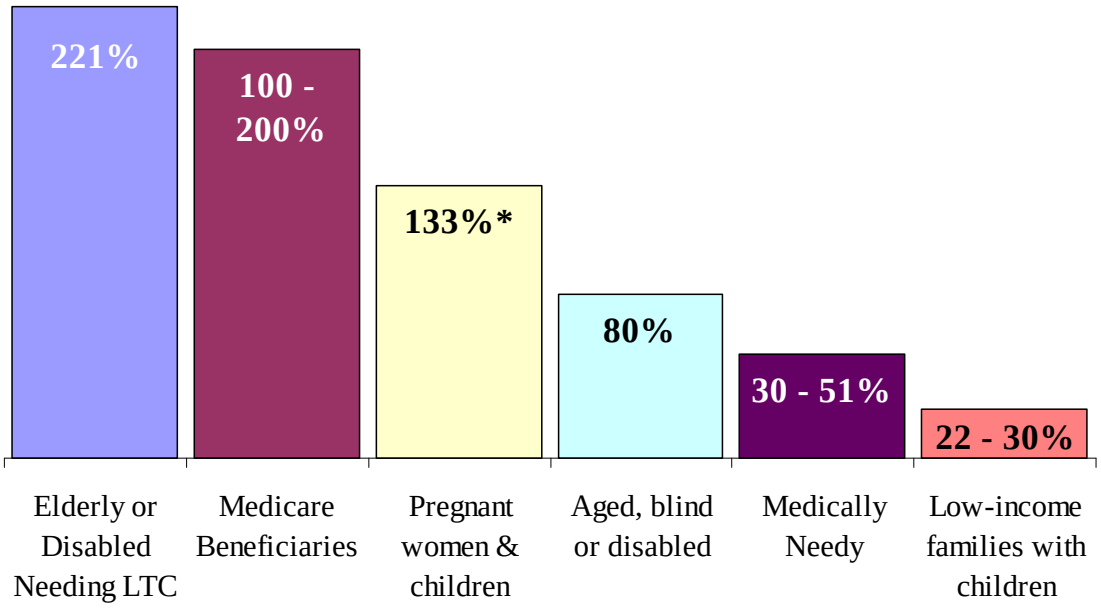
- States that choose to expand coverage beyond "mandatory population groups" are eligible for federal Medicaid matching funds.

Optional Population Groups
"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

Appendix II

Current Income Eligibility Levels for Medicaid Recipients as a Percent of Poverty

(Poverty level equals $18,310 for a family of three)



* Eligible for FAMIS up to 200% of poverty

Appendix III

Mandatory Medicaid Services
Hospital services
Nursing facility services
Physician services
Medicare premiums, copays and deductibles (Part A and 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
Optional Medicaid Services
Prescribed drugs
Mental health and mental retardation services
Home & community-based waivers
Medicare premiums, copays, and deductibles (Part B – medically needy)
Dental and skilled nursing facility care for persons under age 21
Clinical psychologist
Services provided by certified pediatric nurse and family nurse practitioner
Intermediate Care Facilities for the Mentally Retarded (ICF/MRs)
Optometry, podiatry, and home health services (PT, OT, and speech therapy)
Certified pediatric nurse and family nurse practitioner services
Case management services
Prosthetic devices
Other clinic services
Substance abuse treatment
Hospice
*** Bold denotes one of 10 largest Medicaid service expenditures.**