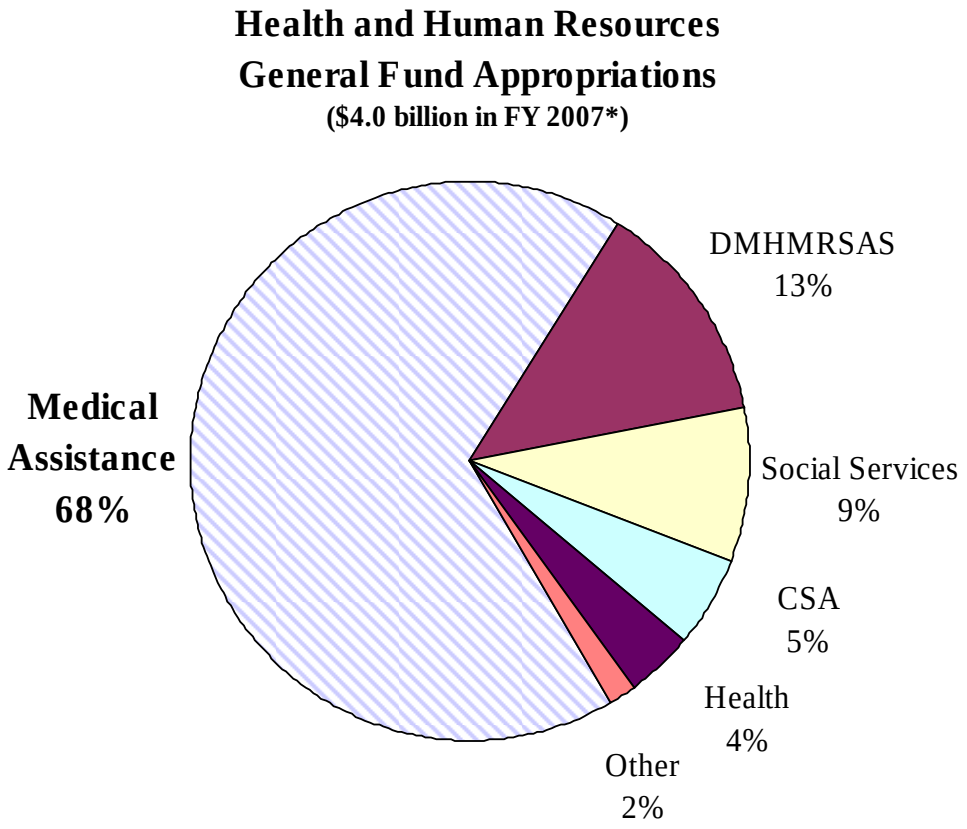
Introduction

- Recent growth in Health and Human Resources spending has been dominated by Medicaid, which tends to dwarf all other program spending in HHR.
  - A one percent increase in Medicaid spending translates to $27 million in state funds.

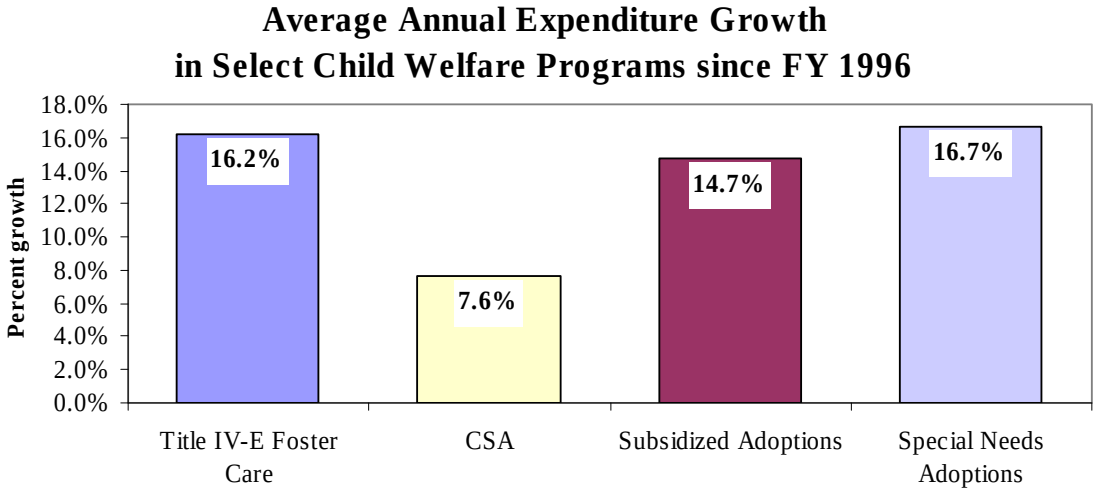


* Includes Virginia Health Care Fund dollars.

** Department of Mental Health, Mental Retardation, and Substance Abuse Services

Introduction (continued)

- While much smaller than Medicaid, several HHR programs have grown at rapid clips in the past decade.



- Declining caseloads and falling spending has made funding for the Temporary Assistance for Needy Families (TANF) program a non-issue in recent years.
  - Federal reauthorization of the TANF program earlier this year changed that.
  - Mandatory changes are expected to have a dramatic impact on the number of individuals required to engage in work activities, resulting in additional work-related and child care spending.
- Recent growth in all of these programs has not gone unnoticed; the General Assembly has commissioned task forces and study groups to research and analyze program spending in order to recommend appropriate future action.

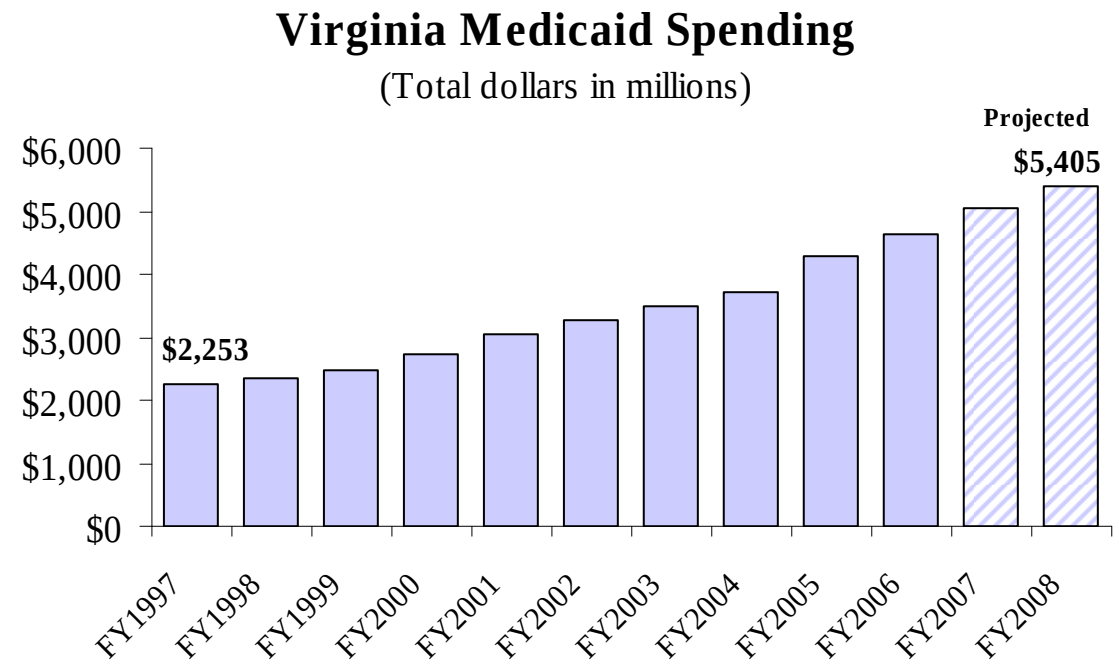
Introduction (continued)

- An issue that has not received a lot of attention in recent years is substance abuse.
  - Substance abuse, in the form of alcohol and drug abuse, imposes hidden costs on many areas of state government.
- In the only comprehensive analysis of state spending and substance abuse, it was estimated that 11.5 percent of the Commonwealth's FY 1998 budget was spent "shoveling up" costs incurred from substance abuse.
  - Of each dollar spent on substance abuse, 95 cents was expended on the burden this problem imposes on public programs, translating into a cost of $261 per Virginian.
  - Approximately half of that spending was related to adult corrections, juvenile justice, and the judiciary.
- Based on the current GF budget of $16.8 billion in FY 2007, the cost of substance abuse in Virginia translates into a $1.9 billion problem.
- What is the impact of substance abuse on the Commonwealth's programs? What are we doing about it? What more, if anything, needs to be done?

An Overview of Current Spending Trends in Health and Human Resources

- Medicaid
- CSA
- Federal IV-E Foster Care
- Adoption Assistance
- TANF

Medicaid



Sources: VA Medicaid Statistical Record and Preliminary Medicaid Forecast 2006.

- Projected Medicaid spending is virtually unchanged from the end of the 2006 session, although there is considerable variation within spending categories.
  - Managed care payments rose less than expected due to slower enrollment and lower rate increases; and
  - Costs related to the new prescription drug benefit (Medicare Part D) were less than anticipated; but
  - Payments for dental services payments are up markedly and nursing home costs are increasing between 6 and 8 percent each year.

What is being done to address Medicaid?

- DMAS assembled a committee made up of providers, advocates, health insurers, and program administrators to evaluate specific reform measures and make recommendations to the General Assembly.

  – Committee findings build on Medicaid's strengths in managed care, expand disease management programs, and provide tools and incentives so providers and recipients can achieve optimal health outcomes. Recommendations include:

Expanding managed care into new regions and across eligibility categories where feasible.

Expanding population-based disease management programs for high cost and/or high prevalence diseases.

Expanding participation in Medicaid and FAMIS "buy-in" programs where feasible and cost-effective.

Providing access to enhanced benefit accounts to encourage recipients to assume responsibility for their own health care needs.

Studying changes to current programs to encourage employer-sponsored or private health insurance coverage when it's cost effective for Medicaid.

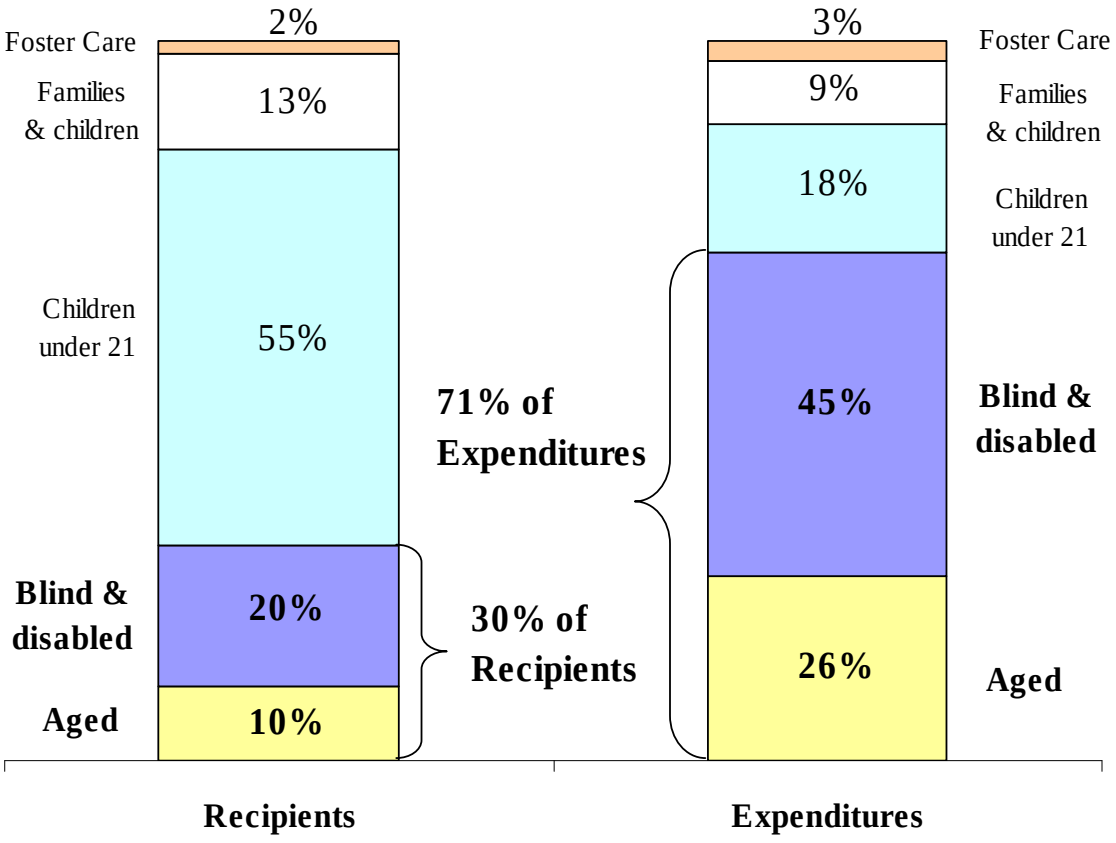
Implementing a web-based claims submission system available free of charge to all healthcare providers.

Requiring electronic payment of health care services to all enrolled Medicaid providers.

What is being done to address Medicaid? (continued)

- DMAS is also developing a plan to integrate acute and long-term care services for individuals who are elderly and disabled that account for 30 percent of Medicaid recipients but 71 percent of expenditures.

Medicaid Recipients and Expenditures (FY 2005)



What is being done to address Medicaid? (continued)

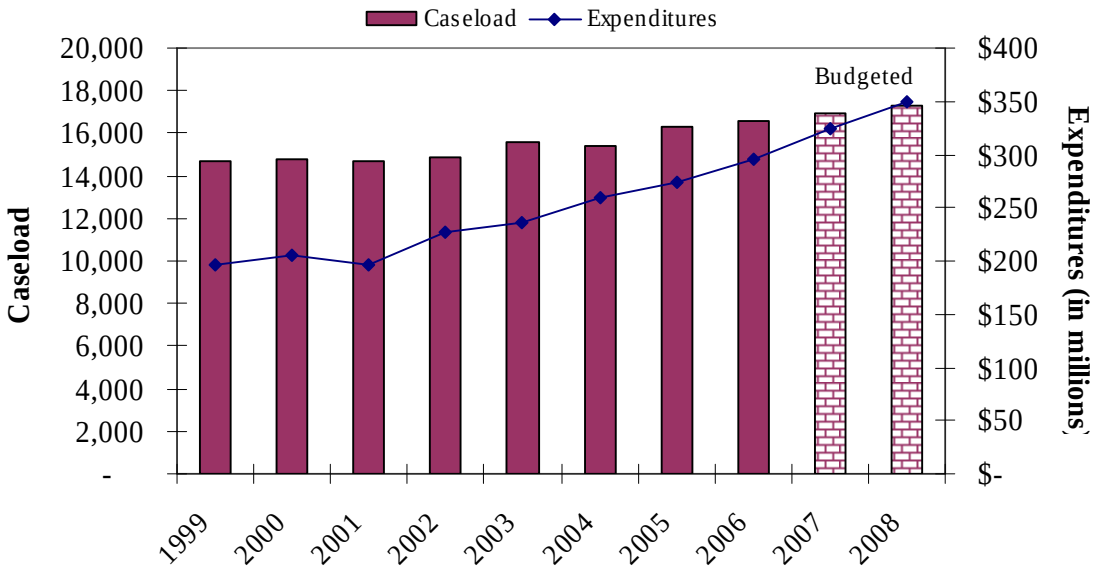
- Start-up funding of $1.5 million GF was provided to establish Programs for All-Inclusive Care for the Elderly (PACE) in six locations across the state.
  - Two rural programs received start-up funding of $1.0 million from the federal government.
  - PACE programs integrate Medicaid funding with Medicare dollars to address the health and long-term care needs of the 55 and older population.
- Compared to other sectors of the economy, the health care industry has largely missed out on the advancements in information technology.
  - DMAS is participating in the Governor's Health Information Technology Council that includes goals of:
    - **Identifying** areas where information technology can lower health care costs;
    - **Encouraging** the adoption of electronic medical records; and
    - **Recommending** strategies to encourage sustained adoption and interoperability of health information technology.

Comprehensive Services Act for At-Risk Youth and Families (CSA)

- CSA caseload growth has remained flat in recent years, averaging less than 2 percent annually, while spending has increased at a rate of 8 percent each year.

  – General fund support for CSA is expected to total $228 million in FY 2008.

State Foster Care (CSA) Caseload and Expenditures



NOTE: 2004 includes an estimate of 800 cases from two localities that did not report.

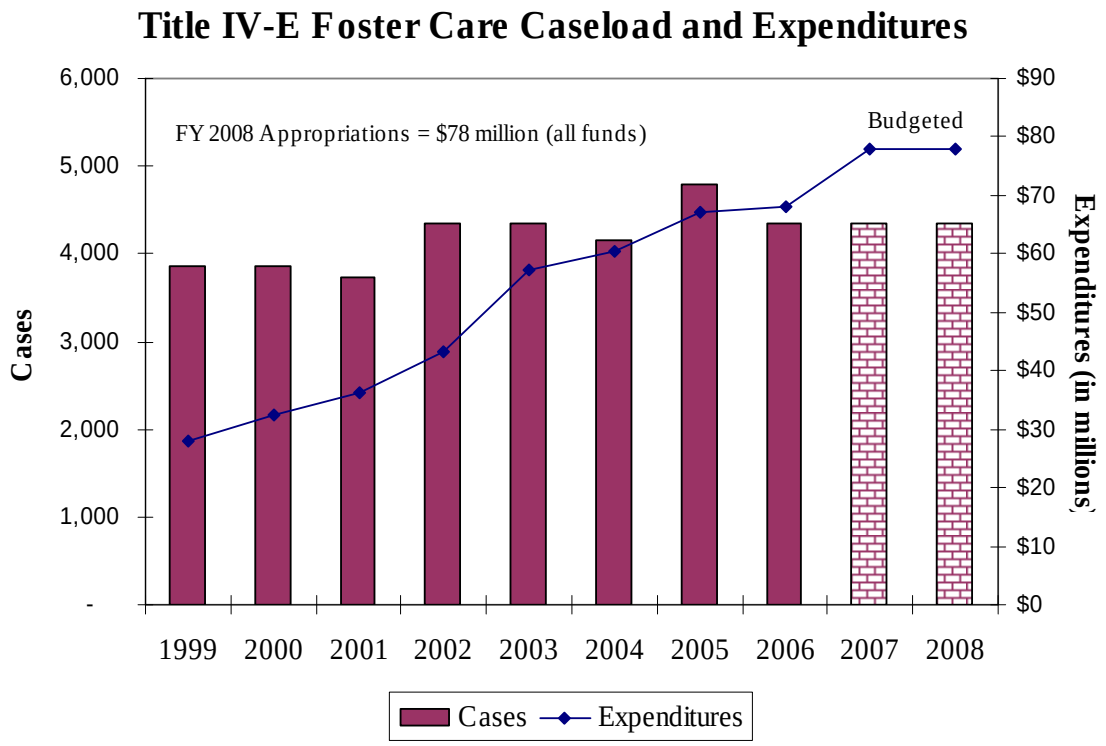
- Seventy-eight percent of CSA expenditures fall into the following categories:

  – 31 percent for residential treatment.
  – 20 percent for special education day programs.
  – 16 percent for therapeutic foster care.
  – 11 percent for group homes.

What is being done to address CSA?

- The 2006 General Assembly provided $1.3 million GF for Community Innovation Service Grants.
  - These competitive grants are designed to spur the development of community-based services for children who are placed or at risk of placement in more expensive, out of community residential care.
- HJR 60 (2006) directed JLARC to review the cost, quality, and effectiveness of residential services as well as the availability of community-based alternatives to intensive residential treatment.
  - The final report will contain recommendations to control costs and ensure the provision of safe and effective treatment services.
- Finally, SJR 96 (2006) created a subcommittee to review administration of the CSA program including caseloads, service needs, costs, and quality.
  - The subcommittee is expected to make recommendations on program improvements and cost containment.

Federal Title IV-E Foster Care Program



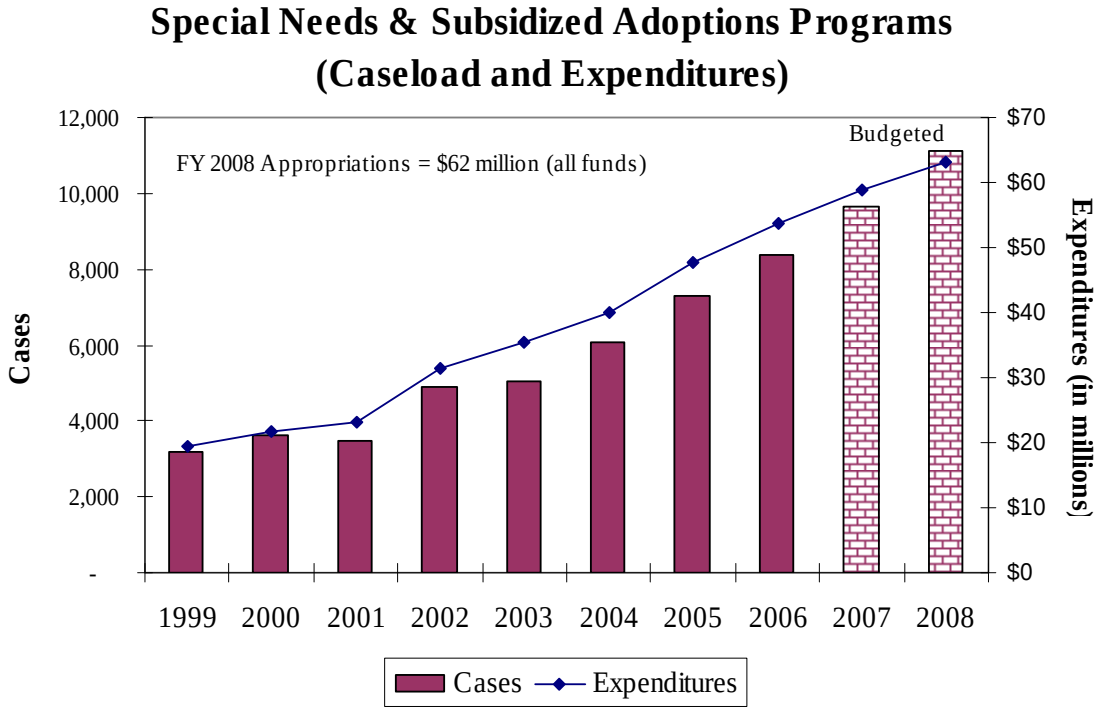
- Steady enrollment in adoption assistance programs appear to be moderating the growth of foster care caseloads but not spending.

  – Since FY 2000, enrollment growth has averaged 2.5 percent annually while per capita spending has increased by 13.5 percent each year.

- In FY 2006, Title IV-E foster care funds were spent as follows:

  – 59 percent for residential care;
  – 21 percent for child placing agencies (for example, therapeutic and treatment foster care); and
  – 20 percent for agency foster homes.

Adoption Assistance Programs



- Annual expenditure growth in the Subsidized and Special Needs Adoptions Programs accelerated since FY 2000, averaging 17 and 24 percent, respectively.
  - Enrollment is driving spending in the Commonwealth's adoption assistance programs.
  - The federal government has actively encouraged adoption as an alternative to foster care.
  - Increased local scrutiny of adoption assistance agreements has contributed to a decline in per capita spending the past two fiscal years.

What is being done to address Foster Care and Adoption Assistance Programs?

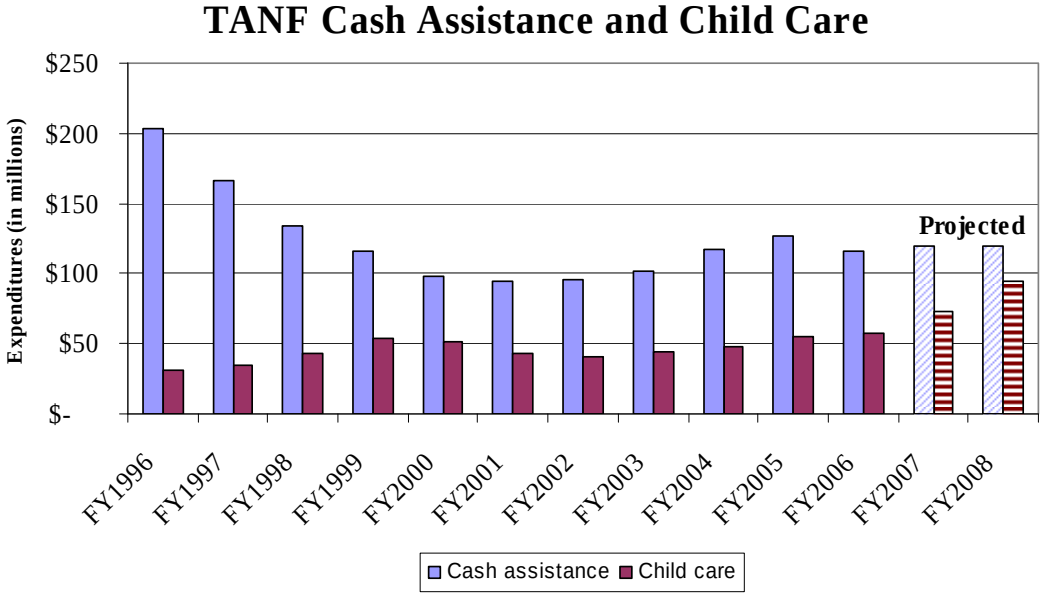
- At last year's Senate retreat, it was pointed out that adoption assistance programs were experiencing extraordinary growth – 35 percent in the state-only funded program in one year.

  – The administration re-examined spending in the adoption assistance program and introduced language to rein in costs.

- Budget language included in the Appropriations Act (Chapter 3, 2006, First Special Session) requires the Commissioner of Social Services to examine the causes of recent expenditure growth and recommend changes to moderate growth, while meeting the needs of the affected children.

Temporary Assistance for Needy Families

- Since welfare reform's passage, spending on cash assistance for TANF recipients has fallen precipitously, declining by 38 percent from fiscal year 1996 to 2005.



- Not surprisingly, welfare reform's focus on work, increased child care expenditures by 75 percent during the same time period.

- Expiration of Virginia's TANF waiver and federal reauthorization of the program in February 2006 are expected to impose sizeable increases in TANF program spending as more recipients are required to engage in work or work activities.

  – Spending on child care and employment services alone may approach $28 million annually.

What is being done to address TANF?

- The Department of Social Services has developed a plan to address the loss of Virginia's waiver and recent federal changes by:

Adopting the federal government's less restrictive definition of work activities;

Allowing recipients to be placed in a work activity prior to a current 90 day waiting period;

Eliminating some of the current exemptions from participation in work activities;

Increasing the number of hours that recipients are engaged in work activities;

Providing a transitional benefit for recipients who work their way off cash assistance; and

Using state dollars for two-parent household that are not meeting the current work participation rate.

- These changes are expected to increase the state's work participation by 6,153 individuals, boosting the compliance rate above the 50 percent federal threshold.
  - Financial penalties for not meeting the new federal requirements are significant -- $22.2 million the first year.

Substance Abuse in the Commonwealth of Virginia

- Estimated prevalence
- Substance abuse defined
- Effectiveness of treatment

Substance Abuse in the Commonwealth

- Substance abuse and dependence are common threads that run through each of the programs previously mentioned.
  - The cost of untreated substance abuse -- alcohol or drug abuse -- arguably contributes to higher expenditures in these programs.

Substance Abuse is defined as *recurrent use* in one or more of the following within a 12-month period:

1) Failure to fulfill major obligations at work, school, or home;
2) Use in physically hazardous situations;
3) Legal problems; and
4) Social or interpersonal problems.

Substance Dependence (Addiction) is defined as *recurrent use* in three or more of the following within a 12-month period:

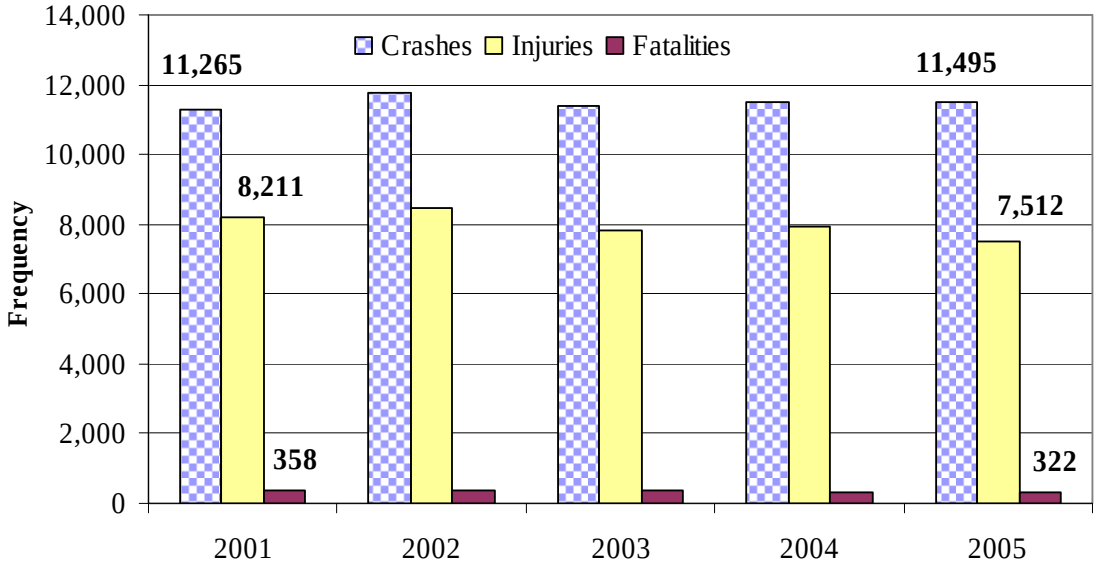
1) Increased tolerance to "get high" or diminished effect of doses;
2) Withdrawal as manifested by physical symptoms or need to use;
3) Substance taken in larger amounts or over a longer period of time;
4) Persistent desire or unsuccessful efforts to reduce or control use;
5) Lot of time spent obtaining substance or recovering from use;
6) Important social, occupation, or recreational activities given up or reduced because of use; and
7) Continued use despite physical or psychological problems.

As defined by Diagnostic Statistical Manual (DSM) IV

Substance Abuse in the Commonwealth (continued)

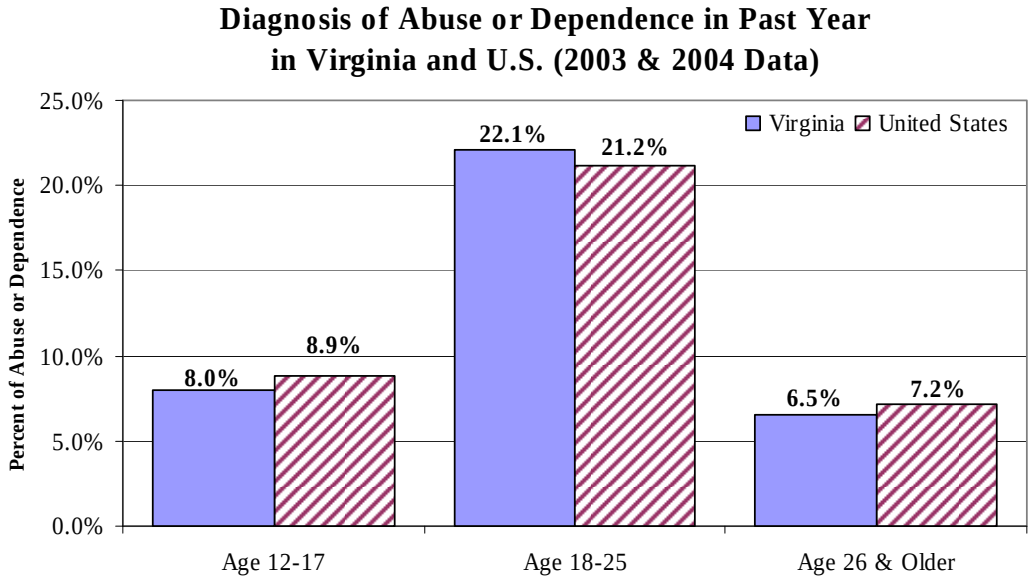
- Other costs are also being incurred in the Commonwealth including costs to other state agency programs.
  - Untreated abuse and addiction has serious and costly social consequences including illness, disability, death, learning disabilities, poor school performance, child abuse and neglect, domestic violence, unwanted pregnancies, and crime.

Alcohol Related Crashes, Fatalities, and Injuries in Virginia, 2001 - 2005



Estimated Prevalence of Substance Abuse

- Nine of every one hundred Virginians, approximately 606,000 people, are estimated to have a substance abuse or dependence problem.



- The problem is particularly evident among those between the ages of 18 and 25, where more than one in five meets the clinical diagnosis of abuse or dependence.

What is Substance Dependence (Addiction)?

- Scientific research indicates that addiction is a chronic, relapsing brain disorder that has considerable psychological, biological, and social consequences.

Four Primary Symptoms of Substance Dependence	
Craving	Strong desire or urge to use
Loss of control	Inability to stop using
Physical dependence	Withdrawal symptoms
Tolerance	Need to use greater amounts in order to get "high".

- While the use of an addictive substance such as alcohol or drugs alters the brain's function, not all people who use alcohol or drugs will experience lasting changes in their brain structure or function.

  – This phenomenon helps explain why some people who use alcohol and drugs become addicted while others do not.

- Like other chronic and disabling diseases, substance abuse disorders have strong genetic components that put entire families at risk.

  – "Children of alcoholics are about four times more likely than the general population to develop alcohol problems." The risk doubles if both parents are alcoholics.

How Effective is Substance Abuse Treatment?

- Treatment of substance abuse is as effective as other chronic medical conditions such as asthma, diabetes and hypertension.
  - Effective treatment requires a change in behavior and adherence to treatment guidelines.
- Unlike substance abuse, relapses in the treatment of asthma, diabetes, or hypertension do not result in termination but a change in treatment.

Comparison of Alcohol Use & Abuse and Other Chronic Diseases in the United States				
	Alcohol-related problems	**Asthma**	**Diabetes**	**High Blood Pressure**
Prevalence	13.8 million	17.6 million	10 million	50 million
Controllable risk factors	Yes	Yes	Yes	Yes
Estimated genetic influence	**50-60%**	**36-70%**	**Type I – 30-55% Type II - 80%**	**25-50%**
Cure	No	No	No	No
Clear diagnostic criteria & research based-treatment	Yes	Yes	Yes	Yes
Treatment compliance rate	**40-60%**	**30%**	**30%**	**30%**
Patient relapse rate (after one year)	**40-60%**	**50-70%**	**30-50%**	**50-70%**
Source(s): National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, National Center for Health Statistics, McLellan et al, American Lung Association, American Heart Association, and National Pharmaceutical Council.				

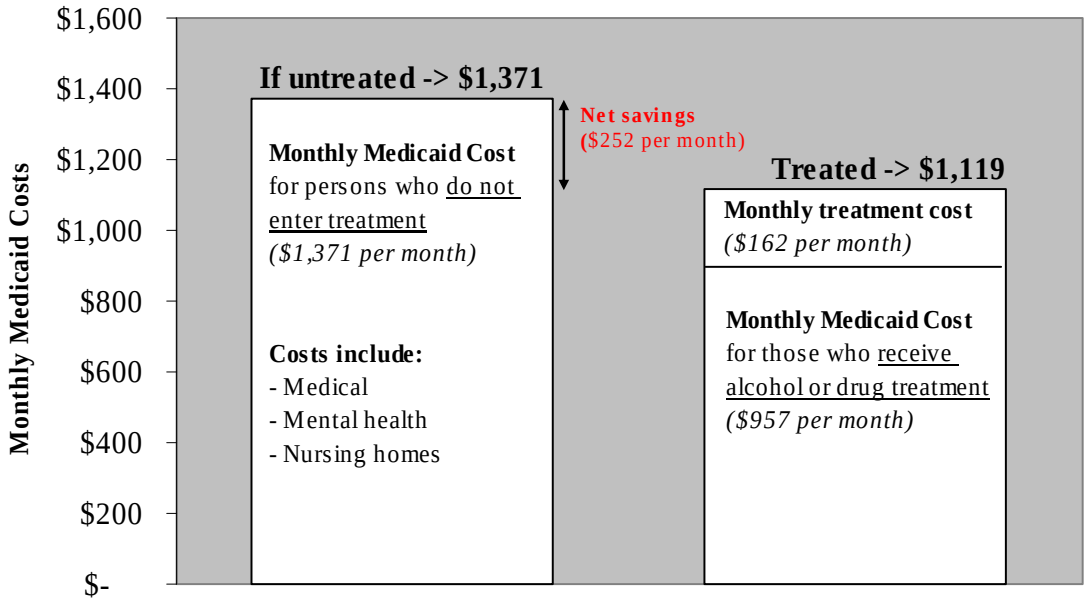
The Cost of Substance Abuse in the Commonwealth

- Health Care Costs
- Youth Access
- Child Welfare
- Juvenile Justice
- Adult Corrections

Substance Abuse and Health Care Costs

- Prolonged alcohol and drug use is tied to more frequent use of inpatient hospital services, greater likelihood of emergency room visits, and higher total medical costs.
  - The National Center on Substance Abuse and Addiction (CASA) estimates that **one of every five dollars spent on Medicaid hospital care** can be attributed to substance abuse.
- After factoring in the cost of treatment, Washington State documented net monthly savings of $252 for supplemental security income (SSI) recipients on Medicaid.

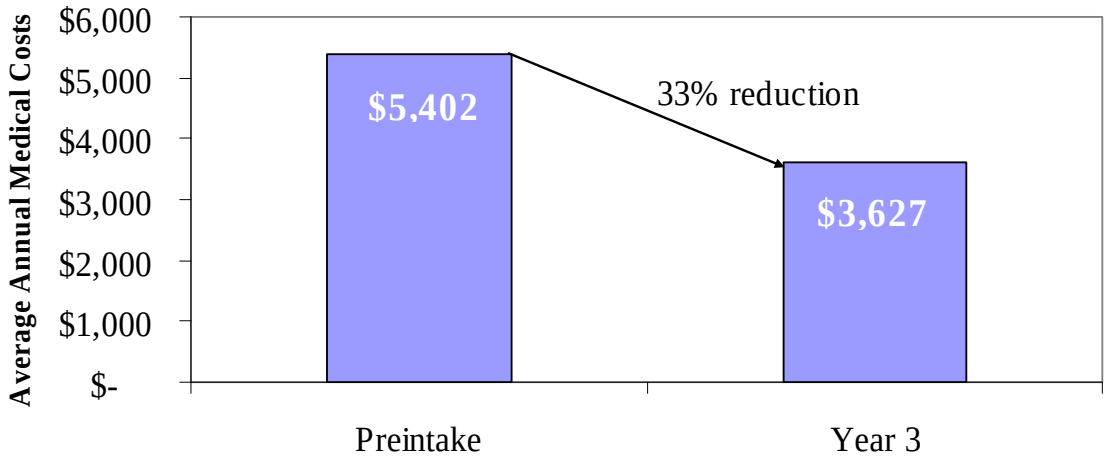
Monthly Medicaid Costs Before and After Substance Abuse Treatment



Substance Abuse and Health Care Costs (continued)

- Similarly, Kaiser Permanente reported a 33 percent drop in medical costs for Medicaid recipients three years after entering substance abuse treatment.

Kaiser Permanente Study of Medicaid Patients Receiving Substance Abuse Treatment (Pre- and post-treatment)



Source: Journal of Behavioral Health Services & Research, 2005.

- Researchers attributed declining expenditures for these individuals to fewer hospital days, emergency room visits, and non-emergent outpatient visits.

- The medical costs of Kaiser Permanente's Medicaid patients one-year prior to intake were 60 percent higher than non-Medicaid patients who entered treatment.

Substance Abuse and Youth Access

- Almost 90,000 Virginia youth between the ages of 12 and 20 have a serious alcohol problem and 85 percent are not receiving treatment.

- In addition to being illegal, underage drinking is likely to result in serious social consequences including academic problems, increased risk of suicide, high-risk sex, alcohol-related accidents and other injuries.

  – 47 youth were killed and 662 youth were injured in alcohol-related crashes in 2005, according to the Department of Motor Vehicles.

- Recent research indicates that brain development is not complete until the age of 24.

  – Substance abuse appears to arrest maturation of the developing brain as it progresses from activities like simple physical coordination to complex decision-making and impulse control.

The Four Stages of Brain Development

1) **Physical coordination/sensory processing**
2) **Motivation**
3) **Emotion**
4) **Judgment**

Substance Abuse and Child Welfare Services

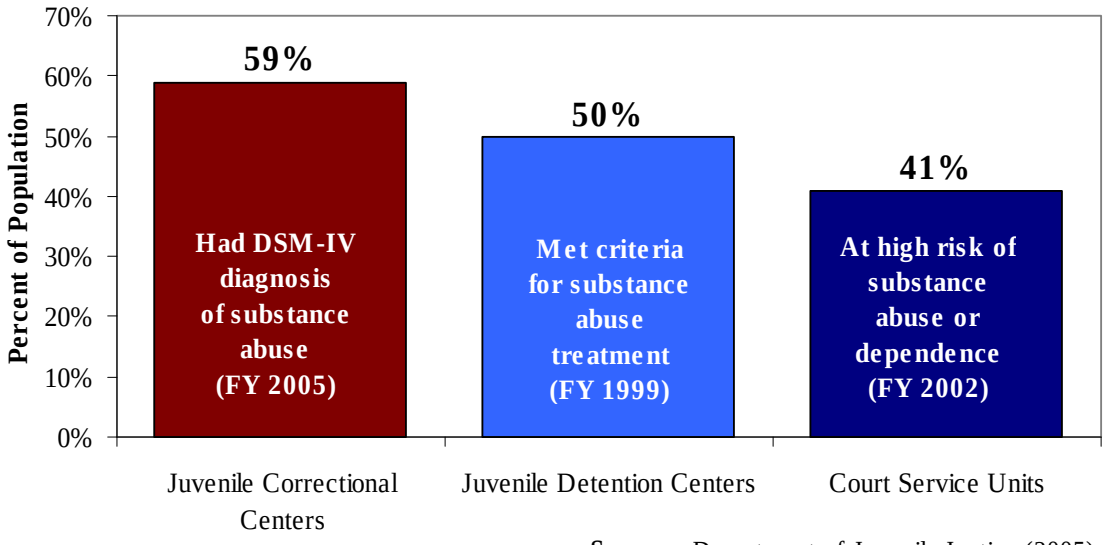
- Alcohol and drug abuse are often referred to as family diseases because these illnesses affect the entire family not only the abuser.
  - Foster children in families in which substance abuse treatment is not provided are likely to remain in care longer and their siblings are more likely to end up in care.
- The Department of Social Services reports that parental substance abuse accounted for the placement of 15 to 31 percent of all children in foster care.
  - Estimates of substance abuse among child protective services and foster care cases vary from 25 to 100 percent according to officials within local departments of social services.
- In 2006, five percent of CSA referrals were attributable primarily to substance abuse.
  - CSA officials believe that substance abuse is an underreported problem.

Substance Abuse and Juvenile Justice

- According to national data, more than half of the juvenile justice population tested positive for drugs (excluding alcohol) at the time of their arrest.

- The prevalence of substance abuse problems among Virginia's juvenile justice population varies by setting.

Substance Abuse Problems Among Department of Juvenile Justice Population



Source: Department of Juvenile Justice (2005)

Substance Abuse and Adult Corrections

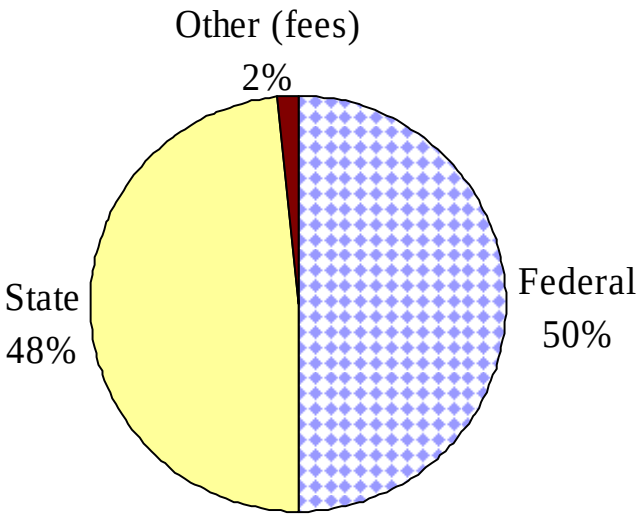
- Research has consistently demonstrated a link between substance use, abuse, and criminal behavior.
  - Domestic violence is highly correlated with substance use, especially alcohol.
  - Illicit drug use is associated with significantly higher levels of criminal behavior and increased recidivism.
  - National data indicate that substance abuse and addiction were implicated in the felony crimes of 80 percent of adult offenders behind bars.
- The Department of Corrections reports that 70 to 75 percent of offenders have a history of substance abuse that contributed to their criminality.

Current Substance Abuse Spending, Indicators of Need and Policy Options

- Current spending
- Indicators of need
- Policy Options

Current Substance Abuse Spending

Substance Abuse Spending in the Commonwealth
(FY 2006 = $100.7 million) *



* Does not include local spending.

- Despite general fund budget reductions earlier this decade, overall support for substance abuse services has increased by $3.4 million since FY 2001 in spite of the loss of $706,656 in federal funding.

- Restoration of services has not been uniform. Funding available for juveniles in the community has fallen by $3.1 million while resources made available to the DMHMRSAS have increased by $5.3 million.

Is Substance Abuse Funding Adequate?

- There is clear evidence to suggest that additional substance abuse treatment is necessary.

- DMHMRSAS reported that 3,389 individuals were awaiting substance abuse services in FY 2005.

  – Of those on the waiting list, 70 percent (2,386) waited between one and three months for an initial appointment.

- On average, it takes more than 25 days for individuals seeking services at Virginia's CSBs to begin receiving active treatment.

  – The inability to access services in more than a few days severely limits motivation for treatment.

- More than 60 percent of localities report that outpatient substance abuse services is one of the top 10 critical service gaps in CSA.

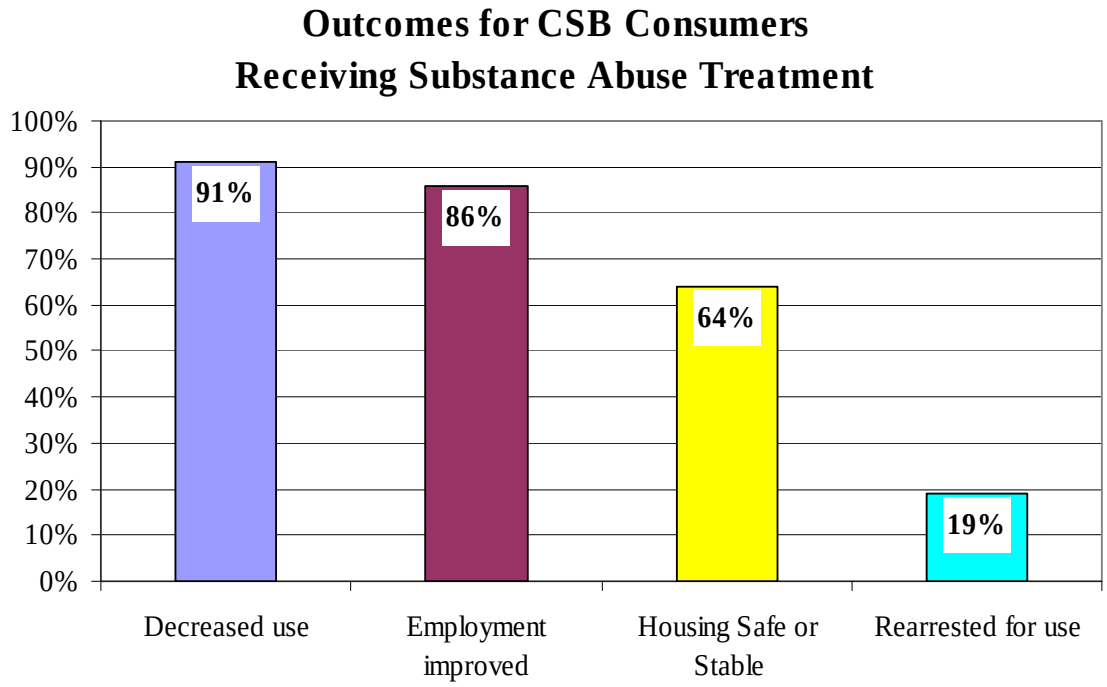
- While DJJ is able to meet the current treatment needs at juvenile correctional centers, it only serves 10 percent of more than 3,000 individuals residing in the community who were identified at high-risk of needing treatment.

  – Unserved youth rely upon CSA, CSBs, or their family's insurance to receive treatment.

Substance Abuse Policy Options

- Require the Joint Commission on Health Care or the Joint Legislative Audit and Review Commission to conduct a comprehensive assessment of the need for substance abuse services in the Commonwealth.
  - More specific data is needed on the scope of the problem and the cost of providing prevention and treatment services.
- In the meantime, immediate action appears to be warranted in a few specific areas:
  - Expand substance abuse treatment services to the Medicaid population.
    - Substance abuse services for individuals already receiving Medicaid is likely to have an immediate impact on an individual's overall health that may, in fact, offset the cost of treatment.
  - Expand funding for evidence-based, preventive services specifically targeted at youth to reduce underage alcohol consumption and drug use.
  - Restore funding for the juvenile justice and corrections populations that was eliminated in 2002.

Benefits of Substance Abuse Treatment



- Consumers at CSBs showed positive outcomes upon receipt of substance abuse services.

- Numerous studies have demonstrated that substance abuse treatment lowers overall health care costs.

- Other studies reveal treatment reduces recidivism among corrections and juvenile justice populations, especially when continued upon discharge.

- Improvements in family life are difficult to quantify but clearly present.

Conclusion

- Despite Medicaid's dominance of health and human resources spending, child welfare programs continue to experience substantial growth.
  - Various task forces, commissions, and work groups set up by the General Assembly or the administration are currently analyzing recent growth with an eye toward future policy action.
- An element of rising program costs may be related to the problem of substance abuse.
  - The cost of untreated substance abuse permeates many state programs and contributes to other societal problems.
- In the short run, targeted investments in prevention and treatment services have the potential to achieve long-term cost savings.
  - At the same time, the Commonwealth should commence a comprehensive analysis of the need for prevention and treatment services.

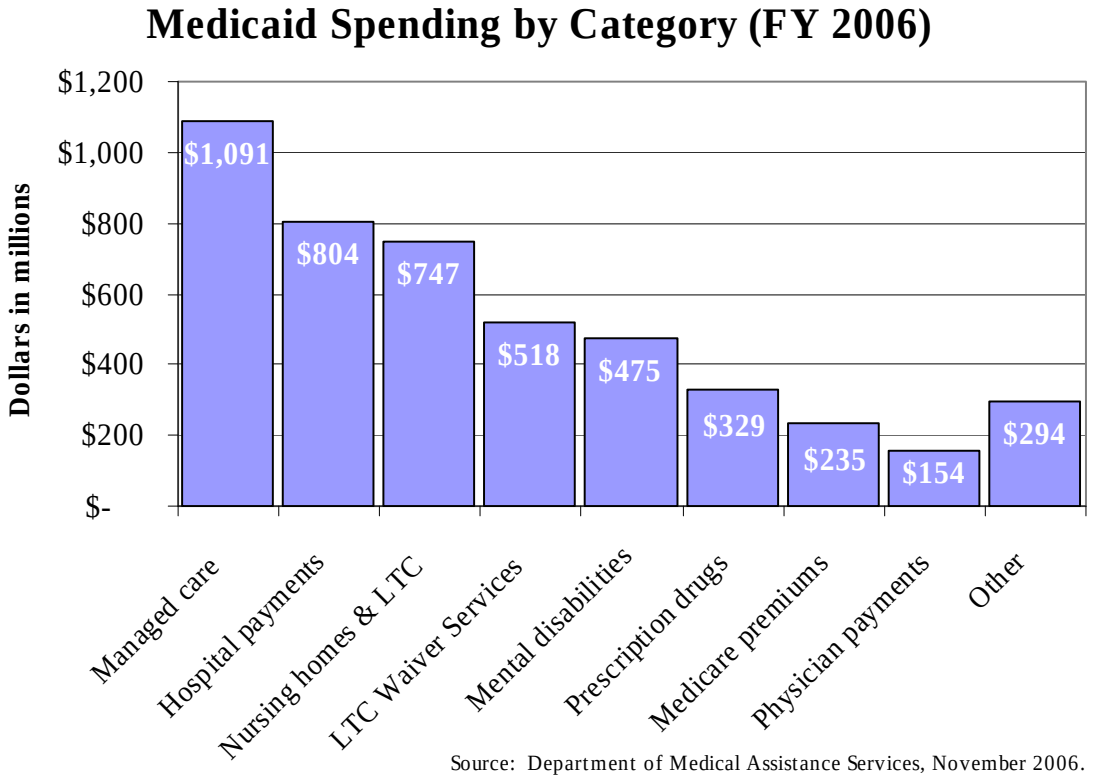
Appendix I

Medicaid Populations Covered in Virginia	
Mandatory	**Optional**
Aged, blind, or disabled	Medically Needy (income exceeds established limits)
Members of families and children	Individuals living in institutions (e.g., nursing facilities, intermediate care facilities for persons with mental retardation) or receiving services through Medicaid home and community-based waivers
Pregnant women	Certain aged, blind, or disabled adults who are not on federal supplemental security income
Certain Medicare beneficiaries	Persons terminally ill and receiving hospice care
	Children under 21 in foster homes, private institutions, in subsidized adoptions
	Women screened and diagnosed with breast or cervical cancer

Appendix II

Medicaid Services Covered in Virginia	
Mandatory	**Optional**
Inpatient, outpatient, and emergency hospital services	Prescription drugs
Nursing facility	Mental health and mental retardation
Physician	Home & community-based waivers
Medicare premiums, copayments and deductibles (Part A & B – categorically needy)	Skilled nursing facility care for persons under age 21
Certified pediatric nurse and family nurse practitioner services	Dental services for persons under age 21
Certain home health services	Physical therapy & related services
Laboratory and X-ray	Clinical psychologist
Early & periodic screening, diagnostic, and treatment (EPSDT)	Podiatry
Nurse midwife	Optometry
Rural health clinics	Services provided by certified pediatric nurse and family nurse practitioner
Federal qualified health center clinic	Home health services (PT, OT, and speech therapy)
Family planning	Case management
Transportation	Prosthetic devices
	Other clinic services
	Hospice
	Medicare premiums/copayments/ deductibles (Part B – medically need)

Appendix III



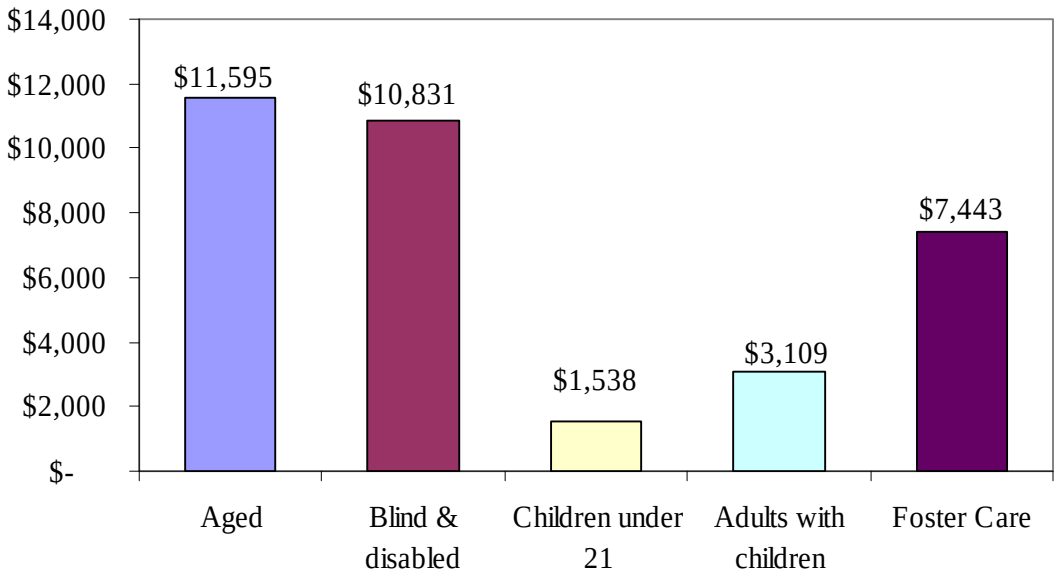
Source: Department of Medical Assistance Services, November 2006.

- Medicaid expenditures in FY 2006 totaled $4.6 billion, divided almost equally between state and federal dollars.
  - Managed care payments are the largest category of Medicaid spending, accounting for 23 percent of expenditures.
  - Long-term care services delivered in institutional and community-based settings accounts for 27 percent of expenditures.

Appendix IV

- It is 7 to 8 times more expensive to serve someone who is aged, blind or disabled than it is to serve a low-income child.
  - The aged, blind, and disabled typically require more intensive and expensive services, whereas low-income families and children generally require routine health care services.

Per Capita Spending on Medicaid Recipients (FY 2005)



Source: Medicaid Statistical Record (2005).

Appendix V

FY 2006 Substance Abuse Services Funding (dollars in millions)				
Department	**Federal**	**State**	**Other**	**TOTAL**
Education	5.1	0	0	**5.1**
Health Professions	0	0	1.7	**1.7**
DMAS	0.4	0.4	0	**0.9**
DMHMRSAS	42.9	41.8	0	**84.7**
DJJ	<0.1	0.7	0	**0.7**
DOC	0.6	5.6	0	**6.2**
GOSAP *	1.3	0	0	**1.3**
TOTAL	**$50.4**	**$48.5**	**$1.7**	**$100.6**
*** Governors Office of Substance Abuse Prevention**				

FY 2001 Substance Abuse Services Funding (dollars in millions)				
Department	**Federal**	**State**	**Other**	**TOTAL**
Education	6.5	0	0	**6.5**
Health Professions	0	0	1.4	**1.4**
DMAS	0.1	0.1	0	**0.3**
DMHMRSAS	40.9	38.5	0	**79.4**
DJJ	0.8	2.7	0.3	**3.8**
DOC	1.1	3.1	0	**4.2**
GOSAP	1.6	0	0	**1.6**
TOTAL	**$51.1**	**$44.4**	**$1.7**	**$97.2**