REPORT OF THE
JOINT LEGISLATIVE
AUDIT AND REVIEW COMMISSION

Review of the Virginia Medicaid Program: Final Summary Report

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

Senate Joint Resolution 180 (1991) requested the Joint Legislative Audit and Review Commission (JLARC) to conduct a comprehensive review of Virginia's Medicaid program. This study mandate was passed in response to the escalating costs of Medicaid in Virginia. Currently, the State spends more than $1.4 billion annually on the program, providing health and long-term care services to more than 490,000 recipients.

This is the final report in the series addressing the issues outlined in SJR 180. Six reports have been completed on issues ranging from hospital, physician, and pharmacy costs to the transfer of assets by persons applying for long-term care benefits under the program. These reports provide detailed descriptions of the major components of the Medicaid program, as well as analysis of significant issues related to access to care, eligibility for the program, the costs of services, and options for containing costs.

In addition to specific findings on issues related to ambulatory care, inpatient and outpatient hospital services, and long-term care, a number of significant cross-cutting findings emerged from the series of reports. Among the most important of these findings were the following:

- Medicaid provides for all federally-mandated services and many others that are optional, but the program is not extravagant in the services provided.

- Eligibility for the Medicaid program is conservative because of its link to other programs such as Aid to Families with Dependent Children, which have strict eligibility requirements.

- Access to care is generally adequate, but problems related to the insufficient supply of physicians in some parts of the State affect Medicaid recipients as well as all other Virginians.

- Medicaid spending in Virginia is not "out of control" — the increases are the result of inflation and decisions by the Congress and the General Assembly to expand eligibility or services covered.

- The General Assembly cannot effectively control increasing Medicaid spending through restrictions on the Medicaid program. Long-term savings for the program can come only from general health care reform which controls costs for all payors.

On behalf of the Commission staff, I wish to acknowledge the support and cooperation by staff of the Department of Medical Assistance Services and various health care providers in the preparation of all of the reports in the Medicaid series.

Philip A. Leone
Director

February 17, 1993

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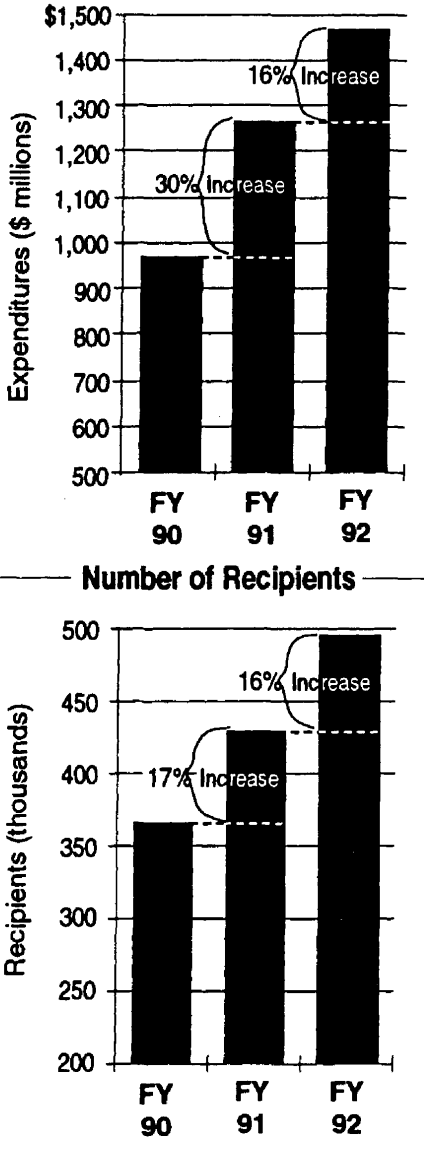
Review of the Virginia Medicaid Program: Final Summary Report

The Virginia Medical Assistance Program, or Medicaid, is a joint federal-state program authorized under Title XIX of the Social Security Act and is the largest of the State's health care programs available to indigent persons. Over the past several years, the program has experienced rapid growth. Total program expenditures for medical care were almost $1.3 billion in FY 1991, representing a 30 percent increase from the previous fiscal year (Figure 1). In FY 1992, expenditures continued to grow, increasing by 16 percent to about $1.4 billion. The number of persons receiving Medicaid services has also increased significantly. In FY 1991, the number of recipients grew by 17 percent to 428,650. Growth continued in FY 1992, when the number of recipients grew about 16 percent to 495,516.

The continuing expansion of the Medicaid program and the significant amount of State general funds expended on it have fueled legislative concerns. The 1991 General Assembly passed Senate Joint Resolution (SJR) No. 180 in response to these concerns (Appendix A). The resolution directed the Joint Legislative Audit and Review Commission (JLARC) to conduct a comprehensive review of the Virginia Medicaid program.

Six reports on the Virginia Medicaid program were completed in 1992 and 1993 to address various issues outlined in SJR 180. The reports provide descriptive and analytic information about the structure of the Medicaid program in Virginia, program expenditures, eligibility for service, methods for reimbursing medical services provided through the program, and cost containment mechanisms. Information about specific findings and recommendations can be found in the following JLARC reports:

Figure 1:
Recent Growth in the Virginia Medicaid Program



Source: Department of Medical Assistance Services, internal expenditure reports, FY 1990 - FY 1992 and HCFA 2082, Statistical Report on Medical Care: Eligibiles, Recipients, Payments, and Services, DMAS, State FY 1990 - FY 1992.

- *Special Report: Evaluation of a Health Insuring Organization for the Administration of Medicaid in Virginia*, January 1992
- *Interim Report: Review of the Virginia Medicaid Program*, February 1992
- *Medicaid-Financed Hospital Services in Virginia*, November 1992
- *Medicaid Asset Transfers and Estate Recovery*, November 1992
- *Medicaid-Financed Long-Term Care Services in Virginia*, December 1992
- *Medicaid-Financed Physician and Pharmacy Services in Virginia*, January 1993

This report summarizes major themes and issues that have been presented in the JLARC series of reports on the Virginia Medicaid program.

The Virginia Medicaid Program

The Virginia Medicaid Program makes health care services available to qualified citizens who do not have the financial resources to obtain them. However, federal program requirements restrict enrollment to individuals who fall within certain eligibility classifications. Therefore, many low-income Virginians are not eligible for Medicaid. Furthermore, eligibility for Virginia's Medicaid program is, in some ways, more restrictive than many other states due to stringent income and resource limits set by the State for certain eligibility categories. The State does extend Medicaid coverage to certain individuals for whom coverage is optional.

Services provided through the Medicaid program cover many basic health care needs for those who are eligible. The program must provide reimbursement for services mandated by federal statute and regulations, such as inpatient and outpatient hospital services, nursing facility services, physician services, diagnostic laboratory and X-ray services, transportation, and family planning services, among others.

The program also covers a number of optional services, such as pharmacy services, psychological services, and limited dentistry, optometry, and podiatry services. The mandatory and optional services provided to Virginia's Medicaid enrollees appear to be similar to those that other states offer.

Some Medicaid enrollees do not have access to the full complement of mandated and optional services available through the Medicaid program, due to limitations set by the program. In general, Medicaid enrollees who are children (age 20 and younger) receive the largest complement of services. Adults and certain other groups of enrollees, such as refugees, have access to more limited services. However, the costs of providing services to adults, especially long-term care, represent almost 60 percent of Medicaid spending.

The Medicaid program functions as a third party payer of medical services for eligible individuals. As such, it reimburses health care professionals and facilities for covered services provided to those enrolled in the program. The Medicaid program does not provide direct financial assistance to program recipients. In FY 1992, about $1.4 billion was paid to health care professionals and facilities for care rendered to Medicaid enrollees.

General Findings and Conclusions

Several major or cross-cutting issues emerged from the JLARC studies. Overall, Virginia's Medicaid program is not extravagant in who is served or in the services provided to qualified individuals. However, access to health care for Medicaid-qualified individuals, particularly primary care, could be improved. Although spending increases for the Medicaid program have been dramatic over the past several years, program expenditures are not spiraling out of control. The State can exert more control over Medicaid spending; however, substantial savings will require difficult choices regarding service reductions. Unless such changes are made, the State can expect to achieve only marginal savings in program expenditures.

The State needs to look beyond the Medicaid program for additional opportunities to contain program costs. Ultimately, increases in the cost of health care services will be reflected in Medicaid program spending. Therefore, the State needs to begin formulating strategies to deal with the rising cost of health care in Virginia. These strategies could assist the State in holding the line on Medicaid cost increases in the future.

Medicaid Coverage in Virginia Is Conservative

The Virginia Medicaid program is not extravagant either in who is eligible for the program or in the services covered. The program provides federally mandated services to eligible Medicaid beneficiaries as required by federal statutes and regulations. The State has also chosen to provide additional services at its option to certain eligible groups of Medicaid beneficiaries. However, Virginia limits the number of mandated and optional recipients served by the Medicaid program by applying strict financial eligibility standards. Virginia's income limits for many eligible groups are linked to the Aid to Families with Dependent Children (ADC) program payment standards. All but three states have ADC income limits that are higher than those applied in Virginia.

The Virginia Medicaid program is not extravagant either in who is eligible for the program or in the services covered.

Extension of the Medicaid program to persons for whom eligibility is optional appears reasonable. Virginia makes Medicaid available to optional groups who are impoverished and who have significant medical expenses that place them at risk. These extensions are similar to those offered by 36 states and the District of Columbia.

The optional services provided through the Virginia Medicaid program also appear appropriate. Many of these services (such as pharmacy services) improve health care access for indigent Virginians, including children. Often these optional services are also cost effective to provide. All states provide optional services to at least some Medicaid-eligible groups. While the Virginia Medicaid program finances a wide range of optional services, more than one-half of the states finance a wider variety of optional services.

Access to Primary Care Is Adequate But Could Be Improved

Medicaid enrollees appear to experience some difficulties in accessing primary care physicians, especially in rural areas. Some of these access problems are related to the inadequate supply and distribution of primary care physicians in Virginia. However, these problems are not specific to Medicaid enrollees, but affect all Virginians as they access primary health care.

Additional problems such as recipient behavior, how Medicaid recipients access care, and low Medicaid reimbursement nega-

tively influence physician participation in the Medicaid program, thereby creating additional access problems for these recipients. JLARC staff found that only about one-half of the physicians enrolled in the Medicaid program actively provide services to Medicaid recipients. This means that many Medicaid enrollees must rely on local health department clinics, hospital outpatient clinics, and/or hospital emergency rooms to obtain needed care.

Recent physician rate increases for primary care services, obstetric and gynecological services, and pediatric services appear to have helped maintain physician participation in the Medicaid program. Many primary care physicians enrolled in the Medicaid program as service providers have increased their level of participation in the program since January 1990, although the rate increases do not appear to be the primary factor explaining these increases.

While recent increases in Medicaid spending appear alarming, Medicaid funding in Virginia is not out of control.

Improvement in recipient access to primary care should be realized as the Virginia Medicaid program moves forward in implementing its managed care program called "Medallion." Recipient education along with expansions in the managed care program statewide for all ambulatory Medicaid recipients could further increase physician participation as well as enhance access to primary care for Medicaid recipients.

Medicaid Spending Increases Are Not Out of Control

While recent increases in Medicaid spending appear alarming, Medicaid funding in Virginia is not out of control. The substantial increases in expenditures for Medicaid services have been the result of specific identifiable factors, many of which have been deliberate federal and State policy choices. Some specific cost increases have also been the result of shifts in the mix of services received by Medicaid recipients over time.

To combat the steadily rising costs of the program, a number of cost containment measures have been implemented over the past decade by the Department of Medical Assistance Services (DMAS) in an effort to prudently purchase services and avoid unnecessary program expenditures. These measures have been successful in containing some of the increases in Medicaid expenditures.

Factors Influencing Medicaid Cost Increases. Recent Medicaid cost increases can be attributed to several factors. Some of these factors have been beyond the control of program administrators, such as: (1) inflation—both general and health care specific, (2) increasing numbers of eligible recipients mandated by federal statute, and (3) increased intensity of services provided to recipients.

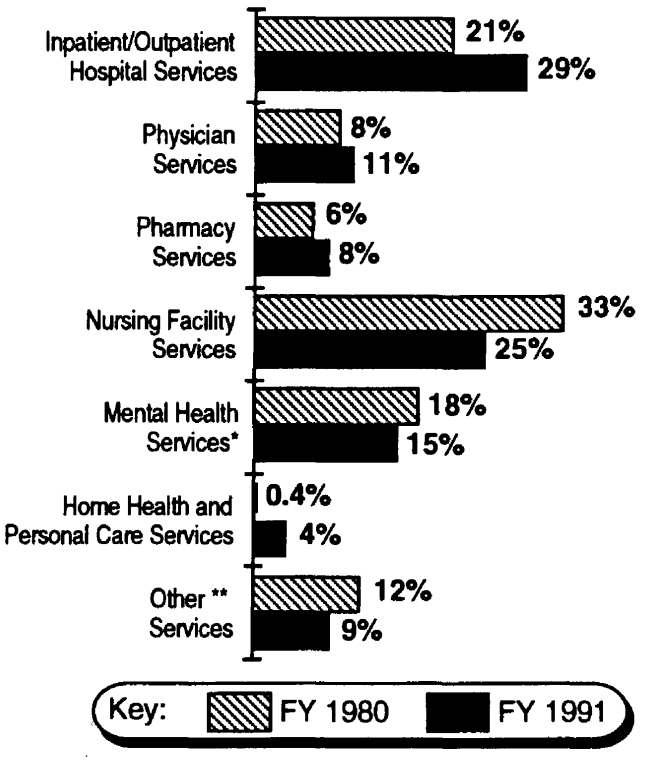
In addition, deliberate federal and State policy decisions have also resulted in increased Medicaid costs. For example, Congress has expanded the program in recent years to provide coverage for certain children, indigent pregnant women, and impoverished Medicare beneficiaries. In addition, the State has made a number of policy decisions to provide optional services, such as nursing home services for the medically needy and pharmacy services. Moreover, State policy decisions have deliberately expanded the program to obtain federal matching Medicaid funds for certain indigent health care services (such as mental health services) that were previously funded solely by the State.

Changes in the Mix of Services Provided Has Resulted in Some Cost Increases. Increased Medicaid costs also have been influenced by the shift in services provided

by the program and their attendant expenses. A growing proportion of Medicaid funding is being expended on hospital inpatient and outpatient care, as well as physician services. The growth in outpatient expenditures and physician expenditures, however, may obscure the savings the program has achieved in inpatient costs through the shifting of some procedures to less expensive settings.

In FY 1980, spending on hospital services represented about 21 percent of total Medicaid expenditures for medical care, about $80 million (Figure 2). However, in FY 1991, the Medicaid program expended about 29 percent of its medical care budget on hospital inpatient and outpatient services, amounting to almost $368 million. Physician expenditures have also increased as a proportion of the Medicaid budget for medical care from 8 percent to almost 11 percent over the same period.

Figure 2:
Medicaid Medical Care Expenditures as a Percent of Total Medicaid Budget FY 1980 and FY 1991



* Mental health services include expenditures for nursing facility services provided to the mentally retarded.

** Includes laboratory and x-ray services, other practitioner services, dental services, transportation, and other services.

Source: Department of Medical Assistance Services, internal expenditure report, FY 1980 - FY 1991.

Currently, a smaller proportion of Medicaid funding is being expended on long-term care services compared to ten years ago. For example, in FY 1980, 51 percent of the $374 million spent for Medicaid medical care was used to pay for long-term care services. By FY 1991, this percentage had decreased, but this type of care still represented 47 percent of total program spending.

Spending for all long-term care services will likely increase in the future due to expected growth in the elderly population in Virginia over the next 30 years. As the number of frail elderly persons increases, demand for Medicaid-financed long-term care services will increase. Meeting this demand for long-term care services could have dramatic effects on the long-term care costs of the Medicaid program.

Cost Management Practices Have Slowed the Growth in Medicaid Program Costs. All states are required by federal regulation to perform a core group of cost management activities for their Medicaid programs. However, the states have some flexibility in how they implement the requirements. The Department of Medical Assistance Services uses a number of cost management techniques to control program

costs. Cost management performance in Virginia appears to have improved with the growth of program benefit expenditures in the past five fiscal years, indicating that DMAS does a capable job of managing program costs.

Cost containment practices implemented by DMAS have been successful in controlling hospital, long-term care, and ambulatory care expenditures. DMAS reported that cost management practices implemented in FY 1991 helped the Medicaid program avoid incurring an additional $431 million in program expenditures. Some cost management practices implemented by DMAS include: changing reimbursement methodologies to prospectively pay for certain services, implementation of a screening system for long-term care services, strengthening utilization review activities, limiting benefits, recovering Medicaid funds expended by identifying third party liability, and implementing information system changes to identify duplicate billings. While these practices cannot halt increases in program expenditures, they can impact the rate of growth in Medicaid expenditures.

Short-Term Cost Containment Will Require Benefit Restrictions

Currently, the State has limited flexibility to reduce significant amounts of Medicaid expenditures. Federal statutes and regulations require that certain groups be covered and that certain services be provided through the Medicaid program. Service providers must be reimbursed at levels which meet tests of efficiency and economy, or that ensure adequate access to care for Medicaid enrollees. This leaves two main alternatives for reducing significant amounts of Medicaid expenditures: (1) limiting eligibility for optional groups or (2) reducing optional services.

These options could result in substantial reductions in Medicaid costs. Examples of optional services which could generate significant program savings if eliminated include:

- $258 million for long-term care services currently provided to medically needy recipients for whom Medicaid coverage is optional

- $113 million for long-term care services currently provided to recipients who are eligible as optional categorically needy

- $110 million for pharmacy services (primarily prescription drugs).

However, major reductions may not be appropriate, because they would result in the loss of health care access to persons who live at the economic margins and are in need of health care services. In addition, some of these choices might result in increased costs in other parts of the Medicaid program, especially if more cost-effective services are eliminated.

While significant reductions outlined above may not be possible, the State can take steps to attain marginal cost savings in Medicaid program. The JLARC reports on the Medicaid program provide a number of recommendations which could result in cost savings for the Medicaid program. Some of these require legislative action, while others require administrative action by the executive branch through administration of the Virginia Medicaid program.

Listed below are some of the major recommendations contained in the JLARC reports, along with the $16 to $32 million in estimated savings which could be achieved if the recommendations are implemented.

- Implement a prospective reimbursement system for hospital outpatient services.

- Eliminate nursing home benefits for the medically needy ($10 million in savings).

- Lower the income standard for persons who establish eligibility as optional categorically needy from 300 to 200 percent of the SSI benefit level ($14 million in savings if initiated in conjunction with elimination of benefits for the medically needy).

- Implement a proactive estate recovery program in the Department of Medical Assistance Services ($2 to $9 million in savings annually).

- Eliminate mistargeting by improving the screening process for persons seeking personal care services ($4 to $16 million).

- Add staff at DMAS to conduct additional Medicaid provider post-payment utilization reviews ($40,000 in savings per staff person added).

- Add State Police staff to conduct additional drug diversion investigations for Medicaid ($175,000 per staff person added).

Long-Term Cost Reductions Will Require Health Care Reform

Marginal cost savings can be attained in the short run by implementing some of the above JLARC recommendations. However, the State cannot rely on Medicaid-specific cost containment alone to hold down program expenditures in the future. The State needs to look beyond the Medicaid program at the health care delivery system in Virginia to begin formulating policies to contain health care costs in general.

Cost saving strategies to address the rising cost of health care on a statewide basis are necessary for several reasons. First, the Medicaid program does not have the leverage, alone, to effect significant savings in the cost of hospital care. Second, health care cost inflation, which has a significant impact on the program's cost, is extraneous to the Medicaid program and largely cannot be controlled by program administrators. Finally, as other third party payers attempt to control their health care costs, medical care providers are increasingly unable to shift costs associated with lower Medicaid reimbursement. As a result, access to care may become more problematic for Medicaid recipients in the future.

Subsequent sections of this report focus on the findings and conclusions related to specific Medicaid issues. These include issues related to Medicaid eligibility, the scope of Medicaid-covered services, Medicaid methods for reimbursing service providers, utilization review practices, and asset transfers and estate recovery practices. More detailed information and specific recommendations covering each issue can be found in the JLARC reports noted earlier.

Medicaid Eligibility

Medicaid program costs are driven to a large extent by federal mandates that control who must be covered by state Medicaid programs. Recent federally mandated expansions have resulted in large increases in the number of persons who are eligible for Medicaid. However, the State can exert some control in the coverage of optional groups of eligible persons and in setting income limits to guide eligibility determinations.

Federal statute and regulations give the states some discretion in deciding who is served by the Medicaid program and what benefits they receive. As a result, one method

to realize savings in the Medicaid program is to restrict the number of persons who have access to the program. As an entitlement program, however, Medicaid must provide services to all who are found eligible under mandated federal eligibility policies or under optional State eligibility policies.

To become enrolled in the Medicaid program an individual must fall within established eligibility classifications. Each Medicaid enrollee is classified as a member of one category and one class. The eligibility category distinguishes the unique characteristic which applies to a certain group of enrollees and is descriptive in nature, while the eligibility class indicates the level of financial need.

As noted earlier, the Virginia Medicaid program is not extravagant in determining who is eligible for the program. The program currently uses fairly restrictive financial criteria in determining eligibility for mandated groups. However, a substantial portion of the long-term care costs in the Medicaid program is due to the extension of benefits to persons for whom Medicaid coverage is optional. In FY 1991, more than one-half of the 44,000 Medicaid long-term care recipients established eligibility for program benefits through provisions that were implemented at the option of the State. The total medical care expenditures for this optional group of recipients exceeded $370 million.

Nevertheless, extension of Medicaid coverage through optional provisions does provide health care services to many Virginians who live at the economic margins. The State could significantly reduce the cost of the Medicaid program by restricting the number of persons found eligible for Medicaid through optional State policies. However, this could result in the loss of Medicaid eligibility to a number of persons who do not have the financial means to pay for their health care and could impose severe hardships on those individuals.

Medicaid Eligibility Categories Have Been Expanded

To qualify for Medicaid an individual must fit into one of several eligibility categories. All state Medicaid programs are required to cover indigent persons who are entitled to benefits due to their participation in two federally supported public assistance programs. These traditional categories of eligibility include:

- aged (age 65 and older), blind, or disabled individuals (including children) who receive Supplemental Security Income (SSI) assistance
- families with dependent children who receive Aid to Families with Dependent Children (ADC) assistance.

The U.S. Congress recently created new categories of eligibility in order to finance pregnancy-related and pediatric services for low-income women and children through the Medicaid program. Coverage of these new "indigent" classifications has been phased-in, initially as options, then as federal mandates. Eligibility requirements are less restrictive and more straightforward than traditional coverage since they are tied directly to federal poverty income levels. For example, federal mandates require state Medicaid programs to extend coverage to:

- pregnant women with incomes at or below 133 percent of the federal poverty income guidelines
- indigent children younger than age six with family incomes at or below 133 percent of federal poverty income guidelines
- indigent children age six and older born after September 30, 1983, with family incomes at or below 100 percent of the federal poverty income guidelines

- indigent children up to age 13 at 100 percent of the federal poverty income level.

Furthermore, the federal government now requires state Medicaid programs to pay the costs associated with ensuring Medicare coverage for certain impoverished Medicare beneficiaries.

These mandated expansions have weakened the link between Medicaid eligibility and eligibility for other government cash assistance programs. Increasingly, federal policy-makers have used the Medicaid program as a vehicle for providing health care to growing numbers of poor, uninsured individuals. The Virginia Medicaid program will continue to be impacted by eligibility expansions as the program phases in coverage of children up to age 18 with incomes at or below 100 percent of the federal poverty income level. However, Medicaid coverage of many of these newly expanded groups is cost effective, particularly for indigent children and pregnant women.

Medicaid coverage of many of the newly expanded groups is cost effective, particularly for indigent children and pregnant women.

Medicaid Eligibility Classes Include Mandatory and Optional Recipient Groups

Individuals seeking eligibility are classified according to their level of financial need as either: categorically needy (mandatory or optional) or medically needy. Federal statute requires that states provide Medicaid coverage to certain individuals. These groups are classified as mandatory categorically needy. This class originally described those persons whose eligibility for Medicaid was based exclusively on their participation in two other federal assistance programs: ADC and SSI. However, additional groups have been added to this class in recent years.

Optional categorically needy refers to groups to whom the State has the option of extending Medicaid benefits. Virginia began covering selected optional categorically needy groups in 1970. For example, the State has opted to extend Medicaid coverage to persons who meet a special income limit through what is generally called the 300 percent rule. Under this guideline, the State can extend Medicaid coverage to persons who are either institutionalized or at-risk of institutionalization, and have incomes that are greater than the State's limits for SSI but lower than 300 percent of the SSI level. Virginia uses the 300 percent rule to determine eligibility for individuals who are receiving care through the home and community-based waiver or who are in State institutions for mental diseases and intermediate care facilities for the mentally retarded.

In 1970, the State also elected to provide medically needy coverage. Many State residents who cannot establish eligibility through guidelines for categorically needy coverage can gain access to Medicaid benefits as medically needy. This class includes individuals who have too much income to meet the financial eligibility requirements of the SSI and ADC programs, but not enough income or resources to pay their medical bills.

Applicants whose income and/or resources exceed the Medicaid limit must "spend down" by incurring medical expenses in sufficient amounts before qualifying for Medicaid coverage. "Spending down" in Medicaid can be a complex process that requires applicants to accumulate medical bills, meet with the eligibility workers to have them verified, and then be approved for benefits. As of October 1991, 36 states and the District of Columbia provided Medicaid coverage to medically needy individuals.

Eligibility Changes to Realize Cost Savings Should Focus on Optional Groups

As mentioned earlier, one key finding of the JLARC studies is the State could reduce Medicaid program costs by changing Medicaid eligibility policies. Although Medicaid eligibility is based on federal requirements, the State is able to control certain income and resource criteria established for the ADC and SSI programs. To the extent that cost savings can be realized through the implementation of tighter eligibility guidelines for any group of potential recipients, basic principles of equity dictate that this should come at the expense of persons for whom Medicaid coverage is optional.

Virginia has already limited the number of persons covered through the Medicaid program by imposing restrictive income eligibility criteria for the ADC program and more restrictive resource criteria for SSI-related applicants. These limitations narrow the number of persons who could be eligible for the program under mandatory categorically needy coverage. In addition, these restrictive criteria also limit the number of persons who could be eligible for the program through optional categorically needy and medically needy classes.

JLARC staff found that a substantial portion of the cost of long-term care in Virginia is due to the extension of benefits to persons for whom Medicaid coverage is optional. In 1991, the DMAS stated that elimination of coverage for the medically needy would result in $10 million in savings. This assumes that many of those affected by the elimination of the medically needy program would be able to establish eligibility as optional categorically needy recipients. Therefore, to obtain additional cost savings, it would be necessary to lower the income standard for optional categorically needy individuals who obtain eligibility through special income requirements set at 300 percent of the SSI monthly benefit level.

There are no federal restrictions preventing states from lowering this standard to any amount between the SSI monthly benefit and 300 percent of that benefit. If the State lowered the income standard to 200 percent of the SSI benefit level, savings to the Medicaid program could result. In light of this, two strategies could be used to effectively reduce the future cost of the long-term care for the Medicaid program: (1) eliminate coverage for the medically needy and (2) reduce coverage for the optional categorically needy. Together, these strategies could save the Medicaid program about $14 million.

However, there are disadvantages associated with both of the above options. Medically needy income levels are still considerably less than the federal poverty income level. Furthermore, lowering the income standard for optional categorically needy could restrict access to care for special populations. While the State has the discretionary authority to reduce the size and cost of its Medicaid program by eliminating and restricting coverage of these groups, the outcome could impose severe hardships on many elderly and disabled citizens who either live at the economic margin or rely almost exclusively on Medicaid for support of their basic health care needs.

Medicaid-Covered Services

Another method to achieve significant cost savings in the Medicaid program is to limit the range of services available to program enrollees. Currently Virginia provides a greater array of services to Medicaid eligible persons than mandated by the federal government. Nevertheless, many of these optional services represent reasonable ex-

tensions of the program that improve health care access for many indigent Virginians. In addition, provision of many of these optional services appears to be cost effective.

Medicaid policy includes provisions that are designed to elicit prudent utilization of services. This is accomplished by requiring most recipients (with some exceptions) to make copayments or meet a deductible charge for certain services. The Medicaid program also applies limits to certain services for many recipients. For example, all recipients except children are limited to 21 days of inpatient hospital care per illness. Routine dental examinations are only available to children, and these are limited to one visit every six months. In addition, the Medicaid program emphasizes the provision of services that are medically necessary and provided in the most cost-effective setting.

Cost Savings from Limiting Hospital Services or Increasing Copayments Would Be Minimal

Federal Medicaid policy requires states to provide hospital inpatient and outpatient services to Medicaid beneficiaries. Virginia's Medicaid program provides modest coverage of Medicaid hospital services in terms of: (1) the amount, scope, and duration of services provided and (2) optional services offered. In addition, the State has implemented a demanding copayment requirement. As a result, there is minimal opportunity for additional cost savings from limiting services or increasing copayments without raising serious health policy implications.

Virginia provides a greater array of services to Medicaid eligible persons than mandated by the federal government.

Federal statute allows states to place limits on the amount, duration, and scope of services provided in the Medicaid program. These limits, which can help to contain costs, are allowed as long as they are based on criteria such as medical necessity or utilization control procedures. For example, the Virginia Medicaid program does not reimburse hospitals for acupuncture services provided to Medicaid recipients because medical necessity for these services has not been definitely determined.

The Virginia Medicaid program imposes a number of limitations on the amount, duration, and scope of hospital services. These limits are relatively restrictive when compared to those of most other states. For example, Virginia limits an adult inpatient's length of stay to 21 days, while 36 states do not impose any limit. Additional limits to lower the 21-day length of stay for adult inpatients has the potential for creating additional cost savings for the program. However, this reduction has serious health policy implications involving issues such as recipient access to medically necessary care, the fiscal impact on medical care providers, and the potential impact on other State indigent health care programs.

There are three optional inpatient hospital services that states can choose to include in their Medicaid programs: (1) inpatient hospital services for patients 65 or older in State mental institutions, (2) emergency hospital services at non-Medicaid enrolled hospitals, and (3) inpatient psychiatric services for children younger than age 21. The Virginia Medicaid program includes coverage of the first two optional hospital services listed above. However, elimination of this optional coverage would only result in minimal savings to the program.

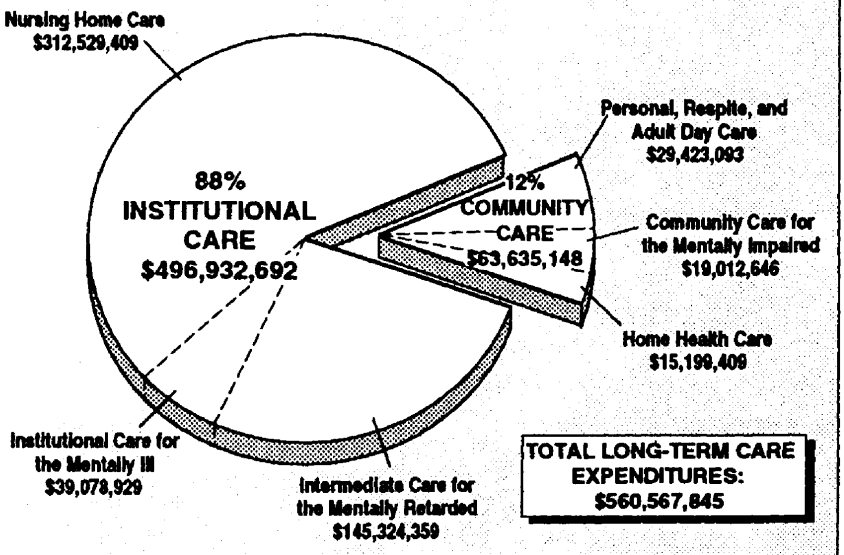
Coverage of inpatient hospital services for patients age 65 or older in State institutions amounted to about $125,000 for 40 recipients in FY 1991. Therefore, savings from the elimination of this optional service would be minimal. Because all Virginia hospitals are enrolled in the Medicaid program, coverage of emergency services at

non-participating hospitals is not an issue.

Federal regulations allow states to impose copayments on Medicaid recipients for hospital services. The Virginia Medicaid program currently imposes a $100 inpatient copayment requirement for many Medicaid recipients. In addition, the program imposes a $2 outpatient copayment requirement.

The inpatient copayment requirement is higher than that imposed by 12 other states for which information could be obtained. The amount of the copayment could significantly impact recipients, because it represents a sizable portion of their monthly income. Further, eight hospitals visited by JLARC staff reported that in FY 1991, they collected less than one percent of the inpatient copayments due. Additional increases in the copayment amount could exacerbate problems such as affordability by Medicaid recipients and the ability of hospital providers to collect the copayment amount.

Figure 3:
Medicaid Long-Term Care Expenditures by Type of Service, FY 1991



Note: Administrative costs are not included in these figures.

Source: Departments of Medical Assistance Services' CARS internal expenditure report.

Reducing Optional Long-Term Care Services Can Achieve Savings

Federal law authorizes a broad range of long-term care services that states can include as part of its benefit package. Some of these services are required and others are optional depending upon the particular recipient group that is being served. Despite changes to federal statutes which are designed to encourage greater use of community-based long-term care, almost nine out of every 10 dollars spent by the Medicaid program on long-term care is still used to support institutional-based services (Figure 3, above). Payments for nursing home care constitute the largest proportion of expenditures on long-term care. In FY 1991, DMAS paid nursing homes more than $312 million — 55 percent of the total expenditures on long-term care. Another 25 percent of the payments ($145 million) can be attributed to the nursing services provided persons in State- and privately-operated intermediate care facilities for the mentally retarded (ICFs/MR).

Virginia spends more than $360 million on long-term care services that are not required by federal law. The two most important and expensive of these are nursing home benefits for the medically needy and institutional care for persons who are mentally retarded. A significant reduction in the Medicaid spending for long-term care services is not possible unless expenditures on one or both of these services are limited.

Better Targeting of Community-Based Care Is Needed

Medicaid provides states with a number of options for developing community care programs through Section 2176 of the Omnibus Budget Reconciliation Act of 1981. One requirement of this provision is that the cost of services provided in the community do not exceed the cost of institutional care. Specifically, states are required to target services provided under the 2176 waiver program to only those people who are at-risk of institutional placement.

JLARC found that, in almost all circumstances, the waiver services are less expensive than costly nursing home care. However, the local screening committees which are responsible for recommending personal care services, have not successfully restricted these placements to persons who are at imminent risk of institutionalization. Personal care services for 57 percent of the current recipients appear to be mistargeted. This has increased Medicaid spending by more than $16 million annually.

Another way in which targeting can affect the overall cost to the State is when people who should be offered personal care are instead steered into a nursing home. Because personal care is a more cost-effective form of care than nursing homes, these services should be offered as an alternative whenever possible. It appears that hospital-based screening committees have a bias toward placing people in nursing homes rather than in personal care. After accounting for the availability of social support and the individual's functional status, hospital screening committees are still 25 percent more likely than community-based committees to place long-term care applicants in a nursing home.

Two recommendations have been made to address issues related to the provision of personal care. These cover: (1) mistargeting of persons for personal care services and attendant reductions in appropriations based on mistargeting, and (2) improved training of hospital-based committees or a study of the feasibility of using community-based screening committees to conduct all or part of the hospital-based screening committee functions.

Community Programs for the Mentally Retarded Have Developed Slowly

While federal waiver authority has been used to divert the aged and disabled from nursing homes to a less expensive form of care over the past decade, the same has not been true for the mentally retarded. Although the 1981 federal legislation that authorizes waivers for the elderly and disabled also allows similar services to be targeted towards the mentally retarded, the State's use of this authority has lagged. The State was not able to obtain approval for the waiver and begin implementing a program designed to divert mentally retarded recipients from care in institutions to community programs until 1991.

Still, it is difficult to determine what impact the State's lack of participation in the waiver has had on overall Medicaid expenditures for the mentally retarded. There is currently no evidence that a more timely development of a waiver program would have led to further reductions in the number of recipients in need of institutional care. Since the early 1980s, the census in State-operated ICFs/MR has declined steadily as most residents who are moderately retarded were placed in community programs.

Further, it is current State policy to limit all non-emergency admissions in these facilities to persons who are severely or profoundly retarded. As a result, the majority of residents in these facilities have complex problems which cannot be easily met in the community. Presently, there is no evidence to indicate that the range of services that would be needed by these individuals can be provided more cost-effectively in the community. JLARC recommendations address the feasibility of developing cost-effective

community-based waiver services for Medicaid recipients who are severely or profoundly mentally retarded.

Reduction of Optional Ambulatory Care Services Does Not Appear Appropriate

The Medicaid program provides an array of ambulatory care services, both mandated and optional. In FY 1991, the Medicaid program spent about $280 million on ambulatory care services. The two largest expenditures for ambulatory care services are physician and pharmacy services. Of the $280 million spent on ambulatory care services in FY 1991, 80 percent (almost $225 million) was expended on physician and pharmacy services. Additional program cost savings can be achieved by eliminating optional ambulatory care services. However, significant reductions would depend on the elimination of the largest expenditures for optional ambulatory care.

The Medicaid program is required to provide physician services to Medicaid beneficiaries. These services cost about $122 million to provide in FY 1991. However, coverage of pharmacy services is optional and the Medicaid program could realize significant savings by eliminating this benefit. About $102 million was spent on the provision of optional pharmacy services in FY 1991.

Nevertheless, the extension of pharmacy services to Medicaid beneficiaries is reasonable. The efficacy of drug therapy and its impact on recipient health status is well established. In addition, the provision of these services is cost-effective. The average cost per recipient for these services is relatively low at about $322 per recipient in FY 1991, compared to $406 per recipient for physician services and $688 per recipient for all Medicaid ambulatory services.

Cost Sharing for Physician Services Does Not Meet Intended Goals

Virginia requires many Medicaid recipients to share in the cost of their physician care by making a copayment for these services. Theoretically, a copayment should discourage unnecessary utilization of physician services, thereby reducing unnecessary program expenditures for these services. Providers cannot deny services if a recipient does not make the copayment, even though their Medicaid reimbursement is reduced by the expected copayment amount.

Although some physicians responding to a JLARC survey support the concept of copayments to control utilization, copayments for these services do not appear to be effective in controlling recipient utilization. About one-third of the physicians who responded to a JLARC survey indicated that they generally do not collect copayments from their Medicaid patients, because the recipients are unwilling or unable to pay their share. In FY 1991, reimbursement reductions due to required copayments for physician services totaled about $56,000. JLARC recommendations address eliminating this requirement.

Medicaid Reimbursement Methods

The Medicaid program provides financial reimbursement to enrolled providers for approved medical services. More than 21,300 health care providers have agreements with DMAS to provide medical services to Medicaid enrollees. Providers who are enrolled in the program include: hospitals, nursing facilities, home health care providers, physicians, pharmacies, transportation providers, clinics, laboratories, medical supply and equipment providers, and other practitioners (such as dentists,

nurse practitioners, optometrists, and podiatrists). Several different reimbursement methodologies are used to reimburse providers for services rendered to Medicaid enrollees.

JLARC analyses focused on reviewing methodologies used by DMAS to reimburse the most costly Medicaid services: hospital inpatient and outpatient services, long-term care services, physician services, and pharmacy services. On the whole, the Medicaid program has implemented reimbursement methodologies designed to promote the cost-effective delivery of services. DMAS has made improvements to its reimbursement methods over the past decade to reflect key factors which influence the cost of services.

JLARC staff found that the reimbursement methodologies could be further refined to achieve a variety of policy objectives, such as: efficiency, cost effectiveness, preserving access to care for Medicaid recipients, and obtaining additional program cost savings.

Nevertheless, JLARC found that the reimbursement methodologies could be further refined to achieve a variety of policy objectives, such as: efficiency, cost effectiveness, preserving access to care for Medicaid recipients, and obtaining additional program cost savings. In addition, the reimbursement process established through the cost settlement and audit function within DMAS can be improved to expedite the reimbursement rate setting process and conduct additional field audits of service providers.

The State Should Prepare for Reform in Inpatient Hospital Reinbursement

Inpatient reimbursement through the Medicaid program is based on prospective payments. Under this arrangement, hospitals are paid based on pre-determined rates rather than the reported cost of providing care. This system was implemented in 1982. JLARC analysis indicates that it has been cost effective for the State, although there are concerns about specific elements of the system. Reimbursement rates for inpatient services appear to have been sufficient to provide access to needed hospital care for Medicaid recipients.

Nevertheless, providers have been dissatisfied with inpatient reimbursement rates, asserting that rate increases have not been sufficient to cover the necessary costs of providing care to Medicaid clients. In 1986, the Virginia Hospital Association (VHA) filed suit against the State, claiming that inpatient reimbursement rates did not meet minimum federal requirements. In February of 1991, the VHA and the State reached an out-of-court settlement, in which the State agreed to make additional payments to hospitals through FY 1996. This settlement agreement also required the establishment of a task force by January 1995 to evaluate the existing inpatient reimbursement system. The agreement also restricts the State's ability to implement changes to hospital reimbursement prior to FY 1997.

Given the magnitude of Medicaid hospital spending, the possibility of future legal challenges, and the possibility of reimbursement reform, the General Assembly will need to become actively involved in the future of Medicaid reimbursement. Specifically, the General Assembly should focus on:

1. ensuring that the State has the ability to evaluate hospital performance

2. clarifying its intent to allow special Medicaid payments for hospitals which serve a disproportionate share of poor patients, and

3. deciding whether reimbursement policy should allow for special treatment of rural hospitals experiencing fiscal stress.

A Prospective Reimbursement System Should be Developed for Outpatient Hospital Services

Outpatient reimbursement rates have been sufficient to enlist a broad base of hospital providers. However, the outpatient reimbursement system does not provide adequate incentives for hospitals to contain costs. DMAS pays cost-based reimbursement rates for most outpatient hospital services. Under this system, providers are assured of receiving payment at the full Medicaid-allowable cost of providing the services, even if that service is provided inefficiently.

While DMAS has taken steps to improve the cost effectiveness of outpatient reimbursement, implementation of a prospective reimbursement system could lead to additional cost savings. Under prospective reimbursement, providers would receive a predetermined payment amount which would create additional incentives to contain costs, similar to principles guiding inpatient reimbursement. DMAS should develop a prospective reimbursement system for outpatient hospital services and implement such a system as soon as the hospital settlement agreement will allow.

The Reimbursement System for Nursing Homes Should be Refined

DMAS has made a number of improvements to the reimbursement system for nursing homes over the past decade. Nursing home rates are now established prospecitvely with payment ceilings to limit the amount of reimbursement a facility can receive from the program. In addition, to enhance access for those Medicaid recipients who have substantial care needs, an adjustment is made to each nursing home's Medicaid reimbursement rate based on the intensity of the facility's case mix.

JLARC staff found that the current reimbursement system is well designed and appropriately considers most of the key factors which influence nursing home costs. Moreover, one effect of establishing payment ceilings has been to slow the growth of nursing home expenditures. Presently, Virginia's Medicaid nursing home expenditures per elderly resident rank among the lowest in the country.

Still, three problems were found with the current system. First, the payment ceilings are not based on measures of efficiency in the nursing home industry. Second, the system does not adequately account for the higher operating costs faced by smaller nursing homes. Third, the reimbursement rates do not reflect the costs nursing homes face as a result of requirements for criminal record checks and protection of employees from bloodborne pathogens.

Cost Containment Incentives Lacking in Reimbursement System for ICFs/MR

Unlike the reimbursement system for nursing homes, the system for State-operated institutions for the mentally retarded contains no cost containment incentives. As result, Medicaid pays virtually 100 percent of the cost for what has become the most expensive form of long-term care in the State. In FY 1991, Medicaid paid the five State facilities an average daily reimbursement of $169. At this rate, the annual cost of care for a Medicaid recipient with no resources to pay for these services could be more than $61,000.

If DMAS were to lower the rates for these facilities, the State would have two alternatives. First, the State could ignore national trends and consolidate these operations. Second, the State would have to use general fund dollars to replace the rev-

enues lost due to the reduction in Medicaid payments.

Reimbursement for Community Care Should Be Reexamined

Although Medicaid expenditures for community-based care represent a relatively small portion of total program expenditures, spending on these services has been growing at a rapid rate of more than 70 percent since 1983. Partly as a result of this increasing trend, there is a heightened interest in the policies used by DMAS to establish reimbursement rates for both home health and personal care services.

A primary concern is whether these policies ensure patient access to community-based care while encouraging the cost-effective delivery of services. Currently, the State reimburses providers of home health care based on a fee-for-service system. However, the methodology used by DMAS to establish the prospective rates does not appropriately consider the key factors that influence home health costs. Also, home health fees may have been set too low to ensure patient access to these services in the future. Further, the policy decision to pay hospital-based agencies higher rates for providing the same service as other operators does not appear justified.

Cost Settlement and Audit Processes Should Be Improved

The Department of Medical Assistance Services uses a cost settlement and audit process to ensure that hospitals and nursing homes are reimbursed payment rates that are based on the approved costs for the services they provided during the previous year. It serves as a financial control to ensure that the Commonwealth pays for only those costs explicitly allowed under the established principles of reimbursement. Financial controls are also necessary to ensure the reliability of a provider's reported cost information. JLARC staff found that this process can be improved to expedite the cost settlement process and conduct additional field audits of hospitals and nursing homes. Recommendations are made to address the timeliness of this process and the need for additional field audits.

The Medicaid Program Uses a Conservative Reimbursement Methodology for Physician Services

States have broad discretion in determining fee levels and payment methodologies for physician services. Federal regulations for physician reimbursement require that payment be consistent with principles of efficiency, economy, and quality of care. The Virginia Medicaid program employs a conservative reimbursement methodology for physician services. Recent increases in Medicaid physician reimbursement rates were necessary to maintain physician participation in the Medicaid program.

The Virginia Medicaid program reimburses physician services on a fee-for-service basis, according to a fee schedule. This reimbursement is based on charges from a past claims year. Consequently, reimbursement may not keep pace with inflation in physician practice costs and charges for services.

Medicaid reimbursement of physician services is generally lower than reimbursement by other third party payers. Studies conducted by the U.S. Physician Payment Review Commission and responses to a 1992 JLARC survey of Medicaid-enrolled physicians support this conclusion. In addition, physician associations reported that other third party payers generally reimburse between 60 and 80 percent of charges or more.

Options for Modifying Pharmacy Reimbursement Could Achieve Cost Savings

The current reimbursement system for Medicaid pharmacy services is based on a fee-for-service, retrospective methodology that contains several expenditure controls.

Provisions in the Omnibus Budget Reconciliation Act of 1990 do not allow the federal government or states to lower the current reimbursement for pharmacy providers or the upper limits imposed on Medicaid payments for drugs until January 1, 1995. Nevertheless, some options do exist for modifying pharmacy reimbursement to allow the Medicaid program to more prudently purchase pharmacy services. Recommendations are made for DMAS to explore implementing options that include:

- planning for reimbursement methodology changes to be implemented January 1, 1995 as allowed by federal law
- obtaining a federal waiver to provide pharmacy services through selected pharmacies chosen through a competitive process
- imposing limits on reimbursement for pharmacy services in conjunction with the implementation of the prior authorization program for high cost drugs
- studying the feasibility of allowing reimbursement for limited over-the-counter drugs for certain Medicaid recipients.

Medicaid Utilization Review

As part of its overall efforts to contain Medicaid spending, DMAS conducts utilization review. Utilization review serves as a control mechanism for the amount and type of medical services provided. Control of utilization is necessary to ensure that the State pays only for those services that are necessary and appropriate. The utilization review process varies according to the type of care provided to program recipients. Utilization review can include elements of prospective, concurrent, and retrospective review. Prospective review evaluates the appropriateness and necessity of care before it is delivered, and can be used to determine whether care should be provided. Concurrent review is performed during the time that service is being delivered and can be used to assess the quality of the care. Retrospective review is performed after the service has been provided and can be used to determine whether reimbursement was appropriate.

For the most part, DMAS utilization review activities have improved over the past few years. These activities have been successful in containing costs that the program would have realized in their absence. Nevertheless additional improvements could be made to utilization review activities undertaken by DMAS. These should result in additional cost savings to the Medicaid program.

Hospital Utilization Review Has Saved Money and Could Be Expanded

DMAS hospital utilization review activities are responsible for saving the program about $43 million in costs from FY 1987 to FY 1991. Hospital utilization review activities have been responsible for the declining average length of stay for Medicaid recipients. While these activities have resulted in the avoidance of certain program costs, there are indications that overutilization of services continues to be a problem. For example, it has been estimated that nationally, approximately 10 to 20 percent of hospital admissions may be inappropriate.

DMAS should consider expanding its current hospital utilization review activities to further achieve cost savings for the pro-

gram. Options for DMAS to consider include:

- incorporating prospective utilization review into hospital utilization review
- expanding utilization review to include outpatient hospital services
- using patient-level data to monitor provider practices
- re-evaluating utilization review strategies when considering Medicaid reimbursement methods.

The JLARC report on hospital-financed Medicaid services provides recommendations that address the use of these options.

Long-Term Care Utilization Review Has Improved But Could Be Strengthened

As part of its overall efforts to contain Medicaid long-term care spending, DMAS conducts prospective, concurrent, and retrospective utilization reviews for home health services, and nursing services provided by nursing homes and ICFs/MR. Utilization review of home health agencies that provide personal care ensures that recipients are at imminent risk of nursing home placement, that authorized personal care services meet the recipient's need, that services rendered are billed properly, and that services are delivered according to health and safety needs.

Over the past several years, certain aspects of utilization review in these areas have been strengthened. Home health agencies are, for the first time, receiving scrutiny. Nursing home and personal care admissions continue to be evaluated to ensure that only those persons who meet nonfinancial as well as financial eligibility criteria receive the services. Still, some improvements are needed. For example, utilization reviews for personal care recipients need to be improved to ensure that those receiving services continue to be only those individuals who are at imminent risk of nursing home placement. Also, utilization review of ICFs/MR services needs to incorporate procedures adequate for evaluating the existence of active treatment. Recommendations are made to address these shortcomings in the JLARC report on Medicaid-financed long-term care.

Activities to Control Fraud and Abuse Meet Minimum Requirements But Could Be Improved

After payments have been made by the Medicaid program, DMAS staff analyze claims data as one means of controlling program expenditures. This "post-payment utilization review" function is done to determine if recipients or providers have developed patterns indicative of excessive use, medically unnecessary use, or unsound billing practices. Although DMAS post-payment utilization review activities meet federal minimum requirements, more could be done to achieve additional cost savings.

A small proportion of active enrolled providers and recipients are reviewed each year through the Medicaid post-payment utilization review process. The administration of this process appears to be successful at controlling abusive recipients and initiating recovery of provider overpayments. The number of reviews initiated complies with minimum federal requirements. However, refinements and expansion of the process may lead to additional cost savings for the Virginia Medicaid program. JLARC staff found that these activities to establish overpayments made by the Medicaid program to providers exceeded the personnel costs by a ratio of almost two to one in FY 1991 and FY 1992.

The method of selecting providers for review could also be enhanced, as well as

increasing the number of providers reviewed. In addition, DMAS needs to focus more attention on activities to control recipient fraud and drug diversion. These functions have lacked adequate staffing over the past biennium to investigate and recover misspent funds. JLARC recommendations in this area focus on expanding the number of provider reviews and selection process, the need for increased focus on recipient fraud activities, and enhanced drug diversion detection activities.

Medicaid Asset Transfers and Estate Recovery

There are growing concerns that a number of Medicaid recipients in Virginia are using "loopholes" in federal and State laws to gain access to the program's benefits while preserving resources for their heirs. These strategies, while legal, effectively undermine the basic intent of Medicaid — to increase access to health care for persons who are poor. Unrelated to this are federal Medicaid laws that require states to exempt the real property of applicants at the time they initially apply for nursing home benefits. This allows more than a third of all program applicants to be approved for care even though they may have substantial resources.

In response to these concerns, JLARC was directed by Senate Joint Resolution No. 91 (Appendix B) to determine the extent to which people use asset transfer laws to establish eligibility for Medicaid nursing home benefits in Virginia. In addition, a separate analysis was conducted to determine the potential benefits of developing an estate recovery mechanism in Virginia. Analysis of these issues found that about eight percent of those who apply for Medicaid nursing home benefits use "loopholes" to shift the cost of their care to the taxpayers while preserving assets for their heirs. If this practice is to be stopped, both the State and federal governments will have to change the laws and regulations that govern asset transfers.

Regarding estate recovery, the lack of a proactive program has prevented Virginia from achieving the savings reported in other states. The results of analysis on this issue show that 16 percent of the Medicaid recipients terminated from nursing homes in Virginia own property. It appears that as much as two-thirds of the cost of providing nursing home care to these recipients could be eventually recouped through estate recovery. JLARC staff estimate that the State could recover almost $10 million through an effective estate recovery program. According to staff at DMAS, of this amount, approximately $2.6 million could be recovered annually.

Several recommendations were made to address issues related to asset transfers and estate recovery. These recommendations cover:

- property checks on persons applying for Medicaid
- counting of multiple transfers in the eligibility process
- counting high cost term life insurance as a resource in determining eligibility for Medicaid
- implementation of a proactive estate recovery program by DMAS
- attaching liens to real property of Medicaid recipients of nursing home benefits.

The reports in the Medicaid series summarized in this document can be obtained by contacting the Joint Legislative Audit and Review Commission, Suite 1100, General Assembly Building, Richmond, Virginia 23219.

Appendix A

Senate Joint Resolution No. 180

Requesting the Joint Legislative Audit and review Commission to study the Commonwealth's Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

Agreed to by the Senate, February 19, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, a goal of the Commission on Health Care for All Virginians is to provide access to basic health care for all Virginians; and

WHEREAS, approximately 330,000 persons in Virginia are eligible for the Medicaid program, but an estimated 300,000 additional Virginians in poverty have no health insurance; and

WHEREAS, the number of Virginians eligible for Medicaid has increased by only 10 percent during the last 10 years, but Medicaid expenditures in Virginia have tripled during that period; and

WHEREAS, costs in the 1990-92 biennium are expected to be more than 40 percent greater than the costs in the 1988-90 biennium; and

WHEREAS, the Medicaid program now represents about 12 percent of the Commonwealth's general fund budget, with an estimated $1.4 billion (general fund) cost for the 1990-92 biennium; and

WHEREAS, Medicaid costs will continue to escalate at a rapid rate as inflation in health care costs far surpasses other goods and services; and new federal mandates are likely to continue as Congress expands health insurance for the elderly, disabled, and poor through Medicare and Medicaid; and

WHEREAS, federal mandates establish the core of the Medicaid program, but states can partially shape the benefits and costs through policy adjustments in reimbursement rates for service providers; services offered to recipients; utilization review to ensure appropriate care; and eligibility for groups of persons, and to some extent, how much recipients pay for their own care; and

WHEREAS, University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads provide a significant amount of care to low-income persons and receive state support for this care through Medicaid and direct general fund appropriations; now therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be requested to study the Virginia Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

The study shall include, but not be limited to:

1. Assessment of the cost savings and health policy implications of limiting the scope or duration of optional services, or adjusting recipients' contributions to their care;

2. Examination of the interpretation of federal requirements to determine if they have been implemented in the most effective and least costly manner;

3. Determination of the effectiveness of current utilization review procedures in controlling costs and exploration of additional options;

4. Evaluation of reimbursement methods to determine if they adequately encourage cost effective delivery of services;

5. Determination of the sufficiency of reimbursement rates to provide quality care at the lowest required cost;

6. Review of budget and forecasting methods to ensure that they adequately identify and project the cost of policy changes, service utilization, and new mandates;

7. Determination of how the legislative branch could increase its capacity to more closely monitor Medicaid forecasts and expenditures;

8. Exploration of the costs of alternative administrative methods for implementing program requirements and options;

9. Examination of the relationship with other State programs to promote optimal utilization of State funds;

10. Identification of options for using Medicaid funds for services currently supported with general funds; and

11. Review of eligibility, scope of services, and reimbursement rates for indigent care at University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads, and a determination of the appropriateness of general fund and Medicaid allocation methodologies.

All agencies of the Commonwealth shall provide assistance upon request to the study as appropriate.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its findings and recommendations to the Governor and to the 1993 Session of the General Assembly, and shall provide interim reports to the Commission on Health Care for All Virginians and to the 1992 Session of the General Assembly and at other times as appropriate, using the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Senate Joint Resolution No. 91

Requesting the Commission on Health Care for All Virginians to study the issue of property transfer for purposes of Medicaid eligibility.

Agreed to by the Senate, March 5, 1992
Agreed to by the House of Delegates, March 3, 1992

WHEREAS, health care spending continues to increase at a rapid rate; and

WHEREAS, the cost of Medicaid for the elderly is increasing at a rapid rate due to the aging of the general population; and

WHEREAS, the Medicaid budget is projected to grow by $743 million over the previous biennium; and

WHEREAS, many persons give away assets or otherwise dispose of resources they could use to purchase medical care, especially nursing home care, in order to become Medicaid-eligible; and

WHEREAS, the federal Medicaid eligibility rules regarding transfer of assets have been made more lenient in recent years; and

WHEREAS, it is common practice for persons anticipating the need for medical care for themselves or their relatives to consult attorneys and financial planners familiar with Medicaid law and regulations for advice on ways to circumvent the Medicaid rules so as to transfer assets to establish Medicaid eligibility; and

WHEREAS, the Joint Legislative Audit and Review Commission is examining Medicaid financing of long-term care including the issue of asset transfer and asset recovery, as directed by Senate Joint Resolution No. 180 passed by the 1991 General Assembly; and

WHEREAS, the resources of the Commonwealth should be used to help those most in need who do not have resources with which to purchase health care; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Commission on Health Care for All Virginians be requested to study the current practice of persons transferring or giving away assets without compensation so that they can become eligible for Medicaid, and to recommend to the General Assembly options available to limit the financial impact of such practices on the taxpayers of Virginia.

The Joint Legislative Audit and Review Commission shall, upon request of the Commission, discuss its study plan and report its findings and recommendations to the Commission prior to the 1993 Session of the General Assembly.

The Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1993 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

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