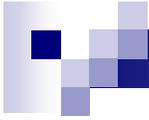




Costs and Trends in the Virginia Medicaid Program

*Presentation to House Appropriations Committee
November 17, 2010
Susan E. Massart, Staff*



- **Overview of the Medicaid Program**
- 2000 – 2010 Enrollment and Cost Trends
- Acute Care Services
- Long-term Care Services
- Services for Persons with Mental Disabilities
- Implications of Federal Health Care Reform



Virginia Medicaid Program

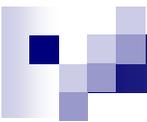
- Largest health care financing program for low-income persons in Virginia
 - Aged, blind or disabled
 - Children
 - Member of a family with children
 - Pregnant women
 - Certain Medicare beneficiaries
- In FY 2010, Medicaid provided payments on behalf of 937,522 recipients at a total program cost of \$6.5 billion
- Program costs are shared by the state and federal government
- Virginia's share is typically 50%, but with the ARRA enhanced federal match was 61.59% in FY 2010
- Rates for FY 2011 vary:

July 10 – Dec 10	Jan. 11 – March 11	April 11-June 11
61.59%	58.59%	56.59%



Medicaid Eligibility

- Originally eligibility linked to “categorical” relationship to two cash assistance programs:
 - Aid to Families with Dependent Children (AFDC)
 - Supplemental Security Income (SSI) for low-income aged, blind and disabled persons
- Federal mandates expanded eligibility to selected low-income groups:
 - Indigent pregnant women and children with incomes up to 133% of the federal poverty level (FPL)
 - Children in families with incomes up to 100% FPL
 - Certain low-income Medicare beneficiaries



AFDC-Related Eligibility

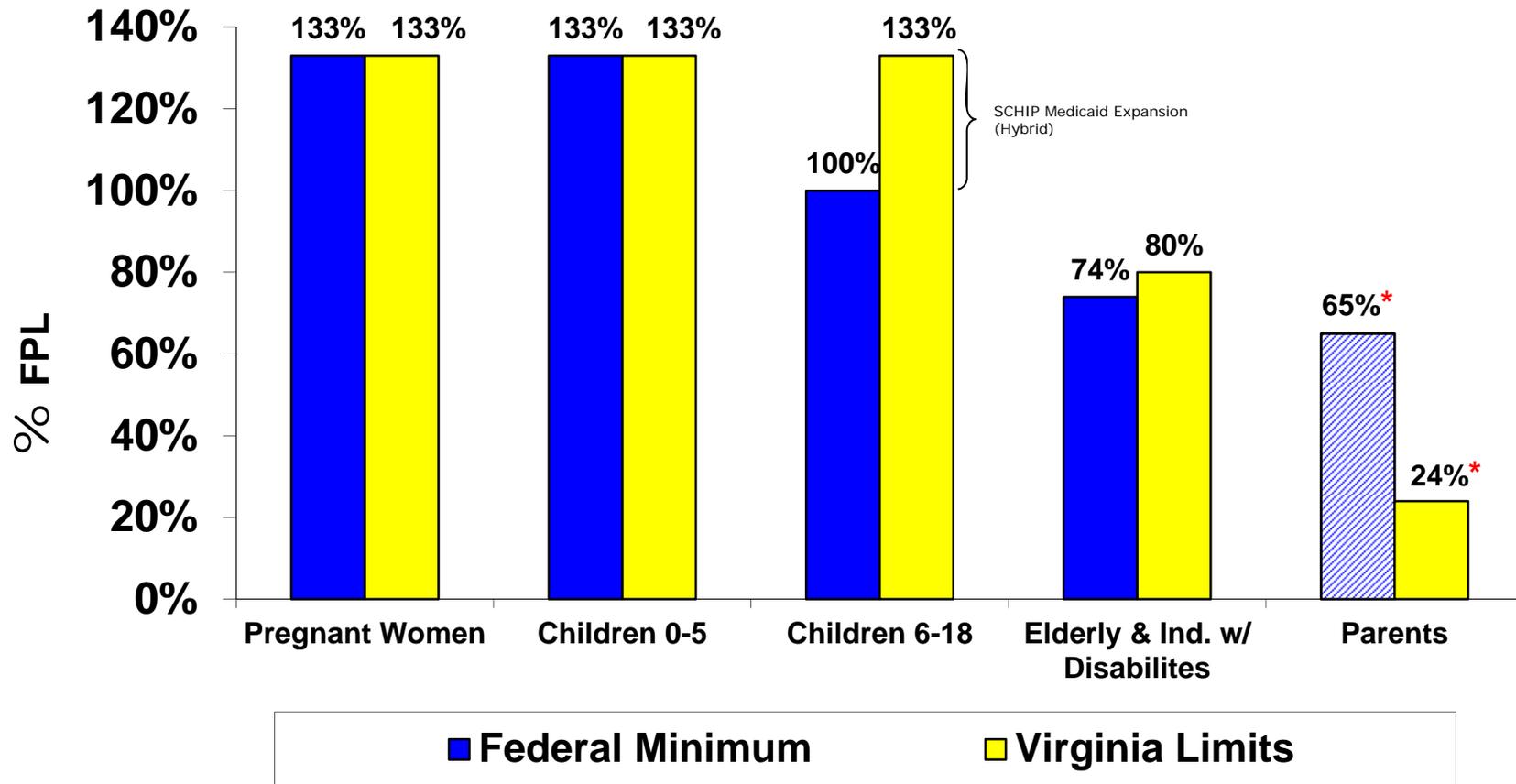
- 1996 federal welfare reform delinked Medicaid eligibility from cash assistance under AFDC
 - Froze Medicaid eligibility based on AFDC criteria in place on July 16, 1996
- On average, income eligibility for these Medicaid recipients is equal to about 34% of the federal poverty level depending on place of residence
- Covered Groups include:
 - Families in which a child is deprived of parental support or care, or one parent is unemployed
 - Families in work supplement programs
 - Others deemed to be eligible for cash assistance, but for special circumstances



SSI-Related Eligibility

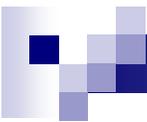
- Virginia applies stricter resource standards for persons receiving Supplemental Security Income or SSI (aged, blind, disabled):
 - States with more restrictive disability standards in place when Congress adopted SSI in 1972 were offered this option under Social Security Amendments “209(b)”
 - Virginia is one of 11 “209(b)” states
- SSI income level as of January 1, 2010:
 - \$674 per month for one person
 - \$1,011 per month for two persons
- Resource limits primarily apply to property ownership, i.e., individual cannot own more than \$5,000 of contiguous property

Medicaid Eligibility Levels



* No federal required minimum currently. Based on national median Medicaid income eligibility level (2007). Virginia statistic is a weighted average.

Source: Kaiser Commission on Medicaid and the Uninsured; DMAS



Virginia Covers a Number of “Optional” Eligible Groups

- Medically needy persons with incomes up to 133% of the AFDC payment standard in place on July 16, 1996
 - Monthly income of \$281, \$323, or \$421 depending on place of residence
 - Medical expenses are deducted from income to determine eligibility (“spend down”)
- Persons in institutions (e.g., nursing homes, intermediate care facilities for the intellectually disabled) with incomes up to 300% of SSI payment level (\$2,022/mo.)
- Certain aged, blind or disabled adults with incomes up to 80% of the federal poverty level (\$722/mo. or \$8,664/yr.)



Optional Eligible Groups

- Persons participating in Medicaid home- and community-based waiver programs:
 - Intellectually and developmentally disabled persons
 - Elderly and disabled
- Terminally ill and receiving hospice care
- Children under age 21 in foster homes, private institutions, in subsidized adoptions
- Aged, blind or disabled persons in group living arrangements as defined by SSI (adult foster care)
- Individuals receiving an Auxiliary Grant payment
- Women screened for breast or cervical cancer under CDC early detection program & who need treatment



Mandatory Medicaid Services

- Hospital Inpatient, Outpatient & Emergency Services
- Nursing Facility Care
- Physician Services
- Medicare Premiums (Part A and Part B for Categorically Needy)
- Transportation
- Certain Home Health Services
- Laboratory & X-ray Services
- Optometrist Services (if comparable services provided by Ophthalmologist)
- Early & Periodic Screening, Diagnostic & Treatment (EPSDT) Services
- Nurse-Midwife Services
- Rural Health Clinics
- Federally Qualified Health Center Clinic Services
- Certain Home Health Services (nurse, aide, supplies and treatment services)
- Family Planning Services & Supplies

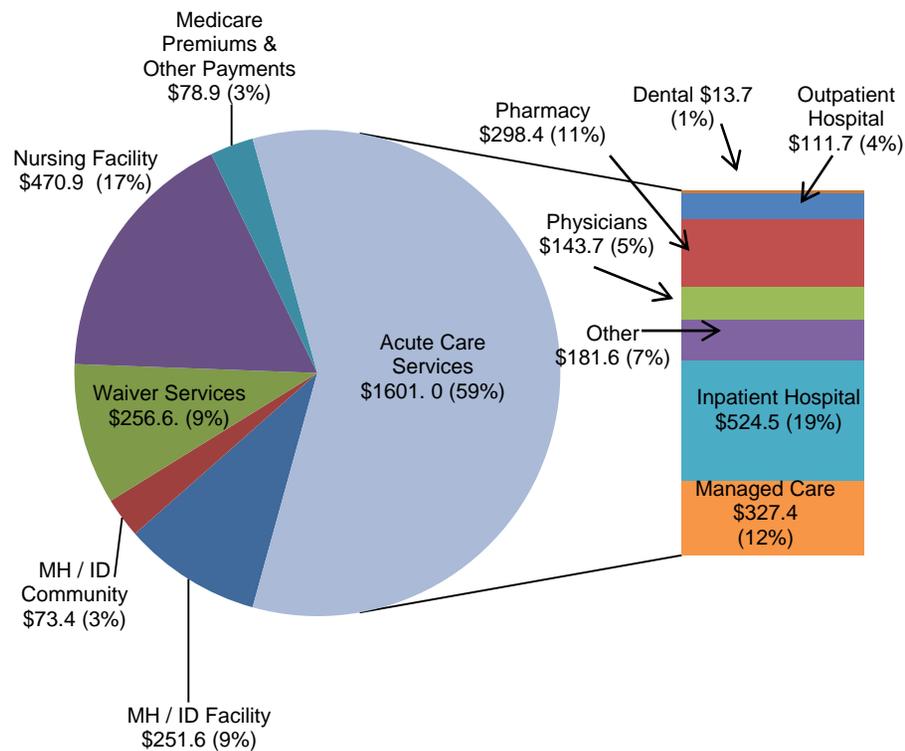


Optional Services Covered in Virginia

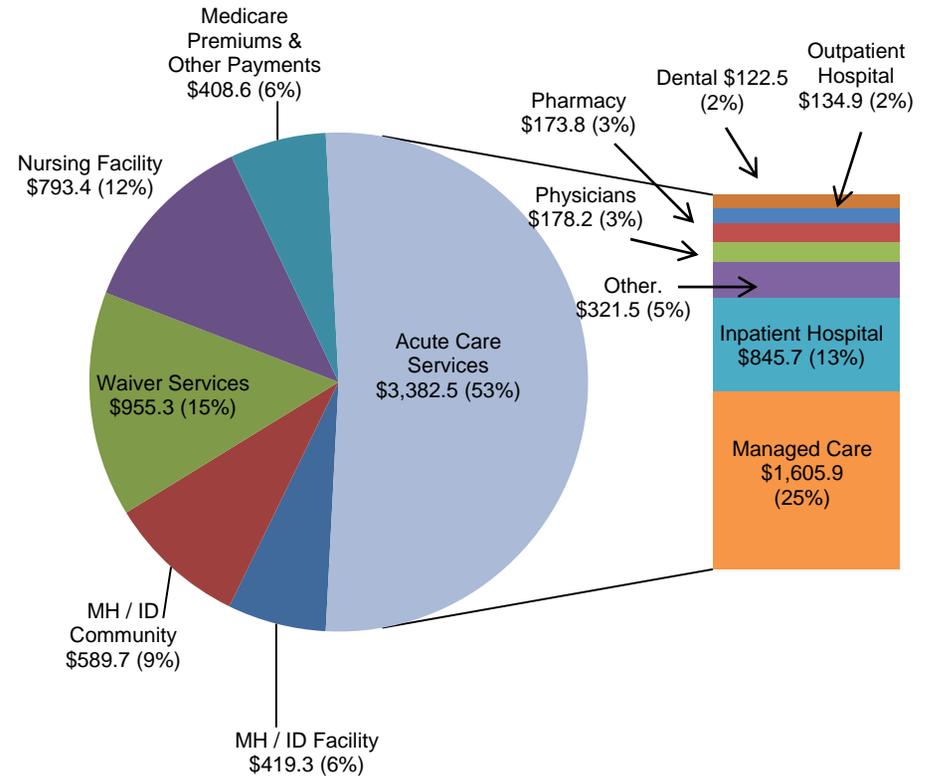
- Prescribed Drugs
- Mental Health & Mental Retardation Services
- Home & Community-Based Care Waiver Services
- Skilled Nursing Facility Care for Persons under age 21
- Dental Services for Persons under age 21
- Physical Therapy & Related Services
- Clinical Psychologist Services
- Podiatrist Services
- Certified Pediatric Nurse & Family Nurse Practitioner Svs.
- Home Health Services (PT, OT and Speech Therapy)
- Case Management Services
- Prosthetic Devices
- Other Clinic Services
- Hospice Services
- Medicare Premiums (Part B for Medically Needy)

Comparison of Expenditures by Service Type FY 2000 and FY 2010

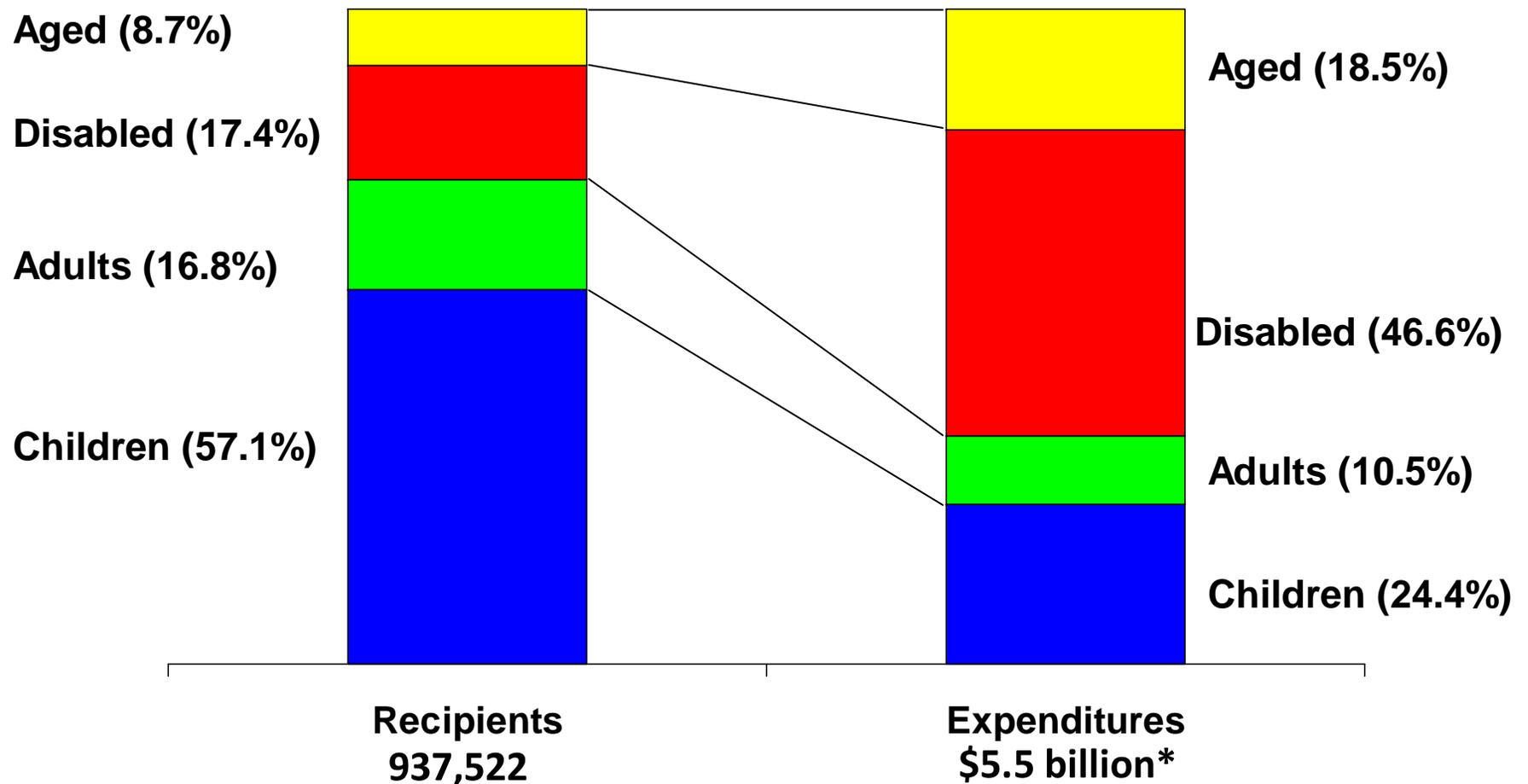
FY 2000 Expenditures = \$2.7 billion
\$ in millions



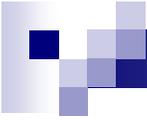
FY 2010 Expenditures = \$6.5 billion
\$ in millions



Comparison of Recipient Groups as a Percent of All Recipients and Expenditures (FY 2010)



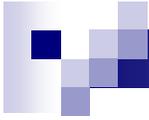
*Does not include approximately \$1 billion in lump sum expenditures that cannot be attributable to individual recipients.



How Does Virginia Compare to Other States?

National Rankings	Rank
Population ¹	12
Per-Capita Income ¹	8
Number of Medicaid Recipients ²	22
Number of Medicaid Recipients as a Percent of Population ²	48
Expenditure Per Medicaid Recipient ²	27

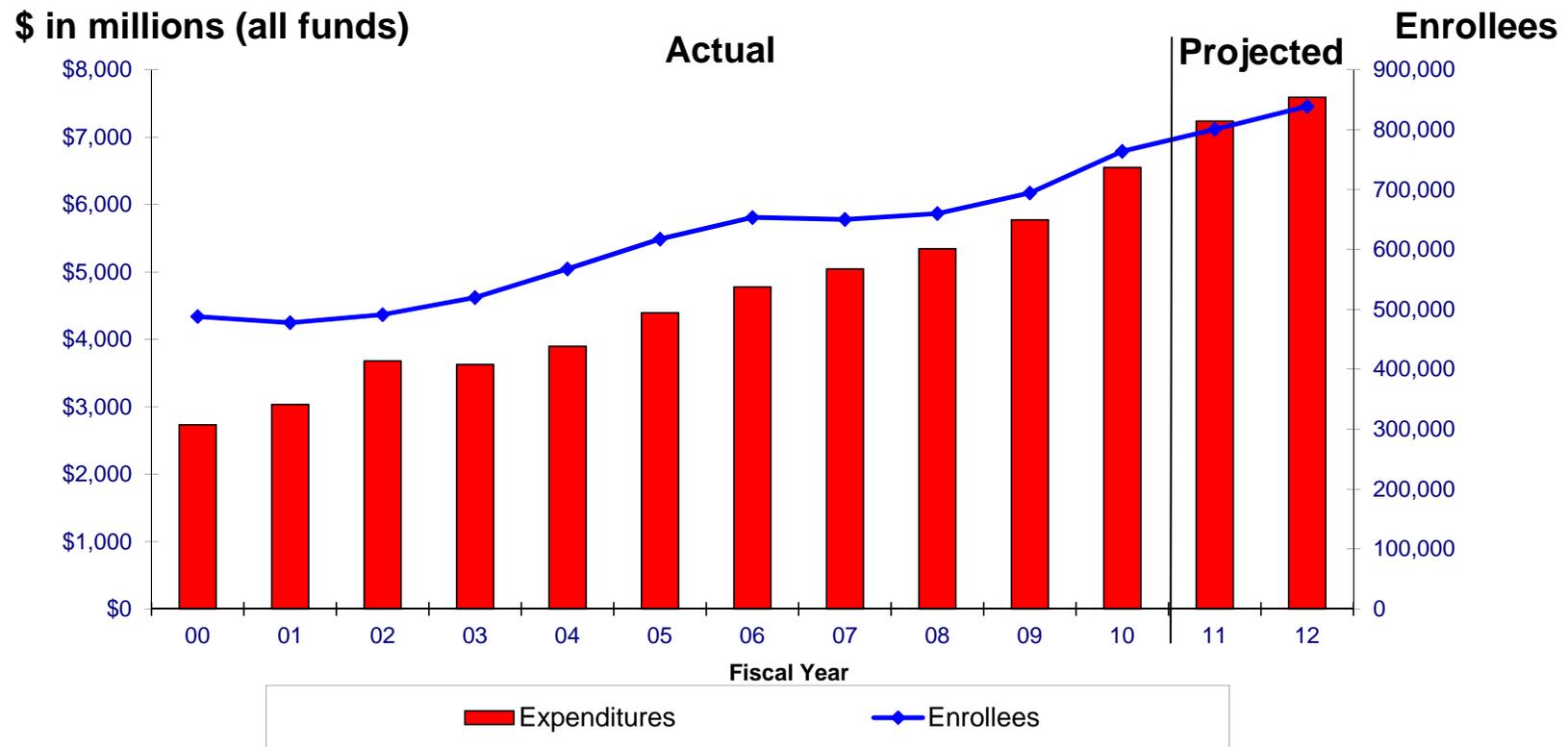
Sources: ¹U.S. Bureau of Economic Analysis BEARFACTS: 2008, and
²Kaiser Commission Estimates 2006



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Growth in Medicaid Medical Expenditures & Enrollees

- 10.8% historical avg. annual expenditure growth*
- 7.0% projected avg. annual expenditure growth**

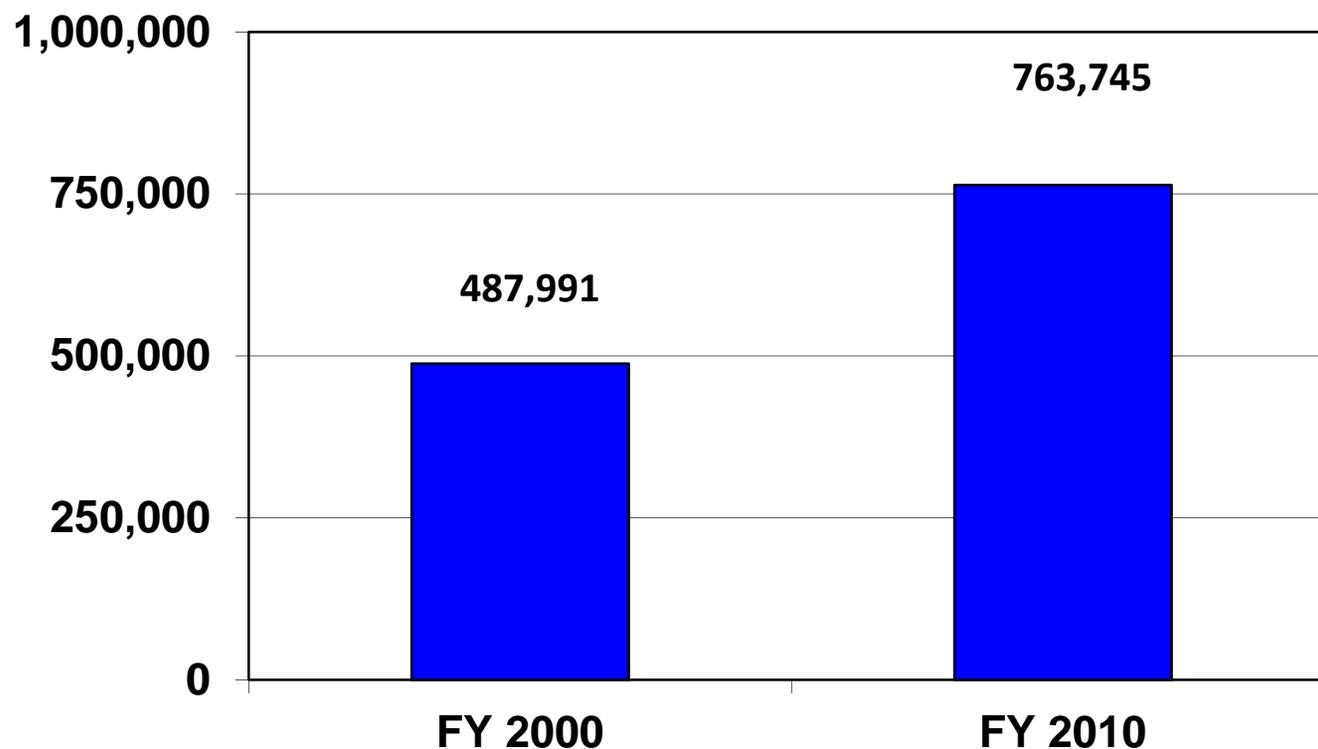


*FY 10 growth is artificially high as it reflects Medicaid provider payments that were lagged from June of FY 2009 into July 2010.

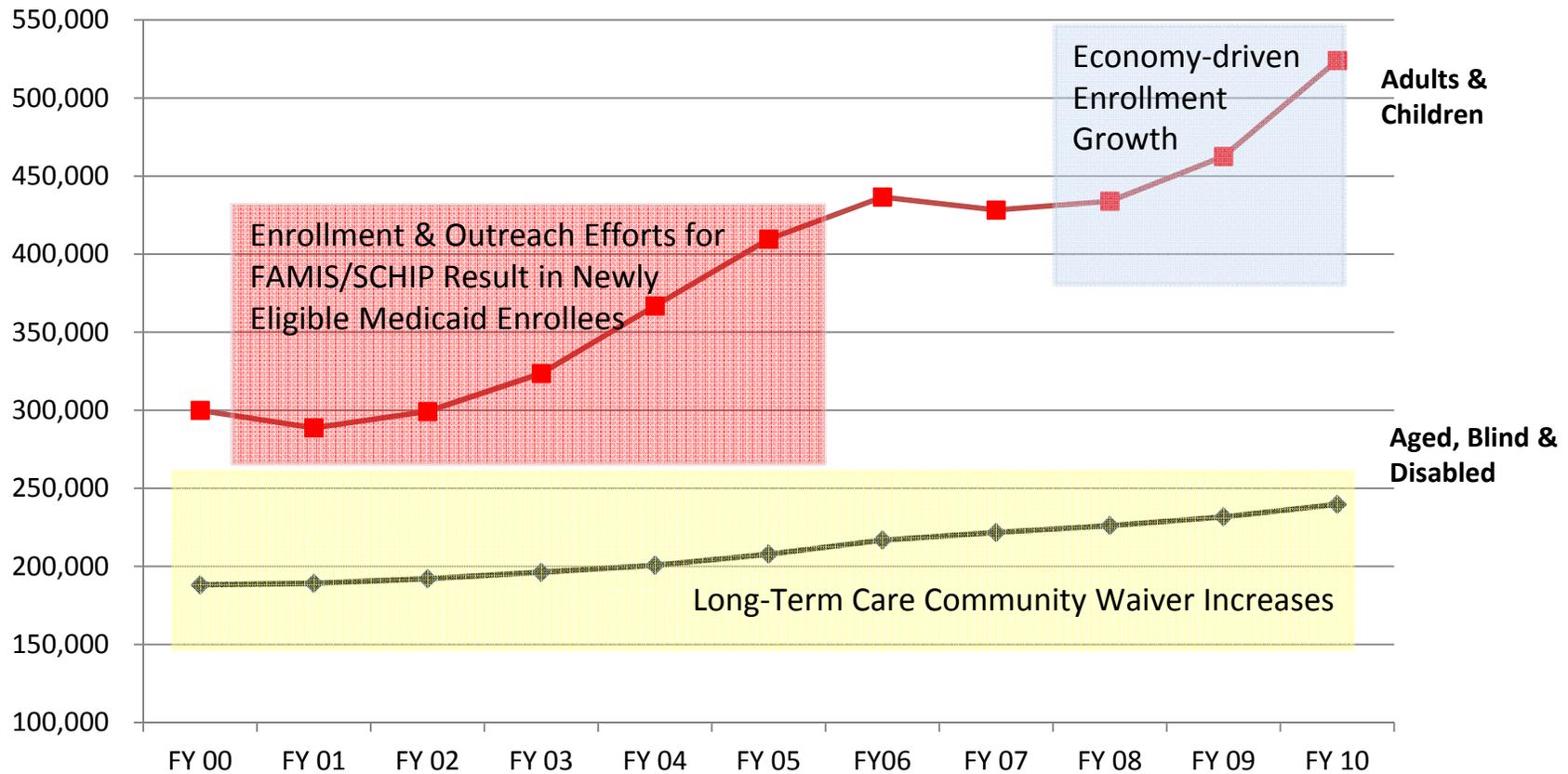
**Projected expenditures adjusted to include projected Medicaid expenditures for MH/ID facilities and CSA.

Average Monthly Enrollment has Increased by 57%

- Medicaid provides coverage to more than 275,000 more members per month than 10 years ago

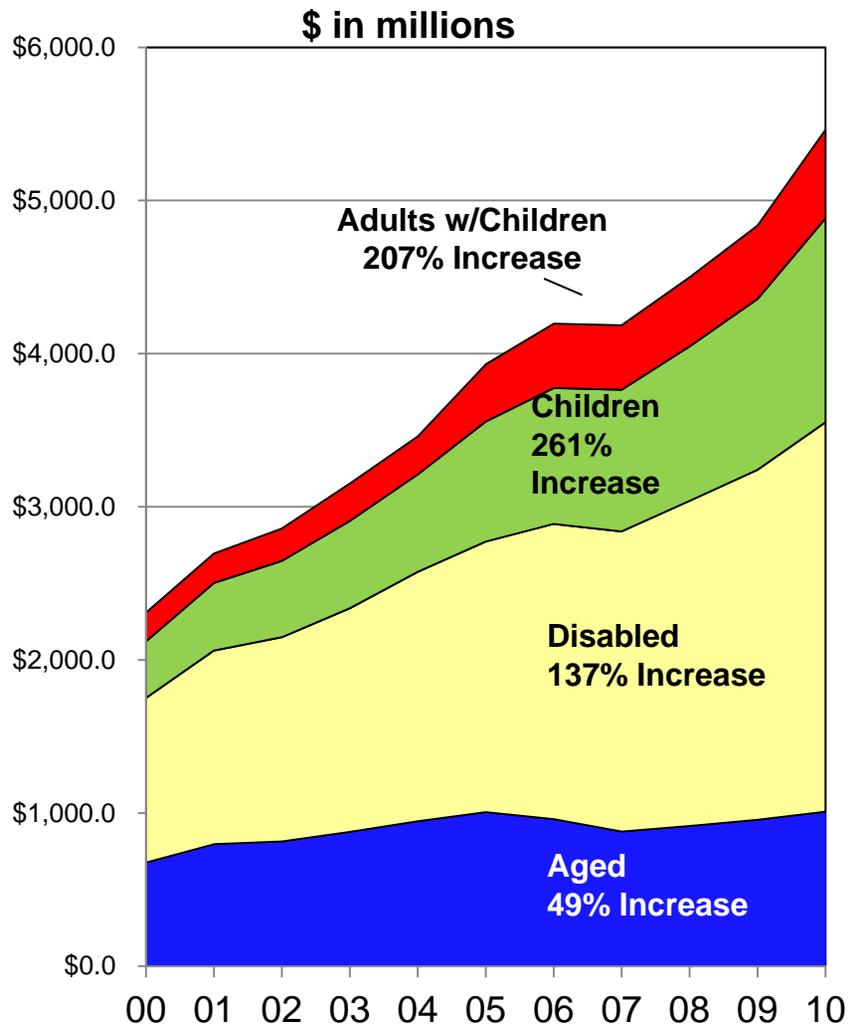


Medicaid Enrollment Trends



- Medicaid provides coverage to more than 275,000 more members per month than 10 years ago
- Fastest growth in children (72%) and adults with children (87%)
- Aged, blind and disabled have grown by about 27%
- Enrollment growth accounts for about a 40% increase in program expenses over the past 10 years

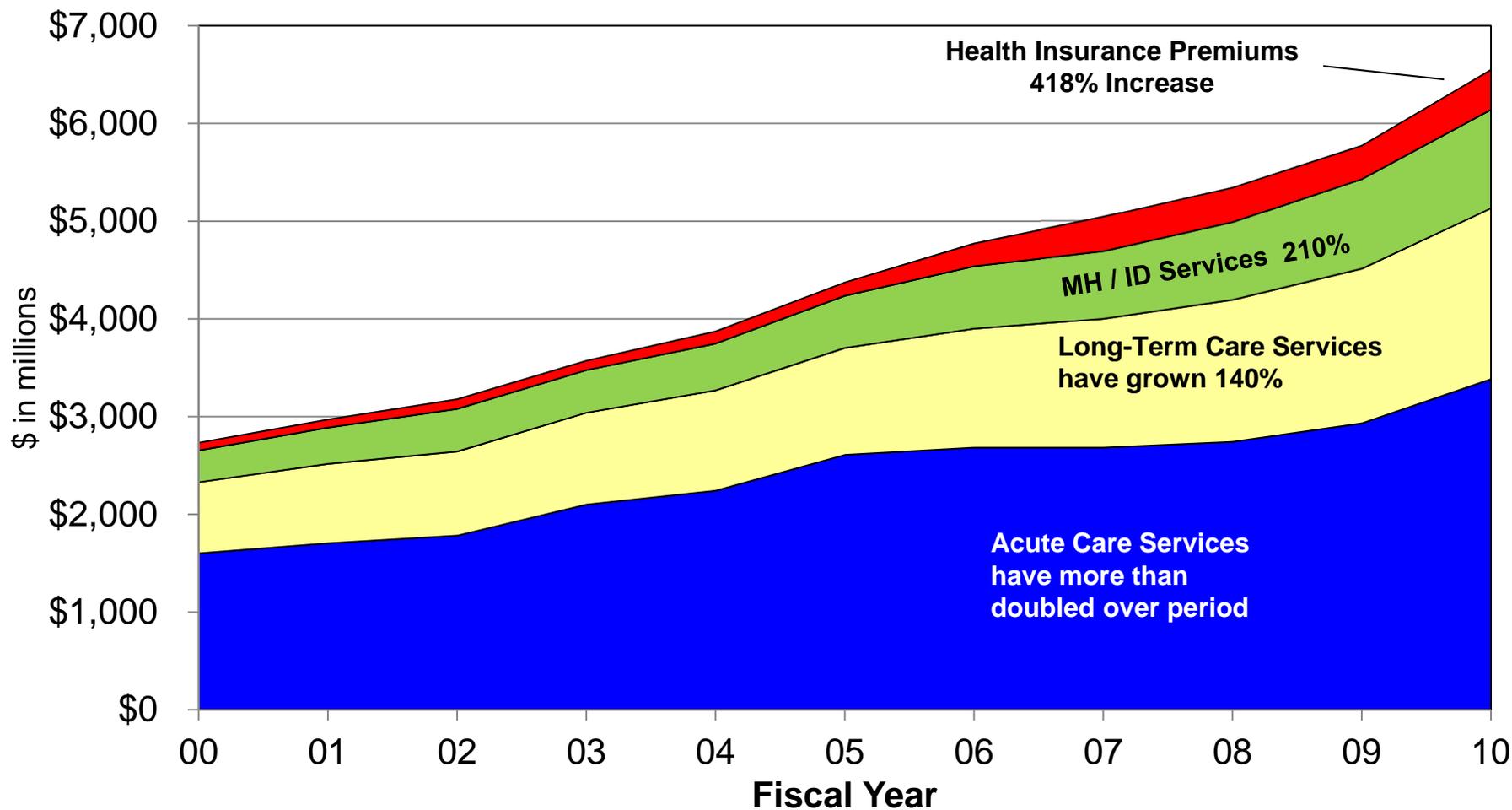
Growth in the Cost of Services By Recipient Type

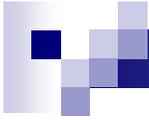


- Expenditures for adults and children have increased more dramatically due to enrollment policies and recession, however their costs account for a significantly smaller portion of Medicaid spending
- Expenditures for the disabled population is driving program costs more dramatically
 - Use a disproportionate amount of higher cost long-term care services, such as nursing facility care and waiver services
- Costs for the aged population have not increased as fast as others
 - Not yet using higher cost long-term care services
 - Costs driven by utilization and inflation in medical costs

Growth in Medicaid Expenditures by Type of Service

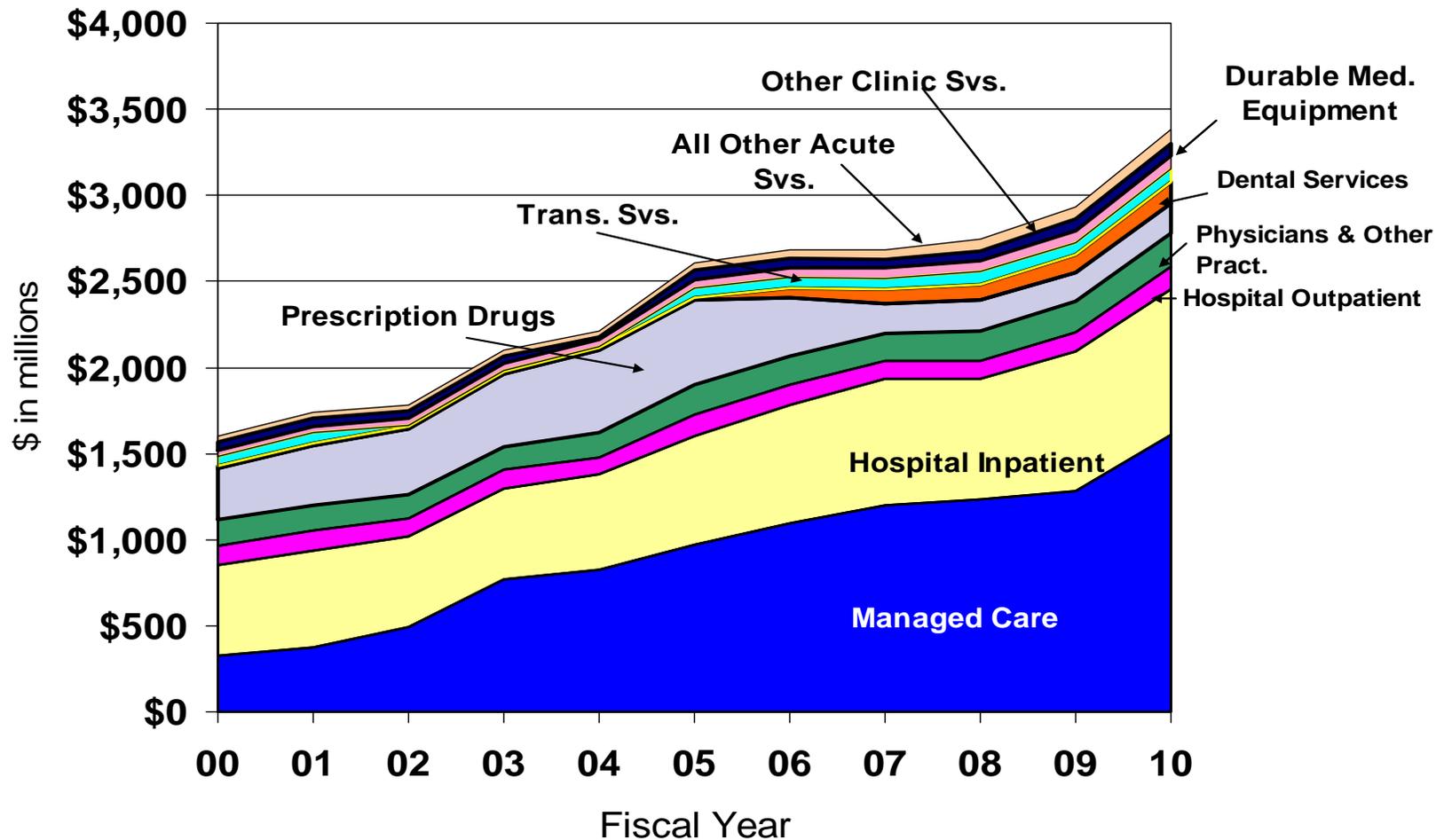
Total Medicaid expenditures have grown by 240%



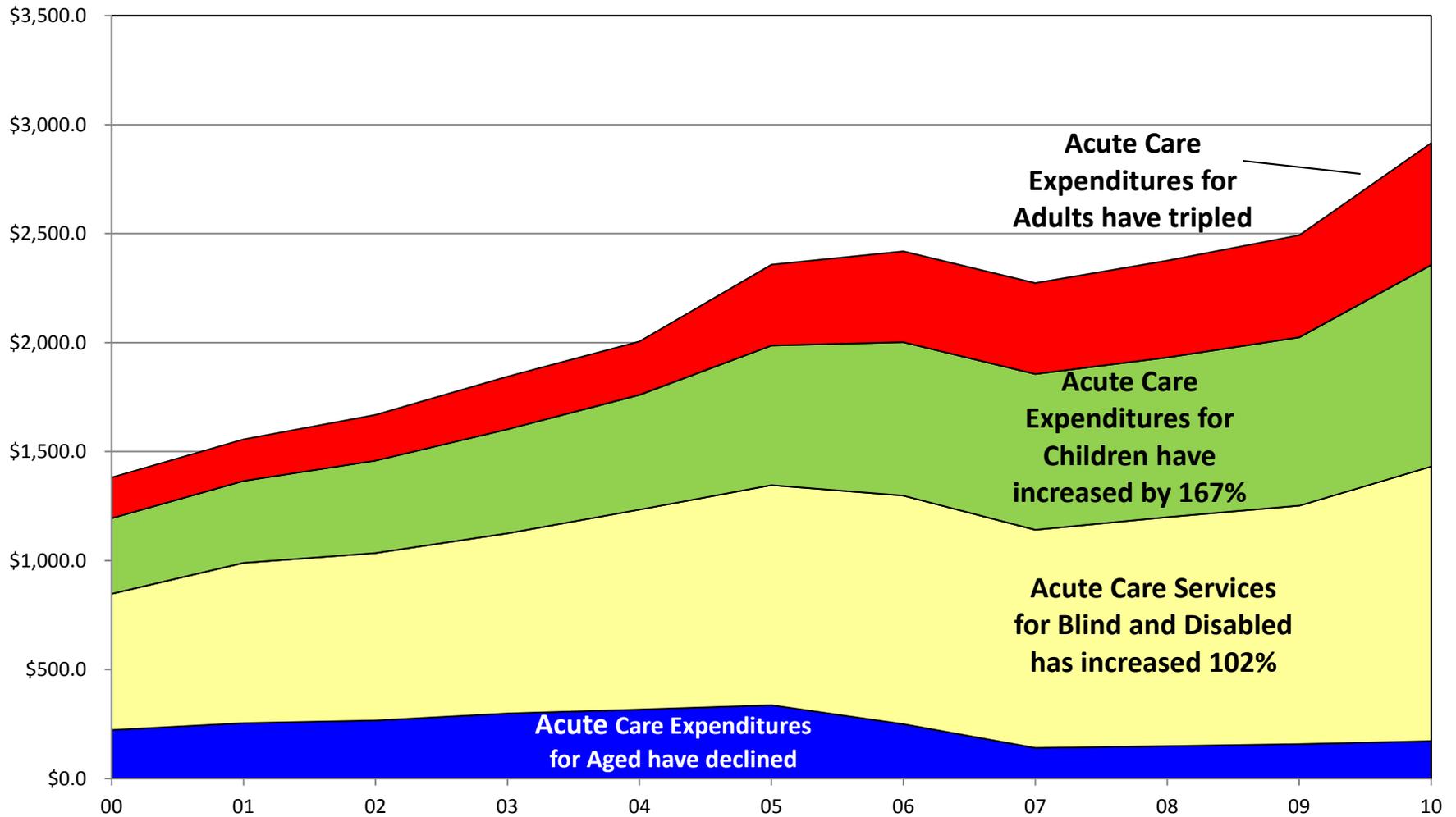


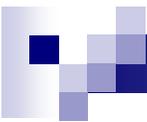
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Acute Care Expenditures Have Doubled over 10-year Period



Low-Income Adults and Children and Account for Largest Growth in Acute Care





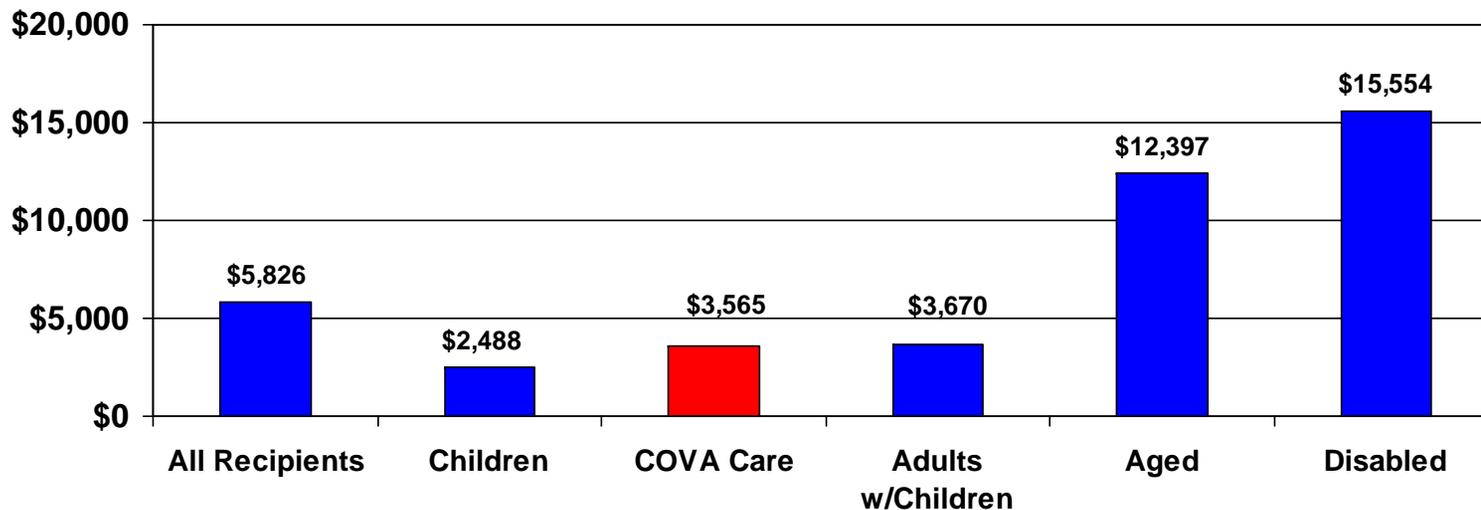
Why the Growth In Acute Care?

- Enrollment growth
 - Growth in low-income adults & children, driving increases in managed care costs
- Eligibility changes
 - Increased medically needy income limits by annual inflation adjustment
 - Implemented Medicaid Buy-In program for up to 200 people with disabilities
- Service expansion
 - Policy decision to increase access to dental services, carved out from managed care
 - Expanded managed care to Northern Virginia, Winchester and Lynchburg
- Increased rates
 - Medicaid regulations and policy require rebasing of hospital rates every 2 years to update costs
 - Policy decisions to increase rates for primary care and selected physician services (OB/GYNs, pediatric services, other primary care, emergency room)
 - Policy decisions to increase rates for dental services
 - Policy decisions to supplement payments for neonatal intensive care
- Inflationary adjustments to certain of medical services
 - Medicaid regulations and policy require inflation adjustments for certain acute care services such as managed care organizations, hospitals, home health and rehabilitation agencies
 - Federal government requires rates for managed care organizations to be actuarially sound
 - Inflation in the cost of medical services and technology
- Utilization of high cost services
 - Pregnancy, childbirth, and neonatal costs appear to be driving hospital costs

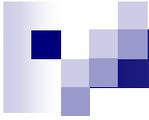
How Do Medicaid Costs Compare?

- Difficult to compare Medicaid to commercial insurance costs
 - Populations vary dramatically
 - Data proprietary and not reported in similar manner
- Selective data available from State employee COVA Care program may yield some light

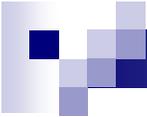
Medicaid Average Cost Per Recipient Compared to COVA Care - FY 2010



Note: Costs for Medicaid recipients reflects costs for acute care and long-term care services not typically covered by commercial health care plans.

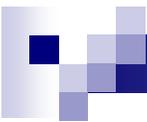


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Medicaid is the Primary Funding Source for Long-Term Care

- Medicaid is the single largest source of financing for long-term care
 - Nationally Medicaid accounts for 67% of financing for institutional care
 - Medicare and private health insurance provide limited coverage
- Institutional Services
 - Nursing facility services, including Specialized Care
 - Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
 - Assisted Living Facilities (limited)
 - Long-Stay Hospitals
- Home and Community Based Care Waiver Programs
 - Elderly or Disabled with Consumer Direction
 - Mental Retardation/Intellectually Disability (MR/ID)
 - Day Support (individuals with MR/ID diagnosis)
 - Individual and Family Developmental Disabilities (DD)
 - AIDS/HIV
 - Technology Assisted

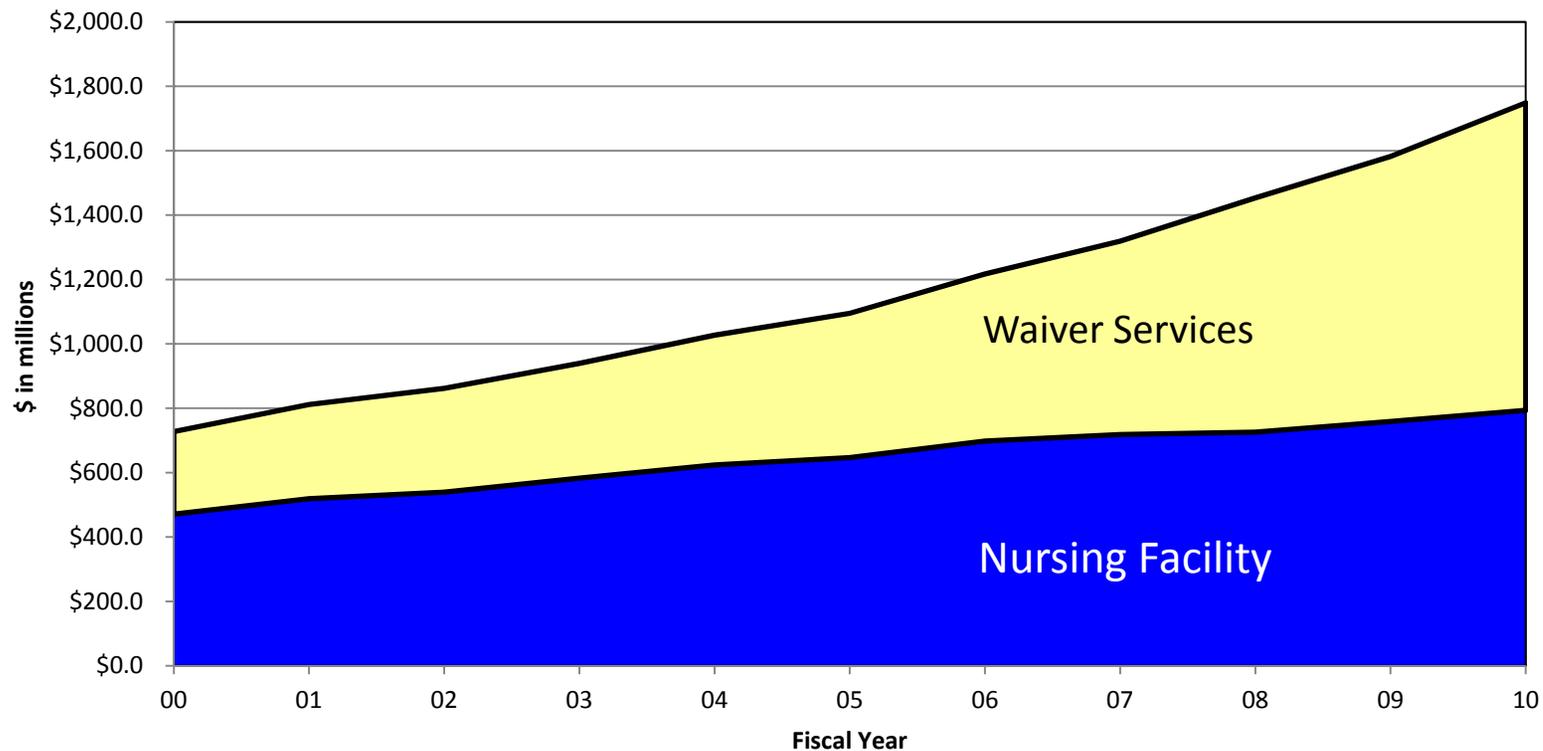


Home and Community-Based Waivers 1915(c) Waivers

- Optional programs designed to provide States flexibility to develop and implement alternatives to institutionalization (Nursing Facilities, ICF/MRs) and target specific populations (aged, disabled, intellectual disabilities)
 - Waiver must offer choice to all participants -- between community or institution, between providers, and services received
 - Waiver cannot fund room and board
 - Waiver must be cost effective
- Applicant must meet the same level of need as someone who qualifies to enter a long-term care facility
 - Meet age criteria
 - Meet diagnosis/need criteria
 - Meet alternate institution criteria
 - Uniform Assessment Instrument (UAI) for nursing facility level of care.
 - Level of Functioning (LOF) Survey for Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care
- Applicant must qualify for Medicaid both categorically and financially

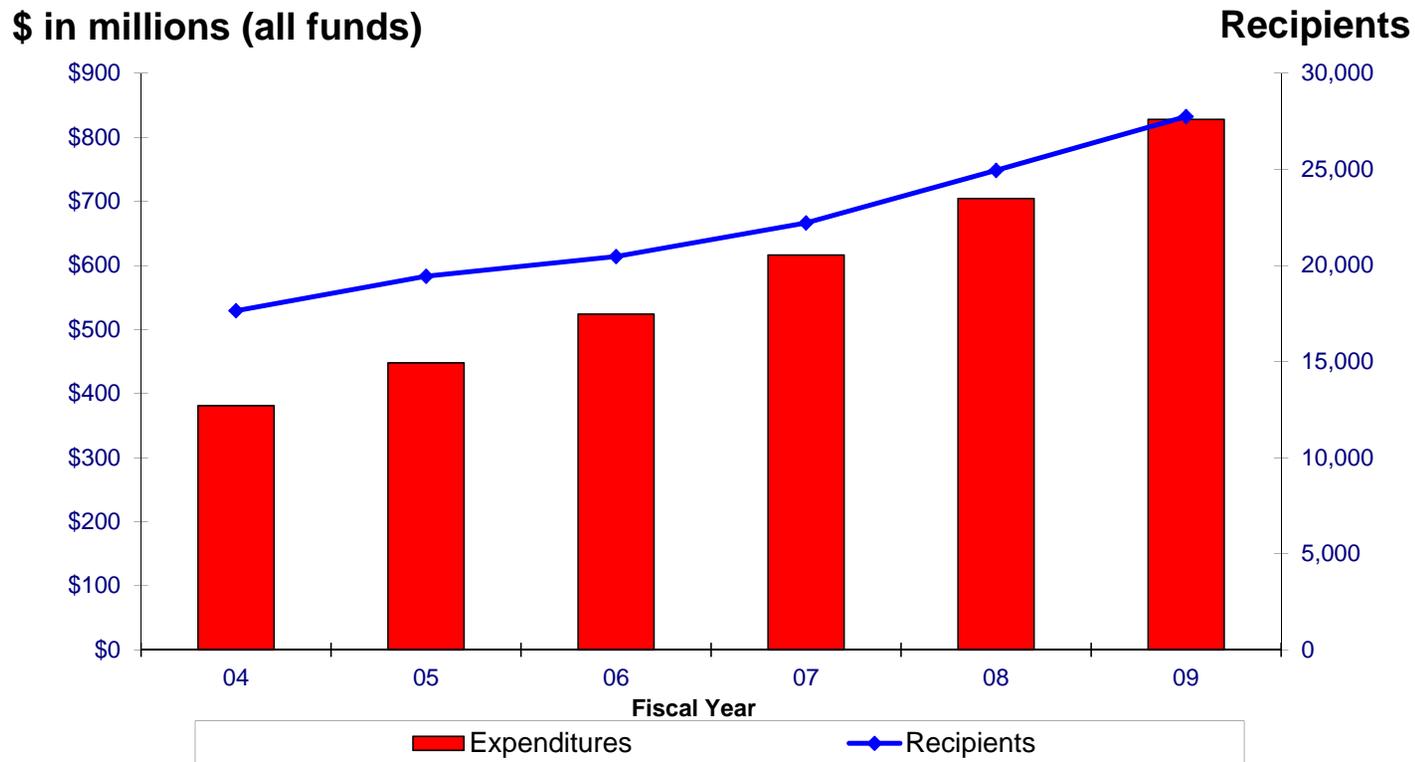
Growth Long-Term Care Expenditures

- Long-term care (LTC) waiver expenditures have almost tripled over the past 10 years
 - Comprise about 55% of LTC expenditures
- Nursing facility expenditures have increase by 68%
 - Comprise about 45% of LTC expenditures



Growth in Medicaid Waiver Expenditures & Recipients

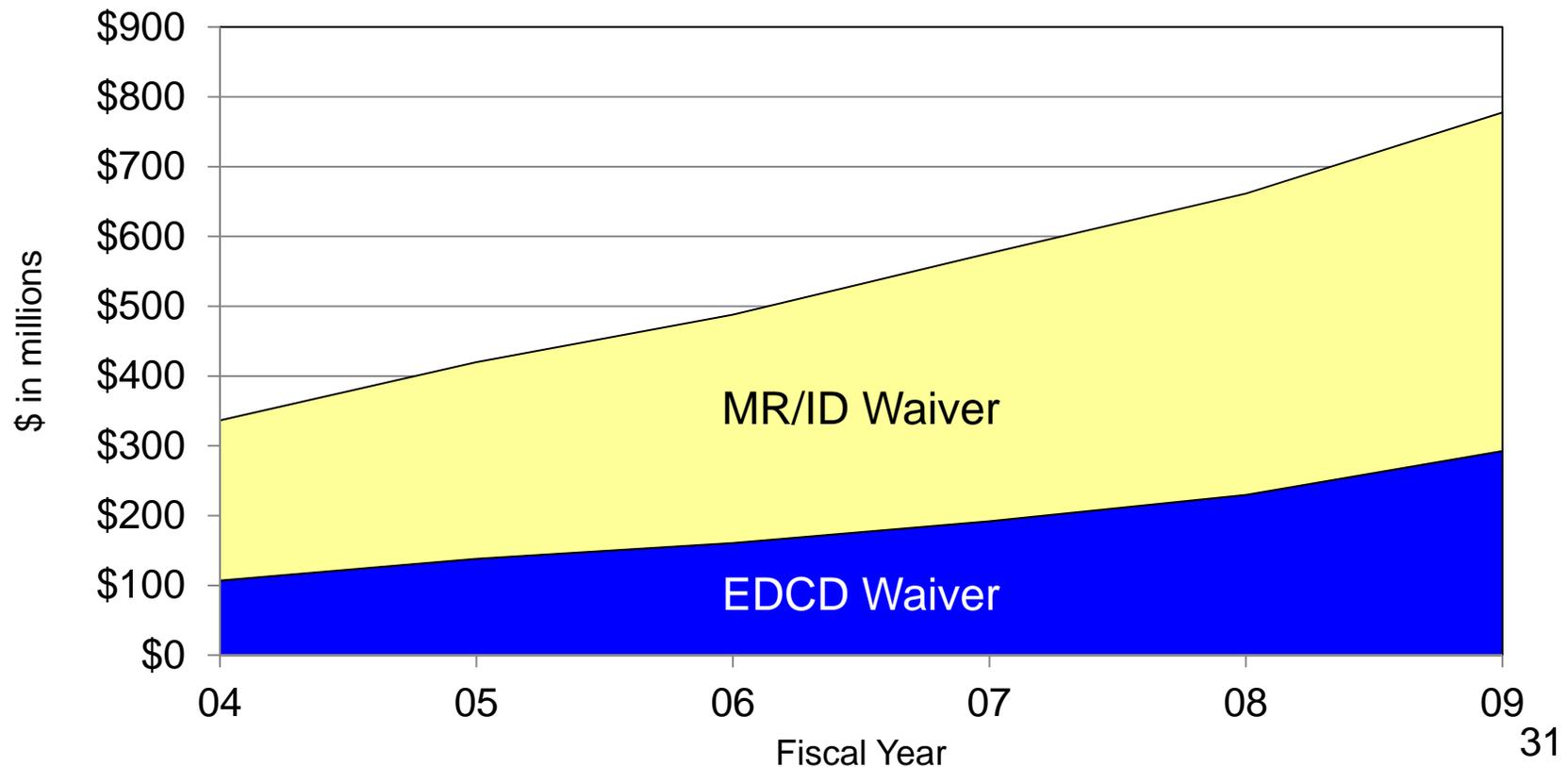
- 16.8% avg. annual expenditure growth, higher than the overall growth rate for the Medicaid program
- 9.5% average annual growth in number of recipients



Note: Expenditures do not include acute care costs associated with serving Waiver recipients.

Growth in Selected Waiver Programs

- Two waivers account for 94% of total waiver costs
 - Mental Retardation/Intellectually Disability (MR/ID) has more than doubled (111% growth)
 - Elderly or Disabled with Consumer Direction (EDCD) has almost tripled (173% growth)
- Average cost of the MR/ID waiver is now \$74,674
- Average cost of the EDCD waiver is now \$21,283



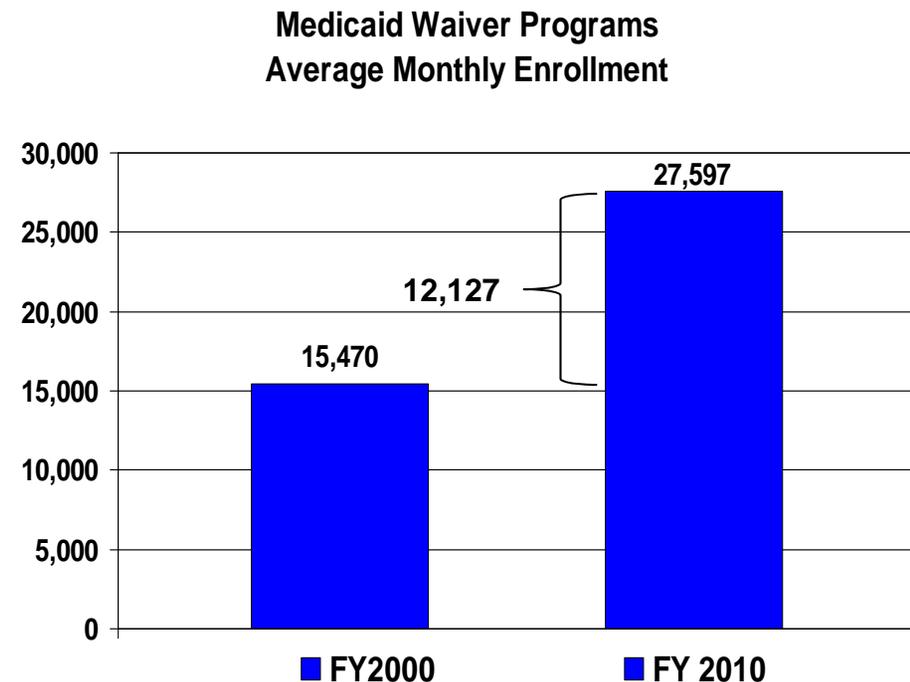
Waiver Programs

Waiver	Number of Recipients	Total Cost (\$ in millions)	Avg. Waiver Cost Per Recipient	Avg. Total Cost Per Recipient*
MR /ID	7,748	\$578.6	\$62,611	\$74,674
EDCD	18,640	\$396.7	\$15,694	\$21,283
Technology Assisted	400	\$51.6	\$75,980	\$129,067
Development. Disability	584	\$22.0	\$26,322	\$37,650
Day Support	283	\$6.4	\$11,908	\$22,580
AIDS/HIV	61	\$1.7	\$14,162	\$28,276
Alzheimer's	32	\$0.5	\$14,916	\$15,449

Note: Total costs include the cost of acute care services.

What Is Driving Cost of Waivers?

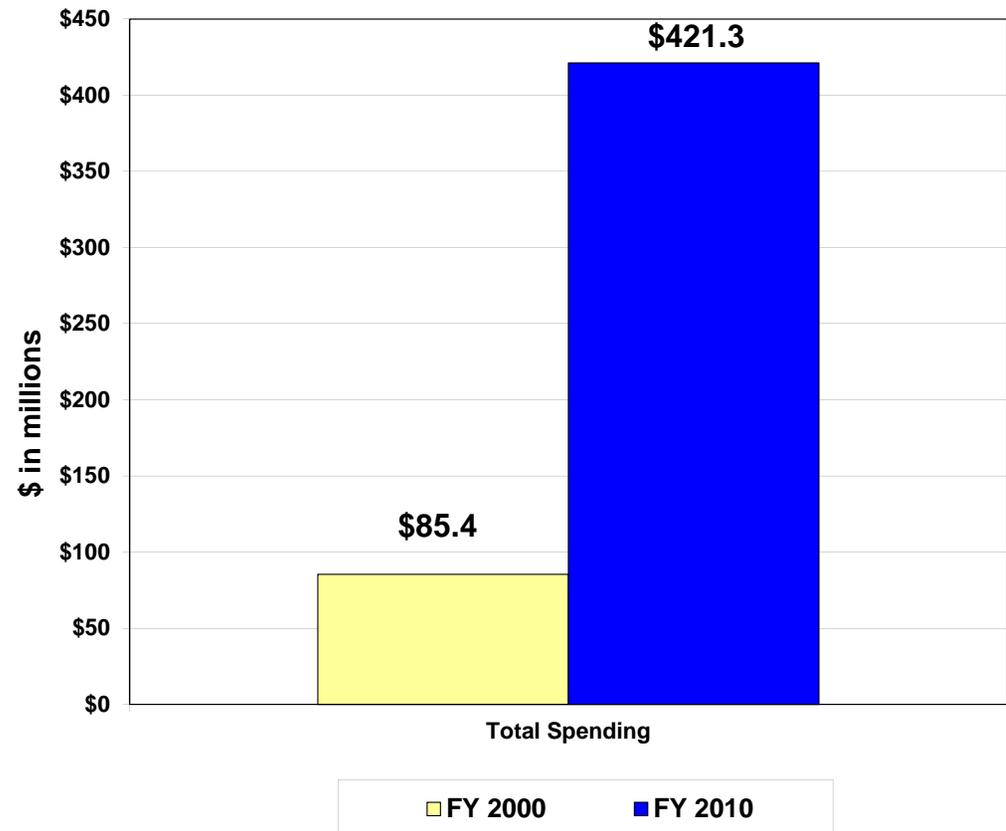
- Enrollment has increased over 70% since 2000
- Policy decisions have added about 12,000 slots
 - 2,451 new MR/ID slots
 - 300 new Day Support Waiver slots
 - 595 Developmentally Disabled Waiver slots
 - 200 Alzheimer Waiver slots
 - 8,581 more individuals in the Elderly & Disabled Waiver (81% growth)



Spending on Specific Services Is Driving Waiver Costs

- Personal care services: Assistance with needs, such as bathing, dressing, eating (known as Activities of Daily Living), monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical conditions
- Two Types of Personal Care
 - Consumer Directed – recipient or family hires aide
 - Agency Provided
- Policy decision in early 2000s added consumer directed care as a cheaper alternative to agency care
 - Hourly rates less than those for agency care

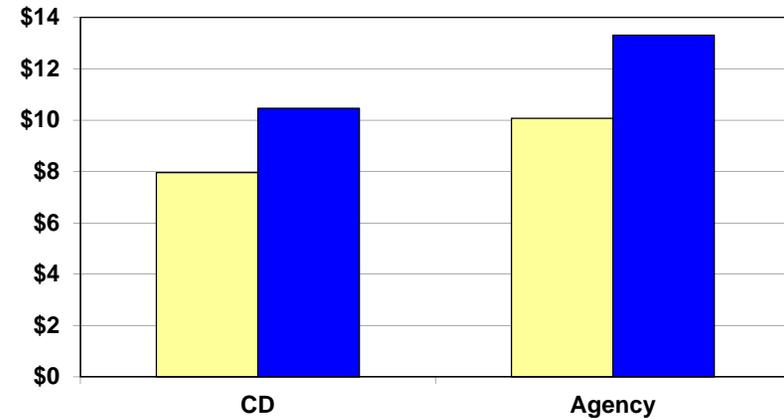
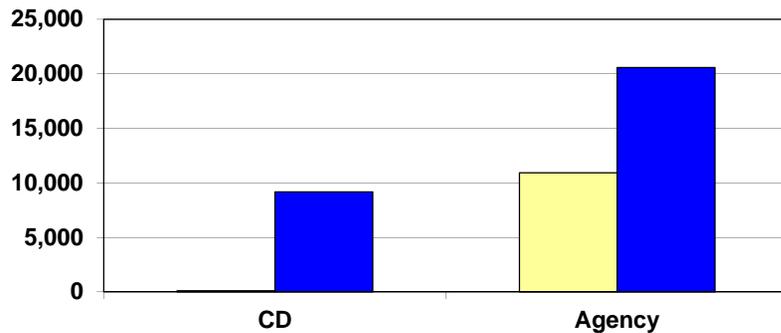
Spending on Personal Care Has Increased Almost 400%



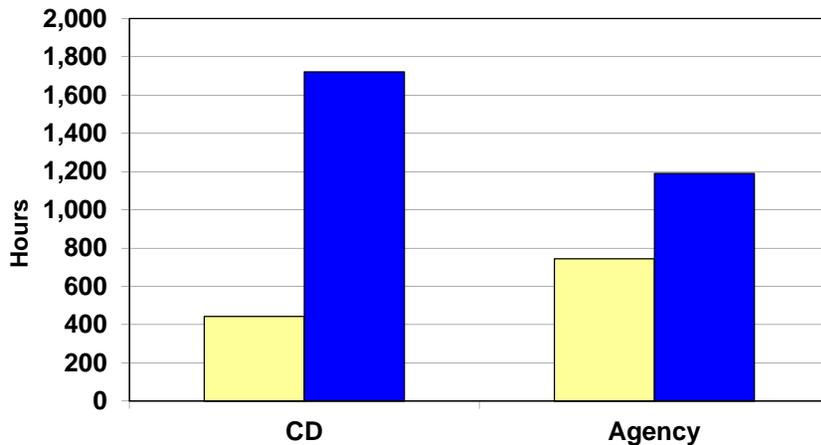
Increasing Number of Recipients, Utilization and Cost Per Hour Are Driving Personal Care Costs

Hourly Rates

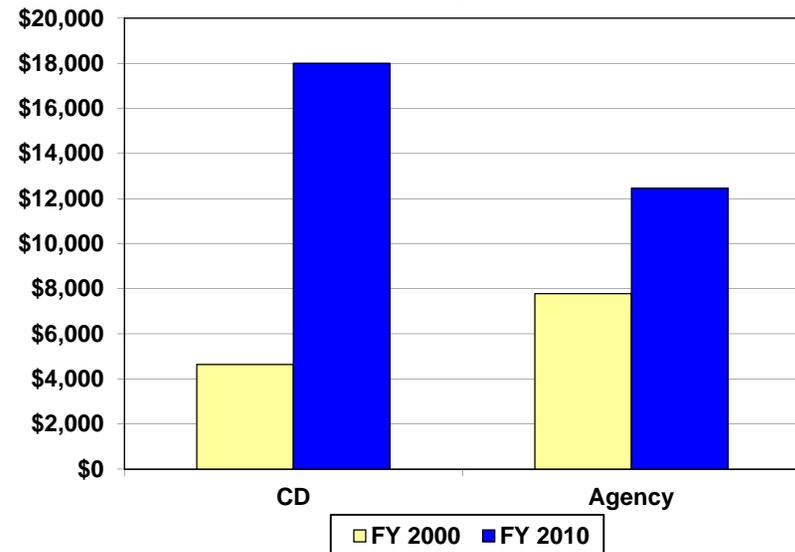
Members Using Services



Number of Hours Per Person



Increase in Average Cost Per Person



■ FY 2000 ■ FY 2010

■ FY 2000 ■ FY 2010



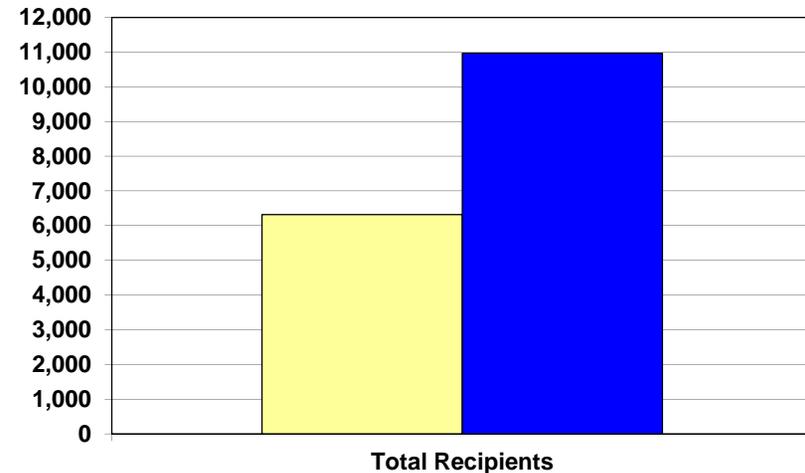
What Else Is Influencing Growth?

- Policy decisions have contributed to increase
 - Virginia income limits for persons in need of institutional care or at risk of institutionalization considers the individual as an income unit of one
 - Olmstead decision to provide consumer choice
 - Continued deinstitutionalization
 - Additional slots to address community waiting list
 - Rate increases
- Growth in the number of recipients receiving services and utilization of those services appear to be the driving factors
- What we don't know is why utilization of consumer directed services is about one-third greater than agency services
 - Amount of hours authorized for each service delivery type are fairly similar according to DMAS staff
 - DMAS currently looking at ways to better monitor and audit services and costs

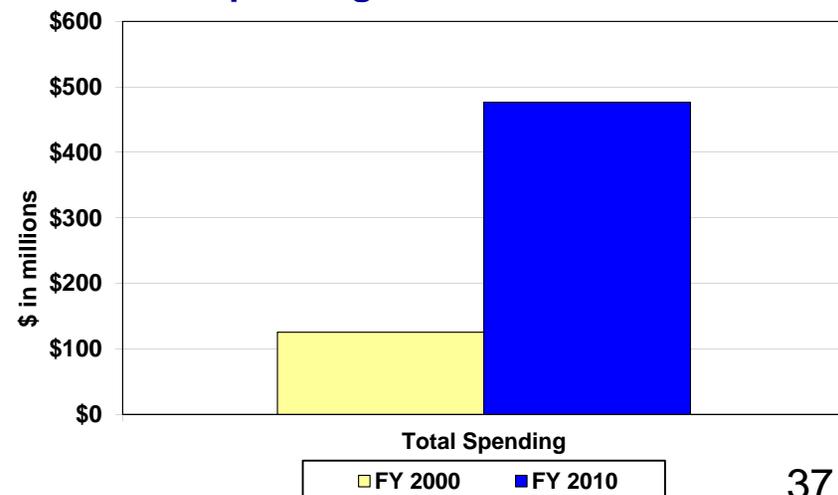
Spending on Congregate Care, Day Support and In-Home Services Also Driving Waiver Costs

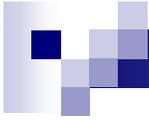
- Increasing enrollment in waiver programs appears to account for about 46% of costs for these services
- Growth in congregate care is largely driven by increased waiver slots (accounts for about 55% of cost increase)
 - Units of services have increase by about 12%
 - Cost per unit have increased by about 23%
- Policy decisions have contributed to increase
 - Additional slots to address community waiting list
 - Olmstead decision to provide consumer choice
 - Rate increases
 - Additional services – day support

74% Increase in Persons Using Services

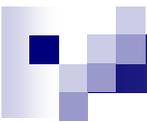


Spending Has Increased 224%





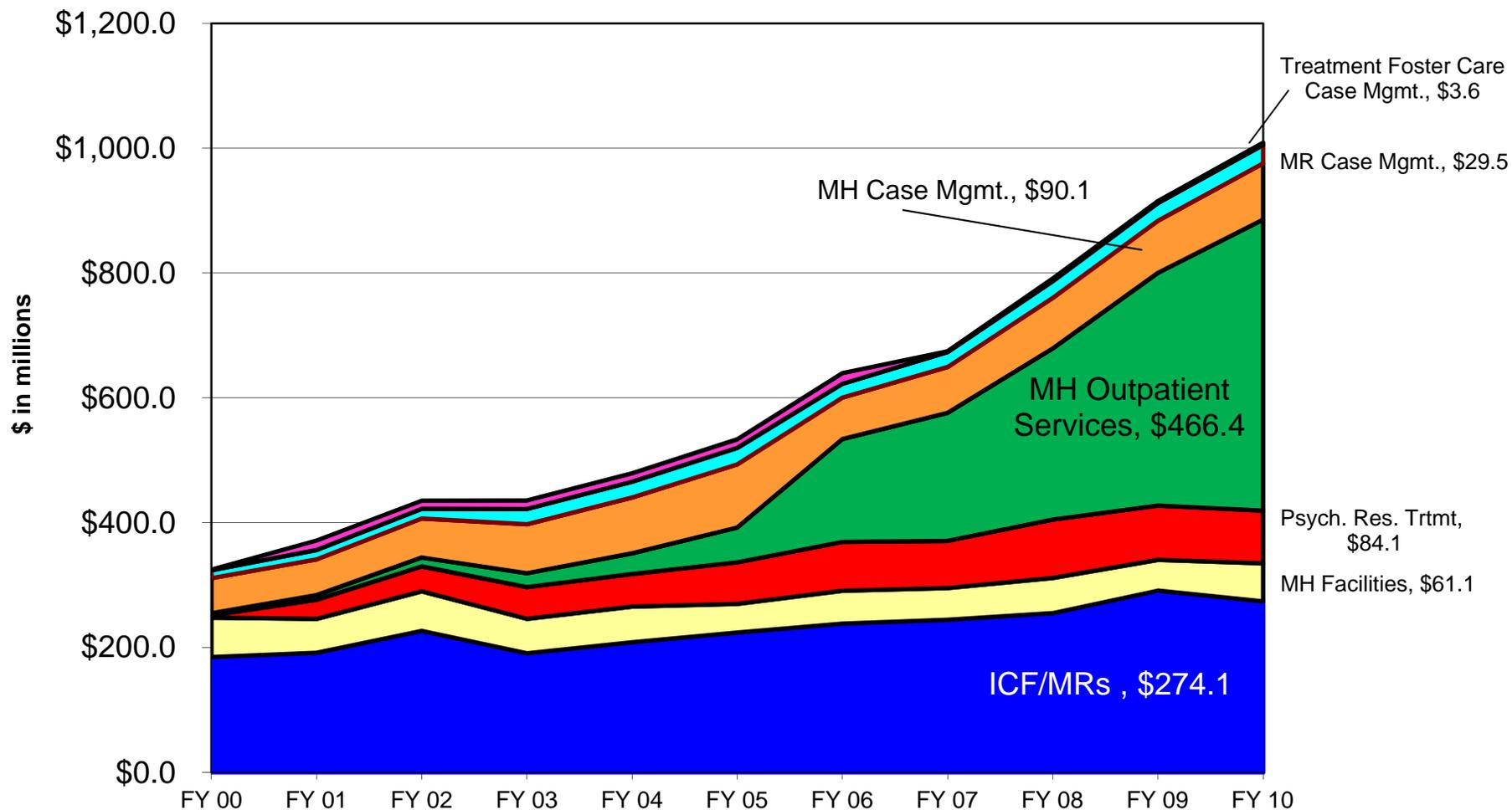
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Medicaid Services for Persons with Mental Disabilities

- Historically, Medicaid has provided reimbursement for institutional care in:
 - State and private intermediate care facilities for the mentally retarded/intellectually disabled (ICF-MRs)
 - State mental health facilities for geriatric patients
- Almost 20 years ago during the recession of the early 90s, Medicaid was used as a fiscal tool to help the state provide and expand community mental health and intellectual disability services

Growth in Services for Mentally Disabled (\$ in millions)



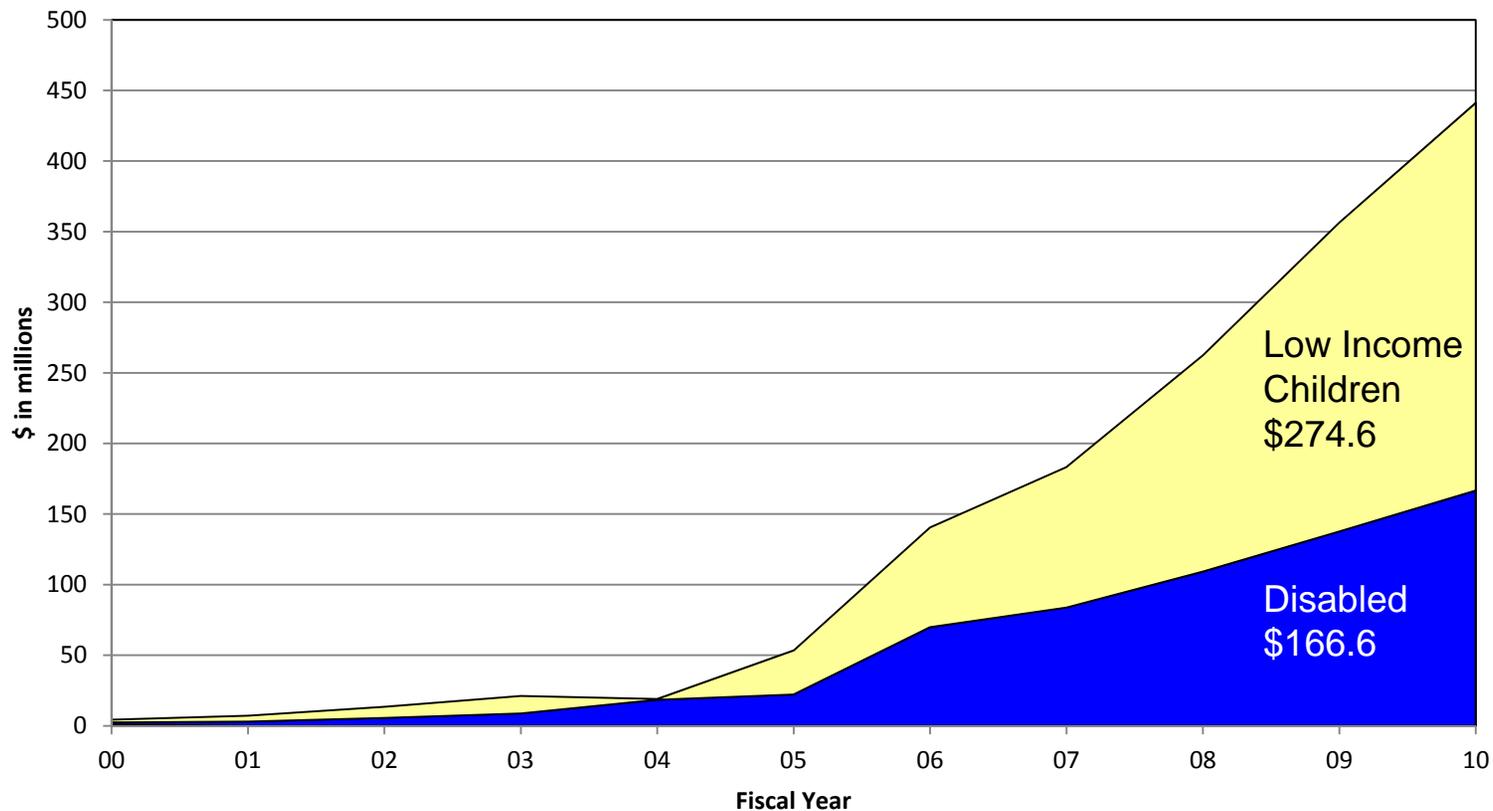
Community Mental Health Services

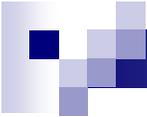
- Optional services
- Early 2000s services only provided by Community Services Boards (CSBs)
- Centers for Medicare & Medicaid (CMS) freedom of choice requirements opened services to be private provider in 2000s
 - Expenditures began doubling each year
 - Expenditures grew to more than \$460 million by FY 2010
- Services are carved out of managed care

	FY 2010 Expenditures	% Private Provider	% CSB
Intensive In-Home	\$176,517,090	98%	2%
Therapeutic Day Treatment	\$144,924,074	76%	24%
Mental Health Support	\$92,629,548	70%	30%
Intensive Community Treatment	\$10,448,302	4%	96%
Psychosocial Rehabilitation	\$26,764,797	24%	76%
Total	\$461,455,390		

Children Account for Largest Growth in Community Mental Health Expenditures

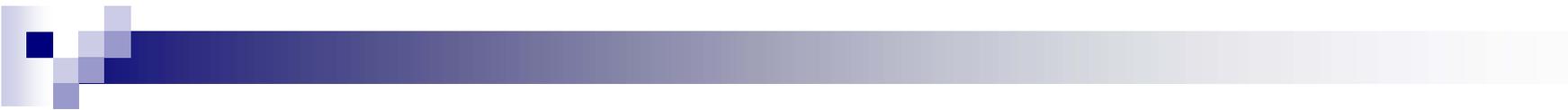
- Children account for almost 60% of the spending
- Disabled account for about 36% of the spending





Two Types of Services Drive Community Mental Health Spending

- Intensive in-home services and therapeutic day treatment for children and adolescents account for almost 70% of total community mental health expenditures
- Intensive in-home services have grown by 250% since FY 2006
 - Time-limited, usually between two and six months, family preservation interventions for children and adolescents with or at risk of serious emotional disturbance, including such individuals with intellectual disabilities
 - Crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24-hour emergency response
 - CSBs payments account for 2% of these services
- Therapeutic day treatment has grown by 418% since FY 2006
 - Services for children and adolescents
 - Combines education and mental health treatment
 - Evaluation; medication education and management; daily living skills; and individual, group, and family counseling



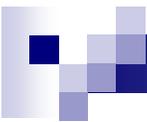
What is Driving these Costs?

■ Intensive In-Home Services

- Policy decisions to move children out of residential care into community (13% decrease in residential services)
- Typical management controls for services were lacking until about two years ago
 - Prior authorization of services only a recent requirement
 - Provider qualifications have only recently been strengthened to ensure qualified individuals deliver services
 - No separation between clinical assessment and provider of services
- Inappropriate marketing of services appears to be leading toward increasing enrollment

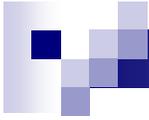
■ Therapeutic day treatment

- Referrals appear to be coming from school divisions, although the individual education plan (IEP) does not state they must have services for their educational purposes
- Many may not have serious emotional disorders that impede their ability to be educated other than those served by CSBs
 - CSBs account for only 24% of the expenditures on therapeutic day treatment
- These children are not mandated for services through the Comprehensive Services Act program (i.e., not special education or foster care children), although they may meet the definition as “non-mandatory” children
 - Most localities do not serve non-mandatory children in CSA

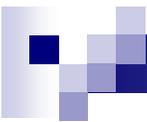


Recent Efforts to Control Mental Health Costs

- DMAS reporting significant efforts to manage community mental health costs recently
 - Implemented restrictive prior authorization requirements on services
 - Increased monthly audits, including auditing compliance with staff qualifications and training as well as expenditures
 - Implemented rules on marketing services and in process of strengthening those to match rules applied to managed care organizations
 - Examining changes to de-link clinical assessment from service provider
- Rates reduced for therapeutic behavioral services
 - Rates for certain therapeutic group home services were reduced by 5% in FY 2010
 - Therapeutic day treatment services reduced by 3% in FY 2011 and 4% in FY 2012
 - FMAP used to restore 9 months of FY 2011 reduction
- Rates reduced for intensive community treatment from \$70 to \$60 per hour effective Feb. 1, 2010
- Rates reduced for psychiatric residential treatment facilities
 - Sept. 2009 reduction in reimbursement of 1%
 - Eliminated annual inflation adjustment
 - Reduced operating rates by 3% in FY 2011 and 4% in FY 2012
 - FMAP used to restore 9 months of FY 2011 reduction



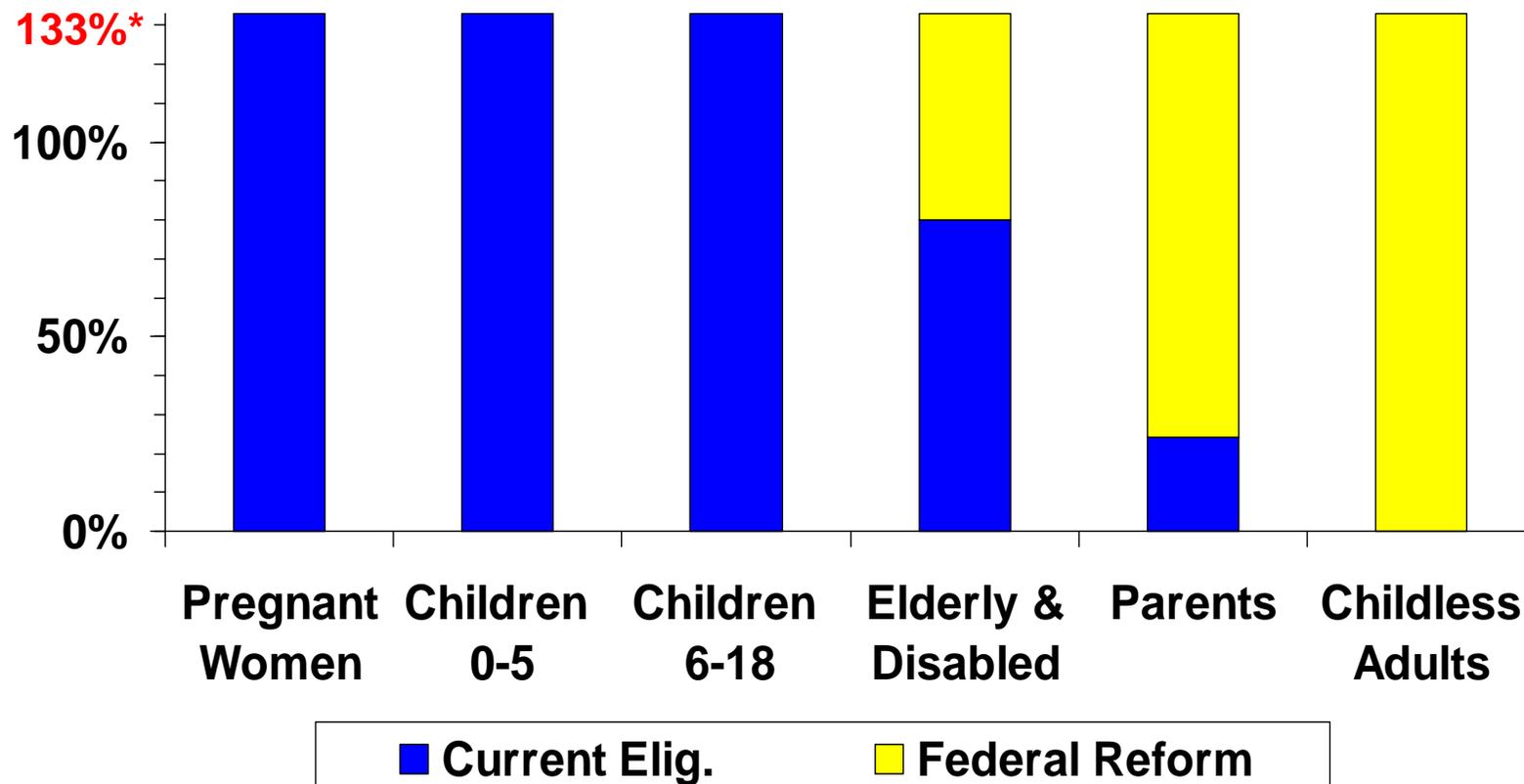
- Overview of the Medicaid Program
- 2000 – 2010 Enrollment and Cost Trends
- Acute Care Services
- Long-term Care Services
- Services for Persons with Mental Disabilities
- **Implications of Federal Health Care Reform**



Eligibility Expansion Provisions of Federal Health Reform Begin January 2014

- Expands Medicaid coverage for adults to 133% of the federal poverty level (FPL), plus a 5% income disregard (also modifies income calculation generally)
 - Expands coverage for groups currently under Medicaid
 - Parents and other caretaker adults who are currently covered up to 24% of FPL
 - Non-Dual Disabled Adults (without need for long-term care)
 - This coverage group is currently limited to 80% FPL
 - Includes new coverage groups under Medicaid
 - Childless adults not currently covered unless they meet some other coverage group (aged, blind, disabled, for example)
 - Former foster care “children” up to age 26 (regardless of income)

Medicaid Expansions Compared to Current Virginia Eligibility Levels



*Does not include 5% income disregard

Preliminary Fiscal Impact Estimate of Health Reform on Medicaid/CHIP

- The impact of federal health care reform by the 2020-22 biennium is estimated to cost Virginia more than \$300 million GF per year

Estimate Component	Lower Bound Enrollment Increase	Upper Bound Enrollment Increase
Assumed Enrollment Increase	271,047	425,930
Expansion Cost	\$2,089,443,970	\$2,784,506,651
Reform Savings	\$625,860,262	\$625,860,262
Net Estimated GF Cost of Reform (FYs 2010-2022)	\$1,463,583,708	\$2,158,646,389
Note: These costs do not include costs associated with reversing eligibility changes prohibited by health reform as contained in the 2010 Appropriations Act.		



Preliminary Fiscal Impact Estimate of Health Reform on Medicaid/CHIP

- In addition to the expansion costs, there are also provisions currently estimated to produce a net savings to the Commonwealth

Provision	GF Savings Estimate (2010-2022)
CHIP Match Rate Increase	\$56,770,696
Pharmacy Rebate Changes	\$428,698,482
DSH Reductions	\$140,391,085
TOTAL Estimated Potential Savings	\$625,860,262

*This table only includes estimated savings associated with these three major items - there are likely additional savings items attributable to Medicaid reform within the federal legislation that are not yet included in this analysis. Furthermore, this table does not address potential savings achieved through health reform outside of the Medicaid program."

Federal Match Rates for Newly Covered Groups

- All *new* coverage (new groups or coverage of existing groups above current levels) is funded with enhanced federal match, stepped down over time

Year	Match by CY (January to December)		Match by SFY (July to June)	
	Federal	State	Federal	State
2014	100%	0%	100%	0%
2015	100%	0%	100%	0%
2016	100%	0%	100%	0%
2017	95%	5%	97.5%	2.5%
2018	94%	6%	94.5%	5.5%
2019	93%	7%	93.5%	6.5%
2020	90%	10%	91.5%	8.5%
2021-beyond	90%	10%	90%	10%

Other Major Medicaid/CHIP Provisions of Federal Health Reform

- Includes a Medicaid increase in payments for primary care services up to the Medicare reimbursement level
 - Required for States
 - 100% federally funded
 - Only in effect for two years (2013 & 2014)
 - 100% Federal Funding ceases after two years
 - States could choose to continue after two years, but at normal match

- Includes a 23 percentage point increase in the CHIP federal match rate effective October 1, 2015 through September 30, 2019, resulting in a savings to the Commonwealth on the costs of the FAMIS program

Medicaid Reimbursement for Primary Care Services	
Type of Service	% of Medicare (FY 2009)
OB/GYN	101.4%
Emergency Room	73.9%
Evaluation & Mgmt. < 21 yrs. preventive	95.6%
Evaluation & Mgmt. <21 other	83.6%
All Other	86.8%
Overall	84.7%
Note: The "Percent of Medicare" reported here is a weighted average of the true percent in NoVA and the true percent in the remainder of the state.	



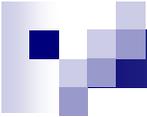
Final Thoughts

- Additional cost containment strategies and program efficiencies are needed given the current trajectory of growth in the program
- Optional services, particularly in the areas of long-term care and mental health services, warrant further analysis for potential efficiencies and quality assurance
- Federal health care reform will further strain Medicaid's ability to manage costs and assure quality



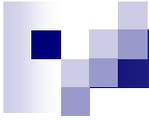
Opportunities Exist to Bend the Cost Curve

- New management information system at DMAS may yield better reporting of data in order to conduct meaningful analyses of cost trends and service utilization
- JLARC analysis of Medicaid fraud, waste, abuse and inefficiency should provide a roadmap to better manage program



Opportunities Exist to Bend the Cost Curve

- **Acute Care**
 - Develop better utilization reporting to make meaningful comparisons to other health care programs and inform policy making
 - Utilization of services by disease categories, including chronic conditions
 - Expenses per admission/discharge
 - Average length of stay
 - Service rates and expenses per service by outpatient site of services and procedure
 - Physician and other practitioner service rates and expenses per service
 - Regional and age related utilization patterns
- **Long-term Care**
 - Further examination of waiver services warranted
 - Utilization of consumer directed personal care compared to agency provided personal care
 - Is the service authorization process working to ensure appropriate level of services?
 - Are services consistent with plans of care?
 - Are the services providing good outcomes?
 - Should certain services be capped?
- **Mental Health Services**
 - Application of best practices for managing costs and quality
 - Better coordination and integration of community mental health services with existing programs that serve children through CSBs and CSA
 - Should localities have to share in the cost of children referred for services?
 - Should we cap or eliminate certain services?
- **Income eligibility**
 - Can we modify income eligibility, impose income caps or stratify services by income levels to serve more clients without violating health care reform legislation?



Appendix A

Federal Poverty Income Levels

2010 Federal Poverty Level (FPL) Guidelines

	Annual Family Income				
Family Size	100% FPL	133% FPL	185% FPL	200% FPL	300% FPL
1	\$10,830	\$14,404	\$20,036	\$21,660	\$32,490
2	\$14,570	\$19,378	\$26,955	\$29,140	\$43,710
3	\$18,310	\$24,352	\$33,874	\$36,620	\$54,930
4	\$22,050	\$29,327	\$40,793	\$44,100	\$66,150
5	\$25,790	\$34,301	\$47,712	\$51,580	\$77,370

Source: 2010 Federal Poverty Guidelines, U.S. Dept. of Health and Human Services