Discussion Points for Jt. Subcommittee on HHR Oversight Response to AHCA

Background on Virginia

- Historically, Virginia has been a prudent steward of Medicaid funding:
  - Virginia's per capita Medicaid spending ranks 47th among states.
  - One of the first states to develop a nursing home screening instrument to ensure appropriate use of institutional care
  - Leader in requiring its Medicaid managed care organizations to be accredited by the National Committee for Quality Assurance (NCQA)
  - Minimal use of financing mechanisms which artificially increase federal Medicaid spending (e.g., provider taxes and intergovernmental transfers)
- Virginia chose NOT to expand Medicaid pursuant to the Patient Protection and Accountable Care Act (ACA) due to concerns about the program's effectiveness and long-term financial sustainability
- Instead, Virginia implemented a multi-year effort to reform the Medicaid program to ensure the efficient and effective use of resources, prior to making a decision on whether to expand Medicaid pursuant to the ACA
  - Focus was on quality improvement, better detection of fraud and abuse, improved service delivery, efficient administration, increase beneficiary engagement and bending the cost curve
    - Implemented Medicaid Dual Eligible Demonstration Program
    - Implemented managed care improvements to include:
      - Commercial like benefit packages and service limits
      - Cost sharing and wellness
      - Coordinate Behavioral Health Services
      - Limited Provider Networks and Medical Homes
      - Quality Payment Incentives
      - Managed Care Data Improvements
      - Serve additional Medicaid populations (foster care children, long-term care recipients)
    - Made significant changes to behavioral health care services including use of a Behavioral Health Services Administrator, provider participation standards, utilization management, service authorization, better definition of covered services and service limitations
    - Implemented new eligibility system

- Virginia has undertaken very limited expansions of Medicaid to comply with federal requirements and serve disabled individuals effectively:
  - Added 1,875 Medicaid waiver slots pursuant to a 2012 U.S. Department of Justice Settlement Agreement to increase Medicaid waivers to serve more individuals with intellectual and developmental disabilities in integrated community settings
  - Extended specific Medicaid mental health and physical health services to additional low-income individuals with serious mental illness.
  - Both initiatives were implemented based on the existing 50% FMAP for Virginia (not enhanced FMAP pursuant to the ACA)
  - Redesigned Medicaid waiver services for individuals with developmental disabilities to better meet needs, enhance community integration and ensure cost effective care in the community
  - Expanded evidenced based addiction recovery and treatment services (ARTS waiver) for Medicaid beneficiaries

Concerns with Federal Medicaid Financing Reform

- The current legislation does not ensure funding equity between Medicaid expansion and non-expansion states
  - Medicaid funding for expansion states continues and they are projected to receive an estimated $680.6 billion between 2012 and 2025
  - In contrast, non-expansion states would safety net funding of $2.0 billion per year over 5 years, with Virginia's share projected at $87 million per year. This funding would be limited to making payment adjustments to eligible Medicaid providers
- The current proposal for per capita enrollee limits will change the nature of Medicaid's financial partnership between the federal government and the states
  - Limits federal participation and shifts the burden of funding an entitlement program created by the federal government to the states
- If a per capita funding mechanism were implemented in 2020, it is estimated that Virginia Medicaid would lose approximately $709 million between 2020 and 2026
- It does not account for critical factors that affect the growth in Medicaid costs:
  - Growth in the aged and disabled populations
  - Behavioral health services
  - Long-term care services and supports typically not covered by Medicare or other third party payers

- Federal mandates, e.g., U.S. DOJ Settlement Agreement to serve additional individuals with developmental disabilities
- Economic downturns
- Emergencies and epidemics (e.g., Zika virus)
- Significant changes in health care (new high cost medical technologies and drugs)

- The proposed per capita limit for spending on enrollment groups are too limited to reflect the higher costs of serving the aged and disabled population
  - Legislation would establish only five enrollment categories for spending for elderly and disabled, children, ACA expansion enrollees and other non-elderly, nondisabled, non-expansion adults
  - Virginia's costs vary significantly between various groups of aged and disabled Medicaid recipients, particularly between Medicaid waivers and whether the individual receives institutional or community-based services. Consequently, an average per capita payment for aged and disabled individuals may not adequately support Medicaid coverage for individuals with high needs
    - Virginia's cost for institutional nursing home care is higher because we have higher acuity in our nursing facilities
    - Virginia's recent closure of two state institutional training centers serving individuals with intellectual disabilities has resulted in higher per capita costs for those residing in remaining centers. Further the cost of community care for these individuals as they transition to community care is substantially higher than those who have been residing in the community.

Recommendations to Improve the Legislation Related to Medicaid

- **Recognize variation in state Medicaid programs in financing reform**
  - Virginia's Medicaid program has undergone significant reforms to control costs and improve quality, resulting in lower costs to the federal government
  - However, Virginia faces growth based on factors listed above which will continue to drive program costs (aged and disabled population growth, federal U.S. DOJ mandated expenditures, payment adequacy to ensure access to services, etc.)
- **Implement Medicaid Cost Controls**
  - Provide states with additional flexibility or tools to control health care cost drivers

- Provide states with the ability to implement innovations and modify federal Medicaid requirements (eligibility, premiums and cost sharing, benefits, provider payments, delivery system, etc.) to control costs while meeting critical needs
- Require high cost states to implement additional Medicaid cost control measures
- Limiting financing mechanisms used by states to artificially inflate their Medicaid expenditures to draw down additional federal funding (e.g., intergovernmental transfers and supplemental payments)

- **Modify the Per Capita Financing Arrangement**
  - Limits should recognize federal requirements that payments to managed care organizations be actuarially sound
  - Limits should be prospective to allow states to appropriately budget for Medicaid expenditures
    - Rebase Medicaid per capita expenditures at least every two years to reflect actual spending
    - Consider using a different annual growth factor other than CPI-Medical to represent changes in per capita Medicaid expenditures
      - CPI-Medical focuses on the consumer's "price" for a specific market basket of medical goods whereas Medicaid services, such as long-term care services and supports, reflect a broader array of medical goods and services
      - Medicaid spending is also influenced by as changes in case mix, medical advances and practice standards, which may affect the type and quantity of services used
  - Expand the per capita enrollment groups to better reflect the varying costs of aged and disabled individuals receiving Medicaid waiver services and institutional care
  - Include exception provisions for growth related to federal mandates (such as the U.S. DOJ Settlement Agreement), emergencies, and unexpected economic downturns
  - Recognize differences in acuity and costs across different categories of enrollees with periodic adjustments to adequately account for the changing health of populations served
  - Recognize unexpected costs due to epidemics (e.g., Zika outbreak), significant developments in the health care environment (e.g. new medical technologies or new high cost drugs which may bend cost curve of lifetime medical treatments)

- Change the base year from FY 2016 for calculating the per capita limits to reflect a base year that allows states to plan and budget for changes
  - Virginia made budget decisions during the 2016 and 2017 Legislative Sessions totaling more than $339.0 million in increased Medicaid spending for specific purposes, which will not be captured in 2016 base year expenditures:

Compliance with U.S. DOJ Settlement Agreement

- $38.0 million in FY 2017 and $74.0 million in FY 20187 in total Medicaid funds to add 1,210 new developmentally disabled waiver slots
- $23.6 million in FY 2017 and $44.4 million in FY 2018 in total Medicaid funds to redesign the services in the developmental disability waivers to comply with DOJ Settlement Agreement

Provider Payment Adequacy

- $44.5 million in total funds in FY 2018 to increase nursing facility payments
- $14.5 million in FY 2017 and $16.7 million in FY 2018 in total funds to increase hospital payments
- $14.2 million in FY 2017 and $16.0 million in FY 2018 in all funds to increase personal care rates in Medicaid waiver and EPSDT programs
- $5.4 million in FY 2017 and $5.6 million in FY 2018 in total funds to increase rates for private duty nursing in Medicaid waiver and EPSDT programs

Expansion of Medicaid Services

- $5.2 million in FY 2017 and $16.8 million in FY 2018 in total funds to expand coverage for Medicaid substance use disorder services to assist in dealing with the opioid crisis
- $3.3 million in FY 2017 and $11.6 million in FY 2018 to expand eligibility for specific mental and physical health services for individuals with serious mental illness from 60 to 100 percent of the federal poverty level (GAP Waiver)
- $2.7 million in total funds in FY 2018 to begin phasing in same day access to community mental health services for seriously mentally ill individuals
- $2.6 million in FY 2018 in total funds to fund 25 Medical residency slots for primary care and high-need specialties in underserved communities

Recommendations to Improve AHCA Provisions on the Health Care Marketplace

- Virginia has 410,726 enrolled in a marketplace plan as of January 2017 and in 2016 Virginians received an estimated $1.06 billion in premium tax credits.
- Any legislation should ensure the appropriate mechanisms are in place to promote stability in the individual marketplace whether this is through cost-sharing reductions or other funding supports.
    - Virginia's health insurance industry has expressed concerns that the proposed funding levels in the House bill are likely insufficient to achieve the sufficient stability in the market.
        - Virginia did not participate in the original high-risk pools under the Affordable Care Act due to lack of adequate funding.