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Putting Medicaid in the Larger Budget Context: An In-Depth Look at Four States in FY 2014 and 2015

Laura Snyder, Kathleen Gifford, Eileen Ellis, and Jenna Walls

Medicaid has long-played an important role in the US healthcare system, accounting for one in every six dollars of all US health care spending while providing health and long-term services and supports coverage to over 66 million low-income Americans. Medicaid also plays an important role in states budgets as both an expenditure item and the largest source of federal revenue for states.

The years 2014 and 2015 will stand out as a time of significant change and transformation for Medicaid programs. With the economy improving from the lingering effects of the Great Recession, Medicaid programs across the country were focused primarily on implementing a myriad of changes included in the Affordable Care Act (ACA), pursuing innovative delivery and payment system reforms to help assure access, improve quality and achieve budget certainty, and continuing to administer this increasingly complex program.

However, these changes to Medicaid policy, spending and enrollment take place in the larger context of states budgets. Unlike the Federal government, states generally have balanced budget requirements, taking into account the amount of revenue coming in from a state's own resources as well as federal revenues. State lawmakers must balance competing priorities across budget expenditure categories. Even in years of economic growth, state lawmakers face this pressure of balancing priorities.

This report provides an in-depth examination of Medicaid program changes in the larger context of state budgets in four states:

- Michigan
- Utah
- Virginia
- West Virginia

These case studies build on findings from the 14th annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA.) Additional research on budget activity, economic conditions, and other relevant health policy activity was conducted by KCMU and HMA staff members; each case study was submitted to states for their review and comment.

Michigan

Economic and Budget Outlook

Economy

Michigan endured a dramatic shift in its economic strength between 2001 and 2010, largely attributed to declines in manufacturing employment that hit the state particularly hard. For over a century Michigan's economy has been heavily dependent on manufacturing employment, primarily manufacturing associated with motor vehicle and parts production. In the past decade the "Big Three" US auto manufacturers (Ford, General Motors and Chrysler), headquartered in Michigan, shed manufacturing capacity as US automotive sales declined and their share of the automotive market dropped. Since 2010, increases in motor vehicle sales have driven a moderate recovery in Michigan employment and a significant drop in the unemployment rate, which has fallen from 13.2% in April of 2009 to 7.7% in July of 2014, still one of the highest state unemployment rates in the country.[1] After hitting bottom in 2009, employment and state revenues began slow improvement in 2010. State revenues did not regain actual 2008 levels until 2013[2], and in 2014 total employment has not yet regained 2008 levels.[3]

State Budget

The economic downturns that began in March 2001 and in December 2007 affected all states, but hit Michigan's state budget especially hard, as state revenues dropped and spending for Medicaid increased, leading to a period of persistent budget deficits. Addressing these deficits since 2001 largely focused upon reduced support for the state's higher education system, diminished and delayed investment in the state's transportation infrastructure and less support for local governments through revenue sharing payments and tax and fee increases[4].

Like most states, Medicaid spending accounts for a significant and growing percentage of Michigan's state budget. While the appropriation process in Michigan devoted a great deal of energy to identifying General Fund savings in the Medicaid program, Michigan largely avoided significant structural reductions in Medicaid coverage, services and reimbursement since 2000. This was possible in significant part due to the enhanced federal Medicaid matching during these periods and also due to increased use of provider taxes as a source of the non-federal revenue for the Medicaid program. Michigan began with a tax on nursing facilities in FY 2002 and expanded the program to other provider groups in FY 2003. Provider taxes represented nearly $900 million in Medicaid revenues by FY 2007[5] and exceeded $1 billion by the end of the decade.

For the past four years, Michigan has enacted annual budgets without significant General Fund program reductions and has allocated some surplus revenues to program enhancements and to restoring the state's Budget Stabilization Fund.[6]

For FY 2015, which begins on October 1st, the Michigan Medicaid budget is largely a continuation of the FY 2014 budget, with two major adjustments. The most significant adjustment was the full-year 100 percent federal funding of the Healthy Michigan Plan (Michigan's Medicaid expansion implemented April 1, 2014.) The second adjustment provided additional funding ($111.6 million total / $25.0 million General Fund) to support partial retention of enhanced physician primary care reimbursement rates. (Increases in primary care rates to Medicare levels were fully federally funded through the Affordable Care Act in calendar years 2013 and 2014.)[7]

ACA Implementation

The 2010 Affordable Care Act (ACA) has the potential to extend coverage to many of the 47 million nonelderly uninsured people nationwide, including the 1.1 million uninsured Michigan residents. The ACA establishes coverage provisions across the income spectrum, with the expansion of Medicaid eligibility for adults serving as the vehicle for covering low-income individuals and premium tax credits to help people purchase insurance directly through new Health Insurance Marketplaces serving as the vehicle for covering people with moderate incomes (100-400% FPL).[8] Many of these provisions became effective during SFY 2014 with significant implications for state budgets and Medicaid programs across the country, including Michigan.

Marketplace Coverage

As written under the law, states have the option of establishing their own Marketplaces or relying on the federally-facilitated Marketplace, www.healthcare.gov. Michigan was one of seven states that opted for a partnership model, where the state would perform plan management functions and defer other Marketplace management, including consumer assistance, to the federal government.[9] The state's Department of Insurance and Financial Services (DIFS) performs plan management functions for health insurance products offered both inside and outside the Marketplace. Ten insurance providers are offering 106 Qualified Health Plans in Michigan's Marketplace.[10] As of April 19, 2014, over 272,500 Michigan residents had selected a Marketplace plan (approximately 38% of the estimated 725,000 individuals eligible for Marketplace coverage[11]) over 87 percent of whom qualified for financial assistance.[12]

All funding for outreach and enrollment efforts for the Marketplace has come from the federal government and private organizations. Entities providing outreach and enrollment for Michigan's Marketplace include 31 of Michigan's Federally Qualified Health Centers as well as four organizations that received federal Navigator grants to provide consumer assistance for the federal Marketplace; additional consumer information about Marketplace coverage can be obtained from volunteer certified application counselors as well as licensed agents and brokers who sell coverage in the Marketplace. The DIFS website details the consumer assistance available.

Healthy Michigan Plan – Michigan's Alternative Medicaid Expansion

The Medicaid expansion, as written in the ACA, was designed to fill in existing gaps in Medicaid coverage, largely for adults. Under the Medicaid expansion, nearly all individuals with incomes under 138% FPL would be covered. However, the June 2012 Supreme Court decision effectively made the Medicaid expansion optional for states to implement. Michigan is one of the 28 states (including DC) that have adopted the Medicaid expansion as of September 2014. However, the path the state took to implementing the Medicaid expansion differs from those of other states.

In February of 2013, Michigan Governor Rick Snyder made public his support for implementing the Medicaid expansion authorized through the Affordable Care Act in his FY 2013-2014 Executive Budget Recommendation. The initial concept proposed by the Governor would be an expansion of the Medicaid program through a state plan amendment. Those newly eligible for Medicaid would be enrolled in the state's contracted Medicaid managed care organizations.[13] The proposed expansion was considered by the Michigan Legislature, controlled in both houses by Republican majorities. The House agreed to the Medicaid expansion,

but the Senate did not concur, notwithstanding strong support and advocacy from the Governor (also a Republican), and the Medicaid expansion was not included in the final FY 2013-2014 enacted budget.[14]

Following the FY 2013-14 budget process, representatives from the Executive branch along with legislative leadership began to discuss an alternative Medicaid expansion plan. If a Medicaid expansion were to be approved, legislative leadership was interested in achieving policy goals over and above improved access to coverage. The result of this process was the Healthy Michigan Plan (HMP). The HMP makes Medicaid eligibility available to uninsured adults with income below 138 percent of the FPL. Additional policy goals articulated by legislative leaders and included in the HMP proposal included:

- **Recipient Cost-Sharing:** The HMP includes provisions that require beneficiaries to make monthly payments to a managed "healthy behavior incentive account." The monthly payment requirements for all enrollees will be generated using incurred co-payment cost over the first six months of HMP enrollment. Persons with income over 100 percent of the FPL are required to additionally pay a premium equivalent to two percent of their income.
- **Healthy Behavior Incentives:** Cost sharing requirements, detailed above, are to be reduced if enrollees demonstrate positive healthy behaviors. Enforcement of the healthy behavior requirements is the responsibility of the MCOs, with MCO incentive funding tied to enrollee health outcomes and a new requirement that all HMP enrollees have an initial appointment with their primary care provider scheduled within 60 days of initial enrollment.[15] Enrollees can also reduce their recipient cost-sharing amounts when they complete an annual health risk assessment.
- **Delivery System Structure:** HMP, like Michigan's base Medicaid program, relies on contracted Medicaid managed care organizations (MCO.) Nearly all HMP enrollees are required to be enrolled in an MCO.[16] Additionally, services not typically provided through MCOs (like dental) are the responsibility of MCOs for HMP enrollees.[17]

After lengthy and contentious debate, legislation authorizing HMP was passed by the Legislature and signed by the Governor in September of 2013.[18] HMP was implemented in April 2014. In addition to the provisions noted above, the HMP statute included provisions that will require a future waiver, which are described below.

Federal Authority for HMP

A Medicaid expansion program with the policy elements detailed above could not be approved by CMS through an amendment to Michigan's Medicaid state plan. The authorizing language for implementing HMP requires Federal approval of two separate 1115 waivers, one of which has been submitted and approved while the other is to be submitted in the future. The changes under these waivers are discussed below:

- The State of Michigan submitted an amendment to an existing 1115 waiver that authorized the operation of the state's Adult Benefit Waiver (ABW) program. The ABW used Medicaid funding to support a limited benefit physical and mental health program for uninsured adults with income below 35 percent of the FPL. Enrollment in ABW was capped. Michigan shifted individuals enrolled in ABW to the more comprehensive HMP and expanded coverage for adults up to 138% FPL. The waiver was restructured to provide Michigan the authority to administer healthy behavior savings accounts, impose cost-sharing requirements on HMP enrollees over the "nominal" levels in Medicaid programs and to create financial healthy behavior incentives for HMP enrollees. The waiver amendment was approved by CMS on December 30, 2013.[19]
- The legislature also included a provision that calls for enrollees with income above 100 percent of the FPL who have been enrolled in HMP for greater than 48 months to either purchase subsidized coverage through Michigan's Marketplace or remain in HMP with an increase in cost-sharing. Premiums would increase to 3.5 percent of income, with a limit on total cost-sharing (premiums and copayments) to a maximum of 7 percent of income. An additional 1115 waiver will be necessary to allow the state to implement this provision. Language in the legislation authorizing HMP requires approval of this waiver by December 31, 2015.[20]

HMP Enrollment

The State projected enrollment in HMP over the first year of the program of 370,000, with enrollment ultimately stabilizing at around 500,000 individuals. Enrollment in HMP, since the program's launch in April of 2014, experienced a much more dramatic ramp up of program participation. As of October 6, 2014, enrollment in HMP is 405,743.[21]

Delivery System Reforms

Patient Centered Medical Home Initiative

Michigan is one of eight states (along with Maine, Minnesota, North Carolina, New York, Pennsylvania, Rhode Island and Vermont) that were selected to participate in the Multi-Payer Advanced Primary Care Practice Demonstration where states administer a three-year, multi-payer patient-centered medical home (PCMH) initiative across Medicaid, private payers and Medicare (which began participating in Michigan's demonstration in October 2011.) The goal of this initiative is to evaluate whether advanced primary care practices reduce "unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas."[22]

Michigan's initiative, called the Michigan Primary Care Transformation Program (MiPCT), is the largest PCMH project in the United States with over 400 participating primary care practices. Enrollees through Blue Cross Blue Shield of Michigan, the Blue Cross HMO (Blue Care Network), west-Michigan based HMO Priority Health, Medicare and Medicaid are included in the demonstration. MiPCT requires participating primary care practices to achieve designation as a PCMH, either through BCBSM or the National Committee for Quality Assurance (NCQA).[23]

State Innovation Grant

The Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models. One of the opportunities for states offered by the Innovation Center is the State Innovation Models initiative (SIM). The SIM initiative provides "financial and technical support to states to design or test innovative payment and service delivery models that will improve health, improve care and lower cost for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries."[24] In February of 2013 Michigan, along with 15 other states (California, Connecticut, Delaware, Hawaii, Idaho, Illinois, Iowa, Kentucky, Maryland, New Hampshire, Ohio, Pennsylvania, Rhode Island, Tennessee, and Texas), was awarded a Model Design Grant through CMS to support the development of the state's health care innovation plan. In January 2014, the State submitted their "blueprint" for changes in the state's health delivery system. The blueprint includes the following components:

- **Patient-Centered Medical Homes (PCMH):** The State would expand the Michigan Primary Care Transformation Project to additional medical practices, payers and patients. This will include new requirements for contracted Medicaid MCOs to participate in the PCMH initiative and new rules to permit safety net providers to participate in the pilot project.
- **Accountable Systems of Care:** Michigan intends to support the creation of a new healthcare service delivery system by developing new organizations, described as Accountable Systems of Care. Accountable Systems of Care are legal entities built to support a network of providers who are accountable to collectively coordinate the medical, behavioral and social services provided to their patients. The entity would be financially accountable for the performance outcomes of this population but would not be fully at risk like a licensed insurer.
- **Development of Community Health Innovation Regions:** Michigan intends to support the development of local consortiums of community organizations, state and local agencies, business entities, providers and citizens with the goal of increasing local capacity for improving population health.
- **Value-Based Payment Reforms:** Michigan detailed a number of payment reforms that would allow the state to move closer to a "payment for value" structure across payers. Initial payment reforms detailed in the blueprint document include expansion of the PCMH infrastructure in the state, pay-for-performance and shared savings strategies. Michigan established a longer-term goal of making care management payments through the state's new Accountable Systems of Care. These payments would be structured to account for continuity of care and a shared savings component with provider upside and downside risk.[25]

The blueprint identified infrastructure cost associated with implementing the reforms detailed above at $13.0 million with full dissemination of the model in 2019. Based on this blueprint, Michigan submitted an application to CMS for additional funding to test this model. CMS anticipates awarding up to $700 million to fund up to 12 Model Test grants across the country, which will provide financial and technical support four years for states to test and evaluate their models. Round two of the Model Test grants will be awarded sometime in the Fall of 2014.[26]

Health Homes

As part of the state's budget, Michigan committed to pilot Medicaid Health Homes, a new ACA state plan option that provides enhanced matching funds (90 percent for the first 8 quarters) for Medicaid programs to establish person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and community-based long-term services and supports, for beneficiaries who have at least two chronic conditions, or one and at risk of a second or a serious and persistent mental health condition. Michigan implemented health homes in three regions for individuals with a serious and persistent mental health condition beginning July 1, 2014.[27] Community mental health service providers (CMHSP) are designated as health homes.[28]

Integrated Care for Dual Eligible Beneficiaries

In 2011 the State of Michigan was successful in accessing funding through CMS for a Design Contract for the Integrate Care for Dual Eligibles (ICDE) program. Michigan will pilot a new care and supports coordination program for residents enrolled in both Medicare and Medicaid in four markets throughout the state (Michigan's Upper Peninsula, eight counties in Southwest Michigan, Wayne County, and Macomb County.) Dual eligible beneficiaries who participate in the pilot project will be enrolled in an Integrated Care Organization (ICO). ICOs are responsible for all Medicaid and Medicare funded physical health services and supports necessary to meet the needs of the enrollee, including both acute care and long term care. In addition, the ICOs must coordinate care with the Prepaid Inpatient Health Plans (PIHPs) which are the entities responsible for behavioral health care for all Medicaid enrollees, including the dual eligible beneficiaries.[29]

Michigan issued a Request for Proposals in August of 2013 for the state's ICO network; in November of 2013 the State of Michigan identified the organizations that will serve as ICOs during the pilot project period. In April 2014, the State signed a Memorandum of Understanding (MOU) with the Federal Centers for Medicare and Medicaid Services outlining the structure of the state's ICDE. Contracted ICOs are now undergoing a state readiness review process and services will be provided through the ICDE program beginning in January of 2015. The demonstration is estimated to include 100,000 dual eligible beneficiaries.[30] The first phase includes two regions (the Upper Peninsula and Southwest Michigan.) Services for voluntary enrollees in those regions will begin January 1, 2015. Services for passive enrollees in these two regions will begin April 1, 2015. For phase 2 (which includes Wayne and Macomb Counties) services for voluntary enrollees are set to begin May 1, 2015 followed by services for passive enrollees on July 1, 2015.[31]

Additional policy actions the state either implemented in FY 2014 or planned to implement in FY 2015 are detailed in the table that follows:

Michigan Medicaid Policy Changes in SFY 2014 and 2015

Eligibility, Application and Renewal Policies

- The Healthy Michigan Plan was implemented April 1, 2014. The Adult Benefits Waiver (with limited benefits and capped enrollment) for childless adults ended on 4/1/14. On that date current enrollees (about 50,000) were converted to the Healthy Michigan Plan.
- Eliminated Family Planning Waiver. (However due to litigation, FP waiver cases are not closed until eligibility for other Medicaid programs has been explored.)

Premium and Cost-Sharing Changes

FY 2015 for Healthy Michigan Plan:

- A two percent premium will be charged to Healthy Michigan enrollees with incomes between 100% and 138% FPL when they have been enrolled in the plan for six months. The state estimated that during the last half of FY 2014 (the period ending September 31, 2014), a total of 320,000 individuals will be enrolled in Medicaid (beyond the ABW conversions).
- After six months in the plan, all members will pay a monthly cost-sharing amount based on their historical copayments from the prior six month period.
- Enrollees can reduce their annual cost-sharing by participating in healthy behaviors, including completion of an annual health risk assessment.

Provider Rates and Provider Fees/Taxes

- In both FY 2014 & FY 2015: Michigan increased MCO and nursing facility rates. All other rates were flat.
- Effective January 1, 2015, when the ACA primary care rate enhancement to 100% of Medicare rates ends, Michigan will fund half of the value of the enhancement.
- Hospitals and nursing facilities have small provider tax increases in both FY 2014 and FY 2015.

Benefits and Pharmacy

- No changes in FY 2014 or FY 2015.

Managed Care and Care Coordination

- In FY 2014:
  - Enrolled the Healthy Michigan population in Medicaid HMOs in FY 2014.
  - Continued existing Patient Centered Medical Homes initiative.
  - Implemented the new Health Homes (ACA Section 2703) initiative for individuals with both severe mental illness and a chronic physical health condition in FY 2014.
- Dual eligible beneficiaries financial alignment demonstration (MI Health Link) in four regions of the state. Phased enrollment begins in December 2014, with initial enrollments effective on January 1, 2015.

Utah

Economic and Budget Outlook

Economy

As in nearly all of the states, Utah struggled through the recession. The State's unemployment rate peaked in December 2009 at 8.4 percent, somewhat below the national average which peaked at 10.0 percent in October of that year, but still high.[32] Revenues from sales, income and corporate income taxes dropped precipitously – 15.5 percent - between FY 2008 and FY 2010.[33] And like other states, Utah made adjustments by cutting program funding and staff, and utilizing transfers in fund balances and state reserves to bridge the budget shortfalls. Through attrition and early retirement incentives, State Government reduced its workforce by over 9 percent between FY 2009 and FY 2012.[34] The State's Rainy Day Fund fell from $419 million in FY 2009 (8.7% of expenditures)[35] to $210 million in FY 2010 (4.7% of expenditures).[36]

Utah's turnaround, however, began quickly and progressed steadily. By December 2012, Utah was one of only 11 states with employment at or above pre-recession levels.[37] Utah has also enjoyed recent recognition for its business climate, economic growth, and overall state performance. An annual analysis of pro-business metrics ranked Utah as the number one state for three consecutive years from 2012 to 2014.[38] The State ranked 5th in the nation in a 2013 survey as one of the "best managed states" based on financial data, services and residents' standards of living.[39] With a stable economy and one of the lowest unemployment rates in the nation – 4.4 percent in 2013, which had fallen to 3.5 percent by June 2014[40] – Utah anticipates $338 million in new revenue in FY 2015, and now maintains approximately $400 million in its reserve fund balances, representing about seven percent of General Fund/Education Fund appropriations.[41]

State Budget

Utah enacts a state budget annually and finances operations through its General Fund and Education Fund. As required by Utah's constitution, all personal and corporate income tax revenue is used to fund K-12 and higher education[42] while other state operations and programs, including Medicaid, are funded primarily from sales tax revenue deposited in the State General Fund. Governor Gary Herbert signed the FY 2015 budget into law April 2014. The total (federal and state) $13.5 billion capital and operating budget represents a modest 1.2 percent increase over the revised FY 2014 budget.[43] The General Fund/Education Fund appropriations for FY 2015, however, totaled $5.8 billion, an increase of 7.2 percent over FY 2014 appropriations (FY 2014 appropriations had declined by $64 million from FY 2013 due primarily to lower than estimated Medicaid costs.) Governor Herbert has challenged state agencies to achieve a 25 percent increase in efficiency by 2017 through implementing tools and concepts (SUCCESS Framework), to continue to improve government performance.[44]

The Governor's proposed budget included $2.1 billion for total spending on Medicaid in FY 2015. This includes $550 million in General Fund appropriations and $1.62 billion in federal funds.[45] In his budget recommendations, the Governor noted that Medicaid General Fund appropriations were not fully expended in FY 2012 and FY 2013 due to lower than projected enrollment. Additional FY 2013 savings were achieved through a managed care expansion and through recovery of erroneous Medicaid reimbursements.[46] In addition, Utah's Federal Medical Assistance Percentage (FMAP) – the federal share of Medicaid expenses, increased from 69.6 percent in 2013 to 70.6 percent in 2015.[47]

ACA Implementation

The 2010 Affordable Care Act (ACA) was designed to expand coverage to most of the 47 million nonelderly uninsured people nationwide, including a portion of the estimated 407,000 uninsured Utah residents.[48] The ACA enhances coverage across the income spectrum by expanding Medicaid eligibility for adults earning up to 138 percent of the FPL, including non-custodial and childless adults not previously covered by Medicaid, and by providing premium tax credits to help people with moderate incomes (100-400% FPL) purchase insurance directly through new Health Insurance Marketplaces. While these coverage provisions took effect January 1, 2014, the U.S. Supreme Court's 2012 ruling[49] establishing the constitutionality of the ACA individual mandate to obtain coverage, also held that states could not be forced to expand Medicaid coverage, essentially making the ACA Medicaid expansion optional for states. By the end of August 2014, 27 states and the District of Columbia had opted to implement a Medicaid expansion.[50] Utah is one of two states that has not expanded Medicaid but was in open negotiation with CMS as of September 2014.

The Health Insurance Marketplace

Utah took on health insurance reform prior to passage of the ACA. In 2009, state legislation created the Office of Consumer Health Services, which was tasked, in partnership with the Utah Insurance Department, Department of Health and Workforce Services, with creating an internet portal that could:

- Serve as a single access point for private and government health insurance websites, application forms and submission procedures;
- Facilitate private sector collection of premium payments for a single policy by multiple payers; and
- Assist employers to establish mechanisms allowing employees to purchase health insurance with pre-tax dollars.[51]

The resulting Insurance Exchange, called *Avenue H*, became the basis for a state Marketplace under the ACA. The State received conditional approval from HHS in January 2013 to run a state Marketplace, but eventually Utah adopted *Avenue H* as its small business SHOP exchange, and elected to use the Federally Facilitated Marketplace for its individual coverage health exchange.[52]

In 2014, six insurance providers are offering 99 Qualified Health Plans in Utah's Individual Marketplace.[53] Utah is also one of 23 states offering consumer operated and oriented plans (CO-OPs), a new type of non-profit, member-governed health insurance intended to offer more affordable, consumer friendly, and high quality health insurance options to compete with existing health insurers. As of April 19, 2014, over 84,600 Utahns had selected a Marketplace plan (approximately 26% of the estimated 331,000 individuals eligible for Marketplace coverage[54]) nearly 90 percent of whom qualified for financial assistance.[55]

Healthy Utah Plan – Utah's Alternative Medicaid Expansion Proposal

After agreeing to study its options regarding the Medicaid expansion decision, Utah's Governor Gary Herbert announced in January 2014 that "doing nothing is no longer an option".[56] Governor Herbert outlined the concepts of the "Healthy Utah Plan" in a February 2014 press release.[57] The Healthy Utah Plan calls for a three-year pilot program that would cover those under 138 percent FPL. The plan builds on the principles and strategies of: [58]

- Promoting individual responsibility through charging premiums and copays, offering incentives for healthy behaviors, and requiring a work effort or participation in employment training
- Supporting private markets through the use of employer-sponsored insurance and premium assistance to purchase private market plans
- Maximizing flexibility by allowing Utah to use federal savings from Utah's current waiver to support new quality improvement efforts
- Respecting the taxpayer by terminating the plan if federal funding does not come as promised.

The legislative session came to a close on March 13, 2014, without passing Medicaid expansion legislation. Governor Herbert has continued negotiations with CMS over the Healthy Utah Plan, which have for several months largely centered around the work effort requirements and participation in employment training. After meeting with HHS Secretary Sylvia Mathews Burwell on September 9, 2014, Governor Herbert announced that they had reached a "conceptual agreement" on the plan. Details and a formal waiver submission are still forthcoming.[59] The Governor stated that a special session is his "preferred path to finalize the Healthy Utah plan." [60]

Utah's Primary Care Network Waiver

Utah extended health care benefits to non-custodial and childless adults through a Section 1115 waiver in 2002 – long before the passage of the Affordable Care Act. The waiver allowed the State to slightly reduce state plan Medicaid benefits for certain Medicaid eligible parents to fund a limited benefit package – primary and preventive care - for parents/caretakers and non-custodial or childless adults with family income up to 150 percent of the FPL, previously not eligible for Medicaid. The Primary Care Network (PCN) waiver program also provided working adults and their spouses earning up to 200 percent of the FPL with premium assistance to purchase employer sponsored insurance, or continuation of coverage under COBRA, and covered high-risk pregnant women whose resources exceeded Medicaid eligibility thresholds.

The PCN waiver program was scheduled to sunset in June 2013, but the State requested and received two extensions allowing the program to continue through calendar year 2014 and giving the State time to consider and finalize a plan to expand Medicaid. With the extensions, CMS required certain changes; the State could no longer collect an enrollment fee it had previously imposed; cost-sharing for certain State Plan eligible adults[61] was reduced to comply with Medicaid nominal cost-sharing limits; and on January 1, 2014, individuals earning at or above 100 percent of the FPL would no longer be eligible for Medicaid coverage. In the CMS approval letter for the extension, the State was instructed that for individuals earning income at or above 100 percent of the FPL the State was to provide temporary continued coverage through April 30, 2014 and make every effort to assist this population to obtain coverage through the Marketplace by March 31, 2014.

Utah's Primary Care Network Waiver			
PCN Populations	Benefits	Enrollment Limits	Cost-Sharing
Non-Traditional Medicaid Adults eligible through 1925 and 1931; Medically needy non-ABD	Slightly reduced Medicaid benefits	None	May not exceed Medicaid nominal limits
Parent/Caretaker adults with income up to 100% FPL	Limited benefits of primary and preventive care	16,000	May not exceed Medicaid nominal limits
Non-custodial parents and childless adults with income up to 100% FPL	Limited benefits of primary and preventive care	9,000	May not exceed Medicaid nominal limits
High Risk Pregnant women ineligible for Medicaid	All Medicaid state plan benefits related to pregnancy	None	May not exceed Medicaid nominal limits
Working adults and spouses with family income up to 200% of FPL	Premium assistance for ESI or COBRA	None	Set by qualified health plan/COBRA
Eligible CHIP children with family income up to 200% of FPL	Premium assistance for ESI or COBRA plus dental wrap around	None	Set by qualified health plan/COBRA. Not subject to 5% out of pocket maximum

The waiver allows the State to limit enrollment for some populations as shown in the Table above. Although the limits exist, the transition of higher income individuals to coverage in the Marketplace has freed up waiver slots to cover additional lower income individuals. State officials noted that open enrollment, which typically closes after two weeks, remained open for several months. The State may request an additional PCN extension to accommodate a transitional year allowing the state to get a Medicaid expansion in place in 2015 prior to terminating waiver coverage.

Delivery System Reforms

Utah Transitions to Accountable Care Model of Managed Care

In 2011, Utah passed Medicaid reform legislation directing the administration to implement one or more risk-based delivery models that would, among other goals, "[r]estructure the program's provider payment provisions to reward health care providers for delivering the most appropriate service at the lowest cost."[62] In January 2013, the State transitioned from traditional managed care to its Accountable Care Organization (ACO) delivery system in the four most populous counties, engaging four ACOs to provide services through a risk-based system. The program covers approximately 70 percent of all Medicaid enrollees. ACOs have flexibility to decide how to reimburse providers, and whether to share savings achieved through improved quality. The State's focus is on controlling costs but also on improving quality and has incentives within the ACO contracts to achieve these goals. Historically, the State has used HEDIS and CAHPS metrics to monitor quality, but is actively developing Utah Medicaid specific performance measures for ACOs. The State expects to increase the number of ACOs in four additional counties in FY 2015 in order to provide consumer choice and allow for mandatory enrollment.

Long-Term Services and Supports

While behavioral health and long-term services and support benefits are carved out of managed care, all Medicaid participants, except those residing in long-term care facilities, receive their physical medical care through an ACO in service areas with multiple ACOs; individuals in areas with only one ACO may choose to use an ACO for these services. Utah uses a 1915(b) waiver to provide outpatient behavioral health services through pre-paid mental health plans. The State has several ongoing efforts in place to encourage coordination between behavioral health and physical health service providers. The State also administers seven Home and Community- Based Service waivers (including the state's Medicaid Autism waiver) serving approximately 6,500 individuals. In both 2014 and 2015 the legislature increased funding to expand the number of waiver slots for the State's ID/DD and Physical Disabilities waivers in part to address a waiting list.

Additional policy actions the state either implemented in FY 2014 or planned to implement in FY 2015 are detailed in the table that follows:

Utah Medicaid Policy Changes FY 2014 and FY 2015[63]
Eligibility, Application and Renewal Changes
• Reduced eligibility for the state's existing 1115 waiver (PCN) from 150% to 100% FPL. Enrollment cap remains in place in FY 2014. • Implemented Hospital Presumptive Eligibility with nearly all hospitals participating.
Cost Sharing
• Eliminated a $50 enrollment fee for Primary Care Network (PCN) waiver participants. • Reduced cost-sharing for PCN TANF-related waiver participants (1925 and 1931 adults.)
Provider Rates and Provider Taxes/Assessments
• Increased rates for outpatient hospitals (0.85%), MCOs (2.0%) and 340B pharmacy dispensing fee in FY 2014. • Plan to increase rates for dentists (6.0%), MCOs (2%) and nursing homes (3.64%) for FY 2015. • Plan to discontinue ACA payment rate increases for primary care physician services beyond 12/31/2014. • Plan to increase ICF/ID Provider Tax in FY 2015.
Long-Term Care
• Expanded the number of intellectual/developmental disability (IDD) and physical disability waivers slots to address a waiting list in FY 2014. Plan to do so again in FY 2015.
Delivery System and Payment Reforms
• Revised state quality strategy to incorporate Utah specific measures in FY 2014; incorporated new performance measures in ACO contracts in FY 2014.
Other
• Implemented state plan amendment to allow wider application of 340B policy to pharmacy program in FY 2014. • Enhanced use of COGNOS to improve surveillance to identify high utilizers and drug seeking behavior to enroll these individuals in state's "lock in" program in FY 2014.

Virginia

Economic and Budget Outlook

When Governor Terry McAuliffe took office in January 2014, Virginia's economy had largely recovered from the effects of the Great Recession. Virginia's Gross Domestic Product grew annually throughout the Great Recession,[64] the state's personal income grew for 15 straight quarters through September 2013,[65] and by February 2014, unemployment had fallen to 4.9 percent from a high of 7.4 percent in December 2009.[66] However, state economic growth began to slow in FYs 2013 and 2014, driven in part by federal spending reductions from the federal sequester and by other federal spending reductions related to deficit negotiations at the national level.[67] By November 2013, state revenue forecasters predicted that state economic growth would continue, although at a slower rate than the US economy.[68] In December 2013, the state projected a FY 2014 year-end balance of $478.6 million.[69]

In the last half of FY 2014, however, Virginia's economy had "stalled," largely due to federal budget cuts.[70] By the fiscal year-end, total general fund revenues fell 1.6 percent (falling short of the official forecast by $438.5 million), marking the first time outside of a national recession that revenues had declined in the state.[71] After planned withdrawals from reserves and stabilization funds, an updated revenue forecast released on August 15, 2014 projected a $881.5 million budget shortfall for the current biennium (FYs 2015 and 2016).[72]

Having already passed the state budget for FYs 2015-2016 at the end of June, the Governor and legislative leaders began discussions to address the newly-realized budget gap. In September 2014, Governor McAuliffe and legislative leaders announced an agreement to address the shortfall by reducing spending across nearly all state agencies by as much as 5 percent in FY 2015 and 7 percent in FY 2016; elementary and secondary education are exempted and reductions for higher education will be lower at 3.3 percent. The agreement also includes $272 million in budget savings in FY 2016 that will be achieved through measures that the Governor will address through budget amendments in December.[73] The agreement also allows "flexibility in capturing savings from available unexpected balances" to maintain priority items in health care and economic development.[74]

The Affordable Care Act

The 2010 Affordable Care Act (ACA) was designed to expand coverage to many of the 47 million nonelderly uninsured people nationwide, including 1 million uninsured Virginians. The ACA enhances coverage across the income spectrum by expanding Medicaid eligibility to low-income adults with incomes up to 138 percent of the FPL and by providing premium tax credits to help people with moderate incomes (100-400% FPL) purchase insurance directly through new Health Insurance Marketplaces.[75] While these provisions took effect January 1, 2014, the U.S. Supreme Court's 2012 ruling establishing the constitutionality of the ACA individual mandate to obtain coverage, also held that states could not be forced to expand Medicaid coverage effectively making the ACA Medicaid expansion optional for states. [76] Virginia is one of the 23 states that have not adopted the Medicaid expansion as of September 2014. In Virginia, childless adults regardless of income and parents with incomes above 41 percent of the FPL ($660 for a family of 3) are ineligible for Medicaid.[77] As eligibility for Marketplace subsidies starts at 100 percent of the FPL, the state estimates that approximately 195,000 uninsured Virginians remain without an affordable coverage option.[78]

Marketplace Coverage

The ACA provided states the option of establishing their own Marketplaces or relying on the federally-facilitated Marketplace (FFM), www.healthcare.gov. Virginia was one of 27 states that opted to rely on the FFM,[79] but retained responsibility for managing and reviewing rates for health plans sold on the Marketplace. In 2014, eight insurance providers are offering 106 Qualified Health Plans in Virginia's Marketplace.[80] As of April 19, 2014, over 216,300 Virginians had selected a Marketplace plan (approximately 26% of the estimated 823,000 individuals eligible for Marketplace coverage[81]) over 80 percent of whom qualified for financial assistance.[82] All funding for outreach and enrollment efforts for the Marketplace has come from the federal government and private organizations, including 22 of Virginia's Federally Qualified Health Centers and the Virginia Poverty Law Center and Advanced Patient Advocacy.

The Medicaid Expansion Debate in Virginia

Expanding Medicaid was a central policy debate during the 2013 Governor's race. During the campaign, Republican candidate Ken Cuccinelli said that a vote for him was a vote against the Medicaid expansion while Democratic candidate Terry McAuliffe said that he would not sign a budget unless the Medicaid expansion was included.[83] In January 2014, newly elected Governor McAuliffe proposed amendments to the FY 2014 budget in place and to the previous Administration's budget proposal for FYs 2015 and 2016 that reflected his budget priorities including education, mental health system reform, transportation and job growth, and the Medicaid expansion. One amendment authorized the Governor to act on the Medicaid expansion if the existing Medicaid Innovation and Reform Commission (MIRC) failed to act by the end of the legislative session.[84] Established in 2013, the MIRC was comprised of House Appropriations and Senate Finance committee members as well as the state Secretaries of Finance and Health and Human Resources; it was charged with monitoring the development of Medicaid reform proposals, such as the expansion of managed care and the implementation of the Commonwealth Coordinated Care Initiative, among others. If the MIRC determined that specific Medicaid cost-reduction benchmarks had been met, it could then vote to implement the Medicaid expansion.[85]

In mid-February, the Republican-controlled House proposed a budget that did not include the Medicaid expansion while the Democrat-controlled Senate proposed at budget that included the "Marketplace Virginia" plan, an alternative Medicaid expansion that would utilize premium assistance and require individuals to pay 5 percent of their income in cost-sharing or premiums.[86] Federal funding for the plan would be "recaptured" in the Virginia Taxpayer Recovery Fund, estimated to be $1.7 billion a year.[87] House leaders opposed the plan, citing concerns over the sustainability of the federal government's financial commitment.[88] After the House and Senate failed to reach a compromise in conference, the session ended March 8 without a budget agreement.

At the start of the special session two weeks later, the Governor issued a new budget proposal containing a number of spending reductions, totaling $204 million, and a two-year Medicaid expansion pilot program that would result in $225 million in net savings, primarily from savings in indigent care and other public health programs; the need for state funding of these programs would be reduced due to expanded Medicaid coverage.[89] While the House leadership suggested at the end of the regular session and throughout the special session that the Medicaid expansion be separated from the budget,[90] the Governor and Senate leadership insisted that the budget include the Medicaid expansion, noting its importance for the state's budget and economy.[91] The two bodies remained gridlocked, neither side making moves toward reconciliation. The state faced a government shutdown if a budget was not passed before July 1.

In early June, the political dynamics changed when Democratic State Senator Phil Puckett resigned his seat resulting in Republican control of the Senate. Shortly after, the House and Senate reached a budget agreement that did not include the Medicaid expansion. The budget bill also included an amendment, proposed by Senator Stanley, to prevent the governor from implementing the expansion on his own authority without legislative approval.[92] Governor McAuliffe signed the budget legislation, but used his line-item veto authority to remove the Stanley amendment along with funding for the MIRC and other line-item vetoes stating:

> "We have already lost $852 million as of this morning…. And [the budget] contained reductions in spending that were much deeper than necessary because the General Assembly refused to accept Medicaid funding. Frankly, if it were not June 20th – with only 10 days left in this fiscal year, I may well have vetoed the entire budget. But given the severe difficulties the General Assembly had in getting even this weak budget to me, I seriously doubt that they could have prepared a budget in the next week without disrupting or imperiling critical services or jeopardizing our AAA Bond Rating.[93]" *- Governor McAuliffe, June 20, 2014*

The Speaker of the House later ruled that the line-item veto of the Stanley amendment was outside the Governor's authority as it did not delete the entire line item but only a portion; the line item in question related to the appropriation for the state's entire Medicaid program.[94] After the General Assembly voted and approved 6 of the 8 line-items vetoes, including the line-item veto that eliminated the MIRC completely, the budget became law with the Stanley amendment intact.

Recent Proposals to Help Close the Coverage Gap

After the passage of the FY 2015 budget without the Medicaid expansion, Governor McAuliffe announced his intent to move forward with his goal of "expanding access to health care for Virginia residents."[95] At his direction, on September 8, 2014, Secretary Hazel of the Virginia Department of Health and Human Resources released "A Healthy Virginia" plan which recommends a number of steps to address the coverage gap. In presenting the plan, Secretary Hazel made clear that "[t]his plan is not a comprehensive cure, nor is it a substitute for a full expansion in Medicaid in accordance with the Affordable Care Act," but rather "a bridge to true reform."[96] The key features of the plan include:

- Developing of a Section 1115 waiver proposal that would extend limited benefits focused on behavioral health services to adults with incomes below 100 percent of the FPL with severe mental illness.
- Investing in outreach for coverage options through Medicaid, FAMIS (Virginia's CHIP program), and the Marketplace. Outreach will:
    - Target parents of children currently eligible for Medicaid and FAMIS but not enrolled in coverage, particularly parents for whom English is not their primary language.
    - Leverage an existing federal grant to partner with the Virginia Poverty Law Center, one the state's two navigator organizations, to enhance the existing network of consumer assistance. The state will also develop an outreach campaign about the Federal Marketplace.
    - Include the re-launch of the coverva.org website to provide information on coverage options through the Marketplace, Department of Veterans Affairs, the Virginia Chamber of Commerce's Virginia Benefits Market and CommonHelp (Medicaid, FAMIS, and other public benefits).

- Implementing the ACA Health Home option for adults with severe mental illness and children with serious emotional disturbances starting in July 2015.
- Providing comprehensive dental coverage for pregnant women in Medicaid and FAMIS starting March 2015.
- Allowing children of lower-income state employees to qualify for FAMIS.
- Applying for a State Innovation Model grant that, if approved, will bring in $2.6 million in federal funding along with technical support to help transform the health care delivery system in the state. The focus will be on primary care transformation and delivering integrated care models that integrate behavioral health and oral health with primary care.
- Hosting a summit with leaders from the Veterans Health Administration in Virginia and hospital and health system leaders to explore ways to improve timely access to quality care for veterans.[97]
- Creating a Task Force to combat prescription drug and heroin abuse, using a number of strategies such as leveraging the state's prescription monitoring program to identify emerging trends among others.

In response to the Governor's plan, House Speaker William Howell stated, "I am reviewing Governor McAuliffe's proposed changes to Virginia's Medicaid system. The proposal will require General Assembly approval to be made permanent and will, of course, be given due consideration during the 2015 General Assembly session."[98] The General Assembly returned to special session September 18 and quickly recessed.[99]

Managed Care

While the Medicaid expansion debate has garnered much public attention, the state has been heavily focused on delivery system reform and improved care coordination for Medicaid beneficiaries. Recent efforts have focused on continued expansion of managed care and implementation of the Commonwealth Coordinated Care Initiative for those dually eligible for Medicare and Medicaid.

Managed Care Expansion

Virginia has a long history with Medicaid managed care, both capitated and primary care case management (PCCM) models. In July 2012, the state phased out its PCCM as it completed the statewide rollout of its capitated managed care program, now called "Medallion 3.0." Over two-thirds of Medicaid beneficiaries in Virginia are now enrolled with managed care organizations (MCOs) including children, parents, pregnant women, those with disabilities, elderly enrollees, children with special health needs and some HCBS waiver enrollees for acute care services. Foster care and adoptive assistance children were added to MCOs in SFY 2014. In December 2014, the state plans to enroll other eligible Elderly and Disabled Consumer Direction HCBS waiver enrollees into managed care (for acute care services only).

In SFY 2014, the state implemented a Behavioral Health Services Administrator (BHSA) to manage the behavioral health services for the fee-for-service (FFS) population as well as certain components of behavioral health for those in managed care. MCOs are required to coordinate with the BHSA. Opioid drugs obtained through a pharmacy are the responsibility of the MCO, but all other substance abuse related treatment services are handled by the BHSA. Traditional behavioral health services, including inpatient and outpatient services, are generally covered through the MCO while non-traditional services are handled by the BHSA. Magellan, which was awarded the BHSA contract, provides enhanced care coordination for eligible members.

Six[100] different MCOs – Anthem, Coventry, INTotal (Inova), Kaiser Permanente, Optima (Sentara), and Virginia Premier (VCUHS) currently operate in the state. Five of these plans are NCQA accredited as required under the state's managed care contracts; the sixth (Kaiser Permanente) was currently under review for accreditation at the time of this report.[101] Virginia continues to enhance the quality requirements and service coordination under managed care contracts through the Quality Improvement program activities, Quality Collaborative and three new initiatives:

- **Value Based Purchasing through Pay-for-Performance Initiative**: The state has begun to implement a pay-for-performance program with incentive awards for their MCOs based on HEDIS measures which are designed to increase members' use of preventive services and increase administrative efficiency. Performance incentive scores, based on HEDIS 2015, will be finalized by March 2016.
- **Medallion Care System Partnership:** In FY 2014, the state modified existing managed care contract requirements to require the plans to develop two provider partnership projects that allow the MCOs to expand and test different methodologies of provider payment and incentives and support and develop patient centered medial homes (PCMHs).
- **Expedited Enrollment:** In August 2014, the state went live with an expedited enrollment process to get MCO-eligible beneficiaries into MCOs more quickly with a special focus on pregnant women to improve birth outcomes as well as reducing churn.[102]

Commonwealth Coordinated Care Initiative

Virginia began implementation of its Commonwealth Coordinated Care initiative in March 2014; the initiative is one of the ACA-authorized Financial Alignment Demonstrations designed to better coordinate care across Medicare and Medicaid services for those dually eligible for both programs. Commonwealth Coordinated Care will use a capitated managed care model to provide all services (Medicare and Medicaid) through one Medicare-Medicaid Plan, or MMP. The state is rolling out the initiative regionally; each region began with passive enrollment for a period followed by auto-enrollment into managed care plans if one has not been selected. As of August 1, 2014, the state had enrolled 11,176 individuals into the program across the five regions; approximately 13,000 more individuals were auto-enrolled into an MMMP in September. Phased implementation is set to be completed in November 2014.[103] An estimated 75,000 beneficiaries are eligible to participate in the program.[104]

Virginia Medicaid Policy Changes in SFY 2014 and 2015[105]
Eligibility, Application and Renewal Policies[106]
• Income eligibility for the Family Planning waiver was reduced down to 100% FPL effective January 1, 2014. The state plans to restore the income limit for family planning waiver to 200% FPL in SFY 2015.
• Plan to implement 1115 waiver with limited benefits to extend coverage to adults with incomes below 100% FPL with severe mental illness.
Provider Rates and Provider Fees/Taxes
• Increased payment rates for inpatient and outpatient hospitals, MCOs and nursing homes in SFY 2014. Other rates were held flat.
• Plan to increase payment rates for outpatient hospitals, MCOs and nursing homes while holding other rates flat in SFY 2015.
Benefits and Pharmacy
• Added nutritional counseling, inpatient substance abuse services in Medicaid Works program (Jan 2014).
• Modified the allowable dental deductions for dental expenses in long-term care settings (restriction).
• Plan to add mental health drugs to the state's Preferred Drug List in SFY 2015.
• Plan to expand comprehensive dental benefits to pregnant women (both in Medicaid and FAMIS).
Managed Care and Care Coordination
• Implemented the Commonwealth Coordinated Care Initiative, Virginia's Financial Alignment Demonstration to coordinate care for those dually eligible for Medicare and Medicaid in SFY 2014.
• Enrolled foster care and adoption assistance children into MCOs in SFY 2014. Plan to enroll some qualifying Elderly and Disabled Consumer Direction waiver members into MCOs (for acute care only) in Dec 2014.
• Implemented a Behavioral Health Services Administrator to manage the behavioral health services for the FFS population as well as certain components of behavioral health for those in managed care in SFY 2014.
• Starting process to adopt performance incentive awards for MCOs.
• Modified managed care contract requirements on provider partnerships and incentives to allow MCOs to expand and test different methodologies of payment and incentives and support PCMHs.
• Enhanced program contact language to support program integrity efforts and collaboration; created new technical manual and reporting requirements to enhance compliance efforts.
• Created new expedited MCO enrollment process to improve health outcomes, reduce churn and improve provider relations.
• Developed a capitation adjustment process to handle specialty drugs and reinsurance product for the MCOs.
• Plan to implement Health Homes for adults with severe mental illness and children with serious emotional disturbances.
Long Term Care
• Expanded the number of people served in the community by expanding those served in HCBS waivers, PACE programs, and closing/down-sizing state institutions (transitioning residents to the community) in both SFYs.

West Virginia

Economic and Budget Outlook

Economy

After decreasing by 1.4 percent in 2012, the West Virginia economy grew by 5.1 percent in 2013, the third highest rate in the nation behind only North Dakota and Wyoming.[107] Growth in the state's real Gross Domestic Product (GDP) was almost entirely driven by the mining sector, comprised primarily by the coal and natural gas industries. Without this growth, the state's economy would have contracted as growth in other sectors was relatively flat or decreased including notable decreases in the government employment and construction sectors (-.15 and -.34 percentage points, respectively). As a result, the mining sector grew to 17.8 percent of GDP (compared to only 6.5 percent in 2002), reflecting the boom in shale gas extraction even as coal production has declined over the last several years.[108] Positive GDP growth did not translate into employment gains, however, as resident based employment fell by 3,500.[109] The size of the West Virginia workforce also shrank, but by a larger amount – 10,400 – resulting in a net decrease in the state's unemployment rate from 7.2 percent in 2012 to 6.5 percent in 2013, the lowest unemployment rate since 2008. In 2013, government made up the largest share of nonfarm payroll employment accounting for one in five jobs in the state.[110]

State Revenues

With the exception of a one-year state revenue rebound of 8.1 percent in FY 2011, West Virginia state revenue growth has remained low since the onset of the Great Recession with an average annual growth rate of only 0.7% between FY 2008 and FY 2013.[111] Also for the first time in modern history, the state experienced two consecutive years of negative growth in state revenues for FY 2013 and FY 2014.[112] In addition to the impact of the economic downturn, revenue collections have been negatively affected by a temporary motor vehicle tax credit program, the phasing out of a sales tax on groceries for home consumption between January 2012 and July 2013 and the phasing in of a coal severance tax revenue sharing program benefiting local county governments between FY 2013 and FY 2017. Looking ahead, state revenue collections are expected to increase by roughly 3.4 percent per year between FY 2013 and FY 2019.[113]

Budget for FY 2014 and FY 2015

At the start of CY 2014, Governor Earl Ray Tomblin faced both a current year budget shortfall for FY 2014 of $81.5 million and a projected budget gap for FY 2015 of $216 million. To close the FY 2014 shortfall, the Governor implemented a hiring freeze in December 2013 and in January 2014 called on state agencies to make mid-year budget cuts totaling $33 million.[114] In January, he offered an Executive Budget proposal for FY 2015 that closed the projected budget gap which was driven largely by projected Medicaid expenditure increases.[115]

The Governor's FY 2015 budget proposal cut agency spending by $70 million, made $14.5 million in one-time reductions, used $50.4 million from FY 2014 supplemental appropriations and Medicaid surplus, and relied on $83.8 million from the state's Rainy Day Fund.[116] Despite dipping into the Rainy Day Fund, the Governor's budget was designed to ensure the fund's balance would remain above the 15 percent threshold recommended by Wall Street rating agencies thereby assuring the state would retain its favorable bond ratings.[117] His FY 2015 budget also included funding for a 2 percent pay raise for teachers and school service personnel, a $504 million across the board pay raise for state employees, and an $87 million increase for Medicaid.

On March 14, 2014, the West Virginia legislature passed a FY 2015 state budget with higher spending levels that the Governor determined would increase the budget gap in future years. To avoid further depleting the state's Rainy Day Fund, Governor Tomblin exercised his line-item veto authority to approve the FY 2015 budget after cutting nearly $67 million. Most of the cuts ($47.5 million) were to a transfer appropriation from the Rainy Day Fund to the Medical Services Trust Fund to help fund a portion of the Medicaid budget. The Governor planned to restore the Medicaid funding in part from revenues generated by separate legislation passed during a one-day legislative special session (the so-called "haircut bill") designed to funnel lottery revenues into the state's reserve fund.[118]

The second largest reduction was to the much debated appropriation for Medicaid in-home care for seniors. The House of Delegate's original budget included a $12 million increase intended to cover the nearly 2,300 person waiting list. The budget as passed cut that funding in half.[119] The Governor cut an additional $3.5 million; the remaining funding would allow the state to cover 335 additional waiver slots compared to the year before but substantially lower than the 2,300 proposed by the House of Delegates.[120] Other cuts included reductions to local economic development assistance, family resource networks, legal services for domestic violence victims, cars and equipment for the State Police, in-home family education, child advocacy centers, libraries and senior centers.

2014 ACA Coverage Expansions

The 2010 Affordable Care Act (ACA) is designed to extend coverage to many of the 47 million nonelderly uninsured people nationwide, including the 267,000 uninsured West Virginians. The ACA enhances coverage across the income spectrum by expanding Medicaid eligibility for low-income adults and by providing premium tax credits to help people with moderate incomes (100-400% FPL) to purchase insurance directly through new Health Insurance Marketplaces.[121] These provisions became effective during SFY 2014 with significant implications for state budgets and Medicaid programs across the country, including West Virginia.

Marketplace Coverage

The ACA provided states the option of establishing their own Marketplaces or relying on the federally-facilitated Marketplace (FFM), www.healthcare.gov. West Virginia was one of seven states that chose a "State Partnership Marketplace" model allowing the state to rely on the FFM but retain control over plan management and some consumer assistance activities.[122] For 2014, one health insurance company (Highmark Blue Cross Blue Shield) offers 13 Qualified Health Plans in the individual Marketplace.[123] The state received over $20.8 million in federal funding – including an Exchange Planning and two Level One Establishment grants – to develop its In-Person Assisters (IPAs) program and plan management activities.[124] CMS also awarded and funded Navigator grants to three West Virginia organizations and 27 health centers were awarded outreach and enrollment assistance grants from HRSA to assist eligible consumers to enroll in coverage.[125] As of April 19, 2014, over 19,800 West Virginians had selected a Marketplace plan (approximately 17% of the estimated 117,000 individuals eligible for Marketplace coverage[126]), 86 percent of whom qualified for financial assistance.[127]

Medicaid Expansion

On May 7, 2013, Governor Tomblin approved the ACA Medicaid expansion for West Virginia increasing the income standard in 2014 for previously eligible low-income adults from 16 percent and 31 percent of the FPL[128] for jobless parents of dependent children and working parents of dependent children, respectively, to 138 percent and extending coverage to non-disabled childless adults for the first time. While the state's actuaries had predicted new enrollments in the first year of about 63,000, actual enrollment through the end of June 2014 increased by over 130,000 – more than twice the projected first year increase.[129] According to CMS, West Virginia had the fourth highest enrollment increase among all expansion states through June – a 45 percent increase compared to enrollment prior to the beginning of Marketplace open enrollment in October 2013.[130]

West Virginia was one of only a handful of states taking advantage of an optional enrollment strategy offered by CMS that allows states to use income information from the Supplemental Nutritional Assistance Program (SNAP) to conduct "administrative transfers." Using this strategy, West Virginia identified 118,000 people who were eligible for SNAP as well parents of children receiving Medicaid and sent them letters indicating that they would automatically be enrolled in the Medicaid expansion if they signed and returned the letter. State staff also made follow-up phone calls. After receiving a positive response, the state sent out a second round of letters and made more phone calls. An estimated 71,000 individuals responded to the letters and calls.[131]

Delivery System Reforms

Managed Care

West Virginia has operated a risk-based Medicaid managed care program – Mountain Health Trust – since September 1996. Under this program, the state currently contracts with four managed care organizations ("MCOs" – Coventry Health Care of West Virginia, The Health Plan of the Upper Ohio, Unicare, and West Virginia Family Health) to provide medically necessary Medicaid services to low-income families, children and pregnant women in a 55 county area; behavioral health, long term care, and non-emergency medical transportation services are "carved out" of the MCO contracts.[132] Children's dental services were added to the state's MCO contracts in FY 2014, and the state plans to add behavioral health services in 2015. Also, the state plans to enroll the ACA Medicaid expansion population into MCOs in FY 2015 or early FY 2016.[133] As of September 2014, there were approximately 200,000 members enrolled in Mountain Health Trust.[134] West Virginia also operates a small primary care case management program (Physician Assured Access System" (PAAS) program.)[135] As of July 1, 2014, the state estimates that approximately 41 percent of its members were enrolled in MCOs, 1 percent were enrolled in the PAAS program and 58 percent remained in fee-for-service.[136]

Health Homes

On July 1, 2014, the West Virginia Department of Health and Human Resources, Bureau for Medical Services launched a Health Homes initiative (authorized under ACA Section 2703) focused on members in a six county region who suffer from bipolar disorder and who may have Hepatitis B or C.[137] The Health Home consists of a multi-disciplinary team that helps members manage medical conditions and medications, remember doctor appointments and understand medical tests and results. Teams will also work with doctors, counselors and specialists to support recovery and prevent other complications. As of July 2014, eight providers are approved to serve as Health Homes: Cabin Creek Health Systems, FMRS Health Systems, Marshall Health, Prestera Center for Mental Health, Process Strategies, Southern Highlands, WV Health Right, and WomenCare, Inc.[138]

West Virginia Medicaid Policy Changes FY 2014 and FY 2015[139]
Provider Rates and Provider Taxes/ Assessments
• Increased inpatient hospital rates, MCO rates and nursing facility rates; all other rates were held flat in FY 2014. • Plan to increase rates for inpatient hospitals, MCOs and nursing facilities; plan to hold all other rates flat in FY 2015. • Plan to increase the hospital provider tax in FY 2015.
Eligibility, Application and Renewal Changes
• Implemented Medicaid expansion, increasing eligibility for adults up to 138% FPL in FY 2014. • Adopted options to enroll people based on SNAP eligibility and parents based on children's income eligibility in 2014.
Benefit Changes
• Eliminated the Mountain Health Choices Basic and Enhanced benchmark benefit plans resulting in the elimination of coverage for weight management services for children and TANF-related adults. (December 31, 2013)
Copayment Changes
• In FY 2014, imposed new copayment requirements on all non-exempt MAGI based eligibility groups including: ○ 0-50%FPL: $0.50 - $3 for prescription drugs (tiered by drug price); and $8 for non-emergency use of the ER ○ 50-100% FPL: $0.50 - $3 for prescription drugs (tiered by drug price); $8 for non-emergency use of the ER, $2 on outpatient services and $35 for inpatient hospital ○ Over 100% FPL: $0.50 - $3 for prescription drugs (tiered by drug price); $8 for non-emergency use of the ER, $4 on outpatient services and $75 for inpatient hospital.
Pharmacy Changes
• Began receiving rebates for diabetic testing supplies in FY 2014. • Eliminated the Mountain Health Choices Basic and Enhanced benchmark benefit plans resulting in the elimination of the limit on monthly prescriptions in FY 2014. • Plan to add oncology, HIV drugs to manage them more effectively and obtain supplemental rebates in FY 2015.
Managed Care and Delivery System and Payment Reforms
• Dental benefits for children added to managed care benefit package in FY 2014. • Plan to enroll the ACA Medicaid expansion population into risk-based managed care plans in FY 2015. • Plan to add behavioral health services to the managed care benefit package in FY 2015. • Included withhold provisions related to quality standards in the FY 2015 MCO contracts. • Implemented Health Homes (under ACA Section 2703) effective July 1, 2014.
Long Term Services and Supports Rebalancing
• Expanded the number of persons served in home and community-based settings by adding slots to the Aged and Disabled waiver in FY 2014. • Expanded the number of persons served in home and community-based settings by adding slots to the Aged and Disabled, the Individuals with Developmental Disabilities and the Traumatic Brain Injury Waivers in FY 2015.
Program Integrity
• On October 1, 2013, began full implementation of a new case management tool, I-Sight that will assist with reporting and fraud referrals as well as tracking recoveries and actions on ongoing and historical audits. • Began structured collaboration with the state's MCOs by hosting quarterly meetings with the MCOs, Medicaid Fraud Control Unit and the Office of Program Integrity in FY 2014. • Full implementation of the Data Warehouse/Decision Support System by late summer 2014, will provide the state with detailed data of the full range of managed care services which historically had not been easily accessible as well as enhancing the existing data mining tool, JSURS for fee-for-service audits. • Plan to hold an annual meeting with the Office of Program Integrity to identify common provider issues and new fraud/abuse schemes.

This brief was prepared by Laura Snyder from the Kaiser Family Foundation, and Kathleen Gifford, Eileen Ellis and Jenna Walls of Health Management Associates (HMA.)

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[15] Per an October 2014 interview with officials of the Medical Services Administration, the Healthy Behaviors Protocol includes a goal that the appointment is completed within 150 days of enrollment.

[16] MCO enrollment is optional for Native Americans and others that meet the state's Medicaid health plan exemption criteria.

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