COMMONWEALTH of VIRGINIA

Office of the Governor

Robert F. McDonnell
Governor

February 20, 2013

The Honorable Walter A. Stosch
General Assembly Building
Room 626
Richmond, VA 23219

The Honorable Lacey E. Putney
General Assembly Building
Room 947
Richmond, VA 23219

Dear Chairmen Stosch and Putney:

I write to address an issue of importance to both the physical and fiscal health of the citizens of our great Commonwealth. As you are aware, as a result of the Affordable Care Act and the subsequent decision of the U.S. Supreme Court handed down last summer, states are now left with a decision of whether to expand healthcare coverage under Medicaid as of January 1, 2014, to certain individuals who are currently not covered. In an effort to incentivize such expansion, the federal government will provide an initial match of 100% of the cost of such expansion that will, over time, reduce to 90% of the state's costs.

We have a Medicaid plan in Virginia which currently consumes nearly 21% of the Commonwealth's general fund budget. This is up from just 5% of the general fund 30 years ago. Put another way, Medicaid spending has grown 1600% over that time. This growth rate even prior to the implementation of the ACA, is unsustainable. Even with the incentives currently being offered by the federal government, the costs and the share of the state general fund consumed by Medicaid will continue to grow significantly over time. Thus, the time is now to dramatically reform the way we deliver medical services in Virginia to mitigate against and possibly reduce such future spending growth while encouraging a healthier citizenry. As part of our Medicaid overhaul, we must act now to obtain approval for the necessary reforms and flexibility from the U.S. Secretary of Health and Human Services. Unless we maximize the concessions from the federal government in obtaining those reforms prior to considering any specific expansion, our cost savings opportunity will be lost. We have one chance to do this right.

President Obama, as a candidate for President, likewise acknowledged that expansion without first reforming the Medicaid system was a mistake. He said "[a]s we move forward on health reform, it is not sufficient for us to simply add more people to Medicare or Medicaid to increase coverage in the absence of cost controls and reform...another way of putting it is we can't simply put more people into a broken system that doesn't work." I wholeheartedly agree with that assessment. I ask that you not do anything in the budget to diminish my administration's ability to obtain those reforms. Despite little cooperation and few answers to questions from the federal government for many months until the end of last year, Secretary Bill Hazel has several reforms underway. He has also been aggressively pursuing a first phase of

reform by applying for the section 1115 wavier from HHS, in an effort to maximize state flexibility and reform even with our current program.

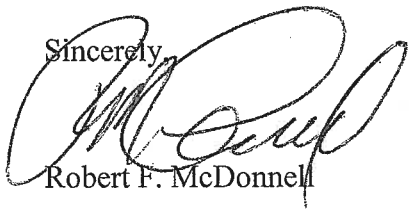
I am most concerned that some may not fully understand the scope and magnitude of reform I believe is necessary to create the kind of cost-effective Medicaid plan that we can build upon. In my view, reform is far more than simply receiving a waiver from the federal government. It also requires completing state based reforms, amending the ACA to provide more flexibility and waiver authority, creating state and federal assurances that the current or expanded program will not break the state budget or add to the federal debt, and facilitating reforms in the private sector health delivery system to reduce costs.

Attached you will find a list of the reforms that we have already implemented, and a blueprint for 5 categories of reforms that we believe are necessary in order to make a meaningful difference in how we deliver these essential services. Please understand that I cannot and will not support consideration of an expansion of Medicaid in Virginia until major reforms are authorized and completed, and until we receive guarantees that the federal government's promises to the states can be kept without increasing the immoral national debt. To do so, would be irresponsible and place crushing financial burdens on future governors and legislatures. The country is broke, and I will not support policies that make it worse.

We have a real opportunity to shape the future of health delivery in the Commonwealth for all Virginians, including those who are unable to pay for their healthcare needs. I hope you will review the reforms that I have outlined. Doing anything that suggests that expansion can occur prior to substantial, long lasting, cost saving reforms will damage our efforts to reform the system.

Thank you for your services.

Sincerely,



Robert F. McDonnell

RFM/pdw
Attachment
cc: The Honorable Charles J. Colgan, Sr.
The Honorable Janet D. Howell
The Honorable Emmett W. Hanger, Jr.
The Honorable John C. Watkins
The Honorable Thomas K. Norment, Jr.
The Honorable M. Kirkland Cox
The Honorable S. Chris Jones
The Honorable Johnny S. Joannou
The Honorable R. Steven Landes
The Honorable Beverly J. Sherwood

1. Problems with the current Medicaid system	
Federal Government	**Virginia**
Lack of Flexibility: Virginia contributes 50% of the funding for the Medicaid program; however, it has far less than 50% influence over program policy. The Commonwealth seeks greater flexibility and autonomy to operate the Virginia Medicaid program.	**Low Provider Reimbursement Rates:** The Commonwealth's provider reimbursement rates are low compared to Medicare and commercial rates. Virginia needs flexibility to implement a value-based purchasing model in order to recruit, retain and more competitively reimburse high-quality providers.
Burdensome Approval Process: Current federal rules and authorities limit DMAS' ability to implement a comprehensive market-based reform strategy. The current approval avenues for 1915(b) and (c) waivers and State Plan authority at CMS are complex, fragmented, time consuming, and administratively burdensome.	**Lean Operations:** Administration of the Virginia Medicaid program is lean. The Commonwealth needs a solid federal commitment and agreed upon path at the commencement of its reform efforts to optimally allocate staff and resources.
Lack of Confidence in the States: The drawn out federal approval processes and limited flexibility indicate that the federal government has little confidence to permit the states to administer a Medicaid program that builds upon state-specific resources and best meets the needs of its beneficiaries. Negotiations must reflect confidence in the states' ability to deliver quality care for beneficiaries.	

2. Medicaid Reforms Achieved (and underway) during the McDonnell Administration (2010-2013)

- Expanded Managed Care statewide
  - Completed in July 2012 and available for children, pregnant women, and Aged, Blind and Disabled eligibility groups
- Continued expansion of the Program for All-Inclusive Care for the Elderly (PACE)
- Transitioned foster care children into a managed care delivery model
- Refined home and community based waiver service utilization standards
- Enhanced program integrity and fraud prevention efforts
- Improved assessment requirements for community behavioral health services
- Developing a Medicare-Medicaid Enroll Financial Alignment Demonstration (target launch date January 2014)
  - Finalizing Memorandum of Understanding with CMS;
  - Request for Applications to select health plans is at the OAG for review; and
  - Capitation rates and three-way contract between participating health plans, CMS, and DMAS executed in summer 2013.
- Developing a modern eligibility and enrollment system for Medicaid and other services.

3. Five Tenants of Successful Medicaid Reform to Ensure Maximum Cost Containment and Quality in the Future:

1) Seek and obtain maximum state flexibility under a comprehensive §1115 waiver from the federal government.

    a. Streamline and consolidate state administrative authority for the Medicaid program.

    b. Initial focus on primary, acute, and behavioral health services- serving as a gateway to reform Virginia's six current 1915(c) home and community based waiver services and structure.

2) Optimize existing authority for ongoing reforms at state level.

    a. Part of the §1115 waiver authority negotiation will include static expectations and parameters for expedited development and implementation of innovative Medicaid pilots.

    b. These parameters will facilitate expedited implementation of pilot reforms to enable the Commonwealth to leverage innovative regional variations in delivery systems and test payment reform opportunities.

    c. Enhance Medicaid fraud control policies and resources in order to preserve the integrity of services delivered in the Medicaid program.

    d. Implement cost savings strategies to the maximum extent permitted by law.

3) Identify areas that would require federal regulatory or congressional action to amend the PPACA to give CMS the ability to waive further requirements, generate more creativity and flexibility for the states.

a. According to Centers for Medicaid and CHIP Services (CMCS), the federal government has very limited flexibility under the current ACA statute to waive statutory cost sharing requirements for the expansion population, or for the existing lowest income Medicaid population. Federal cost sharing rules permit significantly higher cost sharing for adults with incomes above 100 percent of the federal poverty line than for those with lower incomes. However, Virginia's current Medicaid eligibility rules are set at a rate in which cost sharing would have the most significant impact within an expansion population.

b. New opportunities to use cost sharing have been proposed by CMS in order to reduce unnecessary emergency room care and to promote the use of preferred drugs. This proposal by CMS requires new administrative operational, and technical processes that will likely cost more and outweigh the benefit of the minimal costs sharing that is allowed.

c. Within the federal statute, however, states have flexibility to vary cost sharing across groups and for services included in appropriate pilot projects that test payment and delivery reforms.

d. Until congressional action is taken, Virginia may pursue cost sharing through pilot projects, for either population. These pilots would meet limits as mandated by federal statute and regulation, but may be varied within appropriate pilot projects that test payment and delivery reforms.

4) Generate state metrics and programs, and seek appropriate federal assurances that any Medicaid expansion will not contribute to growth in future increases in the out-of-control national debt, or significant state Medicaid spending.

   a. Move forward with developing a managed, coordinated delivery system for all long-term care populations and services.

   b. Expedite the tightening of standards, provider qualifications including licensure, and service limits for community behavioral health services.

   c. Implement a commercial-like benefit package for the expansion population, if Virginia moves forward with an expansion. This would include limits on services such as home care, occupational, physical and speech therapy.

   d. Obtain flexibility to implement promising pilot programs to identify and evaluate payment and delivery system reforms.

   e. Strengthen the data analytical capacity of the Department of Medical Assistance Services to identify cost drivers and trends on a "real-time" basis.

   f. Reinvest savings rendered from innovative pilots and commercial based plan structure back into healthcare delivery innovations and services to begin bending the cost curve.

   g. Continue to enhance program integrity efforts and restructure the existing model to avoid the "pay and chase" paradigm

   h. Capture any early annual savings in a special account to offset future cost impacts on the state.

i. Put in place appropriate metrics to ensure that the net result of all cost saving reforms and strategies will approximately offset the certain out year state budget Medicaid cost increases.

j. Receive appropriate guarantees that the federal government will ensure that the 100% federal match for 3 years and the 90% match thereafter will remain in place.

k. Receive appropriate guarantees from the federal government that Virginia's and other states' expansion will not contribute to an ongoing increase in the national debt.

5) Coordination of long-term stakeholder commitment to implement cost containment strategies and reforms to help reduce actual costs of medical services, and thus Medicaid bills to the states.

a. Actual medical costs will only be significantly reduced if stakeholders are engaged, invested and willing to help lead reform efforts.

b. Stakeholders will be asked to participate in reform meetings and will be expected to help design the realignment of how health care is delivered and paid for throughout the Commonwealth. This process will:

- Bring stakeholders together to identify current challenges that attribute to waste and cost increases or over utilization in the current delivery system.
- Upon identification, require stakeholders to implement agreed upon solutions that will shift the current delivery paradigm.