



COMMONWEALTH of VIRGINIA  
*Department of Medical Assistance Services*

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DIRECTOR

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The Honorable Terence R. McAuliffe  
Governor  
Commonwealth of Virginia  
Post Office Box 1475  
Richmond, Virginia 23218

Dear Governor McAuliffe:

As Chair and Vice Chair of the Board of Medical Assistance Services, we are writing to communicate our concerns and those of our fellow Board members and declare our strong opposition to the American Health Care Act (AHCA) of 2017, as passed by the U.S. House of Representatives on May 4, 2017. This federal legislation, or anything similar that may be passed by the U.S. Senate, will inflict a serious cost burden to the Commonwealth, will expose Virginia taxpayers to an increased tax burden, will significantly harm Virginia's Medicaid program, will derail important medical innovation, and will hobble Virginia's ability to care for our citizens most in need.

Most of this potential damage stems from the proposed shift to a per capita block grant, though it is certainly not the only factor. This shift would occur in 2020, but use 2016 as a baseline. What follows are only highlights of some of the AHCA's provisions that would damage our Commonwealth. Although our remarks are focused on the Medicaid program, we also anticipate other adverse impacts on Virginia's commercial health benefits market.

Virginia's Per Capita Spending on Medicaid is Already Very Conservative.

Virginia's legislators elected to not expand Medicaid under the Affordable Care Act, and Virginia continues to have the lowest permissible level of federal matching for Medicaid at 50%. As a result, 75% of other states receive a higher Medicaid match than does Virginia. This alone both puts us at an economic disadvantage. Furthermore, Virginia, unlike 43 other states, imposes no assessment tax on nursing facilities; and unlike 39 other states, imposes no assessment tax on hospitals.

Using 2016 as an Initial Baseline is Flawed.

Any federal funding of new investments made after 2016 would be excluded. Most prominently, Virginia's baseline would exclude the new Addiction Recovery and Treatment Services (ARTS) program designed to address Virginia's opioid epidemic, a public health emergency declared by our Health Commissioner, Marissa Levine, MD, MPH. As another example, the per capita cap baseline would exclude Virginia's \$46 million developmental disability system investment that also begins this year.

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Using the Consumer Price Index –Medical (CPI-M) is Flawed.

CPI-M is a metric that is ill-suited for indexing Medicaid costs because Medicaid pays for services not typically purchased by households, and does not represent costs for a Medicaid-like population. For example, the Kaiser Family Foundation calculated that if CPI-M had been used to limit federal Medicaid spending from 2001 to 2011, Virginia would have received 11% less funding than it did, despite our financial conservatism and low federal match.

Virginia Would Be Exposed to Potentially Devastating Retroactive Federal Funding Changes.

CPI-M, which measures costs for a population mix different than Medicaid's, and does not include all medical costs, is also extremely sensitive to changes. For example, if the CPI-M were to drop by a mere ½ percent, from 3.7% to 3.2%, Virginia's seven-year projected funding gap would grow from over \$700 million to \$2.1 *billion*. This is not a theoretical problem. The U.S. Dept. of Labor reports the CPI-M for 2016 was 3.8 (not 3.7), but also reports the annual CPI-M for 2010 to 2016 as 3.4, 3.0, 3.7, 2.5, 2.4, 2.6, and 3.8 respectively; averaging 3.1.

Costs for the Aged, Blind and Disabled (ABD) Population Substantially Exceeds Proposed Per-Capita Caps.

CPI-M measures costs on an urban-only population, and it does not properly reflect the distribution of costs for the ABD population covered by Medicaid. For example, the projected per capita cap for Virginia's disabled group is estimated to be \$29,344 in 2020, but the average cost of individuals enrolled in the Community Living Waiver, which serves individuals with developmental disabilities and has a waiting list of nearly 12,000 individuals, is over \$80,000 per year, meaning the federal matching rate for this service would only be 17%, not 50%. Based on Virginia's ABD population, per-capita caps would result in a first-year loss of \$22 million, growing annually to total over \$700 million or more over seven years. This does not even fully account for the reality that as Boomers age, we are quickly adding to this population. The Senate bill, which was released today, exacerbates this funding loss problem.

The AHCA Imposes New and Costly Reporting Requirements that Virginia Must Comply With or Face Substantial Penalties.

The AHCA requires states to report "adjusted medical assistance expenditures" separately for the "1903A enrollee groups" beginning in FY 2019, or face a 1% penalty, which is equivalent to a 27% funding reduction. This metric is not even reported by states at this time, and will add another costly administrative burden to the program, on top of other administrative changes.

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All Virginian Taxpayers Would Be Affected.

Because Medicaid is an entitlement program, Virginia lawmakers will need to undertake some (of all) of the following measures: raise taxes to make up some portion of the funding shortfall; eliminate or cut medical, behavioral health services, addiction treatment services, and/or long-term support services; reduce eligibility below already low levels; cut provider payment rates (currently at about 75% of Medicare rates); cut payments to health plans; and/or incur substantial fiscal deficits. All of these options have negative consequences for all Virginians. There is no current proposal to simply roll the clock back to 2009.

The AHCA would Affect Real People in Real Ways.

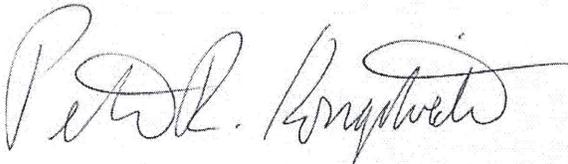
We have attempted to provide some high level examples of the financial damage that the AHCA would inflict on Virginia, but cannot lose sight of the reality of what that means. It is not just the impact on Virginia's fiscal health, it is also the impact on the health of individual Virginians. That, in the end, is the purpose of Medicaid and of all the other health measures we take as citizens. One of our Board members provides a striking example. She would have to choose between no nursing care for her daughter who receives 12-16 hours per day via Medicaid (their primary insurance nursing benefit is only \$500 per year) or pay more than \$86,000 per year out of pocket for nursing care, in addition to having to pay for items such as durable medical equipment and medical enteral formula that would no longer be covered by Medicaid. There are thousands of such examples within our Commonwealth.

Finally, we wish to emphasize one more issue: providing help to our fellow Virginians in need, who cannot help themselves, is a moral imperative, a moral test that we cannot and should not fail. We, as the Board of Medical Assistance Services, strenuously and unanimously urge you to oppose the AHCA or any similar bill that inflicts such undeniable damage to our Commonwealth and her citizens.

Sincerely,



Karen S. Rheuban, M.D., FAAP, FACC  
Chair, Board of Medical Assistance Services



Peter R. Kongstvedt, MD, FACP  
Vice Chair, Board of Medical Assistance Services

Pc: Members of the Virginia Congressional Delegation  
Members of the Virginia General Assembly  
The Honorable William A. Hazel, Secretary of Health and Human Resources