



State of West Virginia
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Hon. Kathleen Sebelius, Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius:

Thank you for your correspondence dated July 10, 2012. My administration is evaluating options available to the State of West Virginia under the Patient Protection and Affordable Care Act ("PPACA"), in light of the recent decision by the Supreme Court of the United States. The decisions we must make will have significant consequences for the State, both as it relates to fiscal and health policy. Before West Virginia can make the crucial decisions required by PPACA, we need answers to questions related to Medicaid expansion and exchange matters. I hope that you can be of assistance as we undertake our analysis and proceed through our decision-making process.

We are not undertaking this analysis lightly and we are attempting to balance several key factors in determining how to proceed. I am committed to maintaining the sound fiscal stewardship that has been the hallmark of our State for the past 25 years. We take our balanced budget responsibility seriously, and health care funding competes with other significant State priorities including education, public safety, infrastructure, economic development, and environmental protection, among others. We must continue our disciplined State budgeting approach by providing stability and predictability to our citizens and use a thoughtful long-term approach designed to identify, model, and address foreseeable challenges.

Moreover, my administration has undertaken a very cautious approach toward adopting new or enhancing existing programs. Over the past several years, we have addressed the long-term employment benefit issues that have plagued our State, as we have addressed funding issues with our workers compensation system and our other post-employment benefits (“OPEB”).

In evaluating our options, we also are mindful of unprecedented fiscal challenges faced by the federal government and the inability of the federal government to adopt formal budgets in recent years. Without further action, the looming sequestration trigger in current federal law will affect Medicare provider reimbursements, which will, in turn, impact West Virginia disproportionately given our demographics. I think we all agree the federal government’s current fiscal path is unsustainable. Therefore, we are very cautious in relying on future funding promises by the federal government. Just like funding for future years by the State of West Virginia, federal funding decisions are necessarily subject to being revisited and revised every budget year. Finally, your Administration has advocated new limitations on West Virginia’s ability to continue collecting State provider taxes at current rates for current purposes, resulting in further uncertainty and instability for our budget planning.

As with many other States, the biggest driver of increased costs for our upcoming general revenue fund budgets is Medicaid and related social and health services costs. My administration is committed to addressing stresses facing our State’s current Medicaid program, while providing accountability for the use of resources and in a manner that provides reasonable access to appropriate, quality health care services for those that need it most. It is our goal to provide these services in a manner that also focuses on long-term sustainability of this important safety net program.

Finally, we know that our health care system must be improved. The promised funding opportunity under PPACA to provide health care coverage to an estimated 130,000 uninsured working West Virginians is significant. That opportunity becomes all the more advantageous

given the state-level match requirements under the first five years of Medicaid expansion, assuming the promised federal funds are available.

With health care coverage under Medicaid, it is hoped that these new recipients will no longer delay seeking care until their condition requires costly emergency room treatment. They can obtain appropriate diagnosis and treatment at a much earlier stage when costs are far lower. These individuals can get regular check-ups with their own doctors. In a state where heart disease, diabetes, and other chronic health conditions occur at levels far too high, this type of access to health care could provide meaningful improvements to the health of our citizens. This, in turn, has the potential to reduce health care costs in the long run, saving taxpayer dollars and keeping insurance premiums and copays lower. The healthier we are as a State, the more productive we can be from an economic perspective.

Our hospitals have suggested that they will see a benefit with the proposed Medicaid expansion. Hospitals must currently provide a significant amount of uncompensated care. And under PPACA, the rate structure for hospitals, particularly as it relates to disproportionate share payments, is drastically changed on the assumption that all states will accept Medicaid expansion. Therefore, if West Virginia chooses not to expand Medicaid, our hospitals would not receive the benefit of being compensated for previously uncompensated care and would still be subject to the new rate structures.

In light of the above and because of the significant discretion authorized to and exercised by your office pursuant to PPACA, we have compiled a number of important questions on matters related to Medicaid expansion and exchanges. We hope that you can be of assistance to us by providing more information about the following:

1. As a result of the Supreme Court ruling, what changes to Medicaid expansion will occur regarding exchange implementation, and when will the United States Department of Health and Human Services (“DHHS”) provide updated guidance in this regard?

2. Will West Virginians with incomes between 100% and 138% of the federal poverty level (“FPL”) be eligible for cost sharing subsidies and tax credits to purchase coverage through an exchange?
3. Will the enhanced federal match rate, i.e., the enhanced federal medical assistance percentage (“FMAP”) be available if West Virginia decides to expand Medicaid coverage for at a level below 138% of FPL.
4. Is DHHS considering allowing states to phase-in Medicaid coverage, eventually achieving 138% of FPL after 2013 and still receive the enhanced FMAP?
5. If West Virginia does not expand, are we still required to convert our income measurement methodology for purposes of determining Medicaid eligibility?
6. If a state chooses not to expand Medicaid to the optional adult category, can a state use Medicaid funding to assist individuals in this group in purchasing health insurance through an exchange? If so, would states be eligible to receive the enhanced FMAP? May states also use Medicaid funds to provide wrap-around services? What is the approval process for this approach?
7. Is DHHS intending to provide guidance to states as to the process by which state plan amendments (“SPAs”) are to be used to adopt Medicaid expansion under PPACA?
8. Will DHHS provide guidance to states regarding subpopulation issues, including whether the expansion of Medicaid to children enrolled in foster care is optional and whether the expansion of Medicaid for children from 100-138% of the FPL is optional?
9. Is DHHS planning any modifications to the manner in which it will reduce Disproportionate Share allotments as it relates to states that do not expand?
10. May West Virginia implement a new DSH diversion program as part of the optional expansion? If so, what parameters might be involved and when will any guidance or rules be issued?
11. When will DHHS provide states with information necessary for us to evaluate Federally Facilitated Exchange (“FFE”) and FFE partnership options? Additionally, how will the funding of the FFEs be sustained?
12. What fees will be charged for the State to utilize the federal data hub, advance premium tax credit/cost-sharing reduction service, risk adjustment and transitional reinsurance programs?
13. When will the operational details of the FFE become available?
14. What level of benefit is required in a specific benchmark to satisfy the ten PPACA “basement” categories identified in Section 1302(b)(1) of PPACA? How should the identified benefit categories be defined?
15. What process will be undertaken by the DHHS to select backfilling benefit options in the scenario that the state defaults to the largest small group product in the West Virginia marketplace?
16. Will DHHS issue guidance related to how states notify individuals about the application of the penalty for not purchasing or enrolling in health coverage?

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Thank you for your prompt attention to this important matter. We look forward to your responses to our questions which will help enable us to knowledgably explore available options for the benefit of West Virginians.

Best regards,



Earl Ray Tomblin
Governor

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