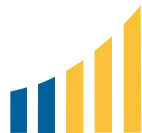


# Medicaid in the Mountain State

A Health and Economic Necessity



WEST VIRGINIA CENTER ON  
BUDGET & POLICY

# Medicaid in the Mountain State: A Health and Economic Necessity

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# Introduction

West Virginia’s Department of Health and Human Resources (DHHR) is the state’s largest agency with an essential mandate: protecting the health and well-being of our residents. In addition to leading the state’s public health infrastructure, the agency oversees health coverage for 584,000 residents and manages food assistance programs for 150,000 families and temporary cash assistance programs for 5,800 individuals. The DHHR also oversees the state’s child welfare system in a state with one of the highest percentages of out-of-home placements in the country.<sup>1</sup>

This report will analyze the DHHR’s budget and responsibilities for the fiscal year 2022 (FY 2022), primarily focusing on the functions and administration of the Medicaid program. West Virginia faces significant health needs, including an addiction epidemic, ongoing impacts of the pandemic, a stubbornly high poverty rate, and an aging population with high chronic disease rates among both the elderly and the non-elderly. As such, the state’s health agency is tasked with a broad mission and administration of many vital programs. State and federal investments in the DHHR impact health and the ability of residents to work, go to school, and thrive, as health has such a significant impact on other basic needs.

## Key Findings

- Medicaid is the health insurer of one in three West Virginians. It covers half of births, health coverage for over 50 percent of children, and 76 percent of long-term care costs.
- Medicaid is both an expenditure and an essential source of revenue for our state’s budget. Federal dollars comprise 70 percent of the total Medicaid budget, bringing critical funds into the state’s health care system and economy.
- West Virginia has one of the most generous Federal Medical Assistance Percentage (FMAP) rates of any state, pulling down an average of five federal dollars for every dollar that the state spends on the Medicaid program.
- Medicaid supports 25,000 jobs and \$5.7 billion in direct and indirect economic activity annually.
- The Bureau for Medical Services, which administers Medicaid, is understaffed by 20 percent; streamlining administrative and enrollment and renewal processes can help in addition to hiring more staff.
- Flat budget projections, tax cuts, and other policies harm Medicaid’s ability to reach vulnerable populations, both in the short and long term.

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1 Department of Health and Human Resources, “Department of Health and Human Resources Budget Presentation: 1<sup>st</sup> Session of the 86th Legislature” (February 2021).

# The Basics of the DHHR and Medicaid

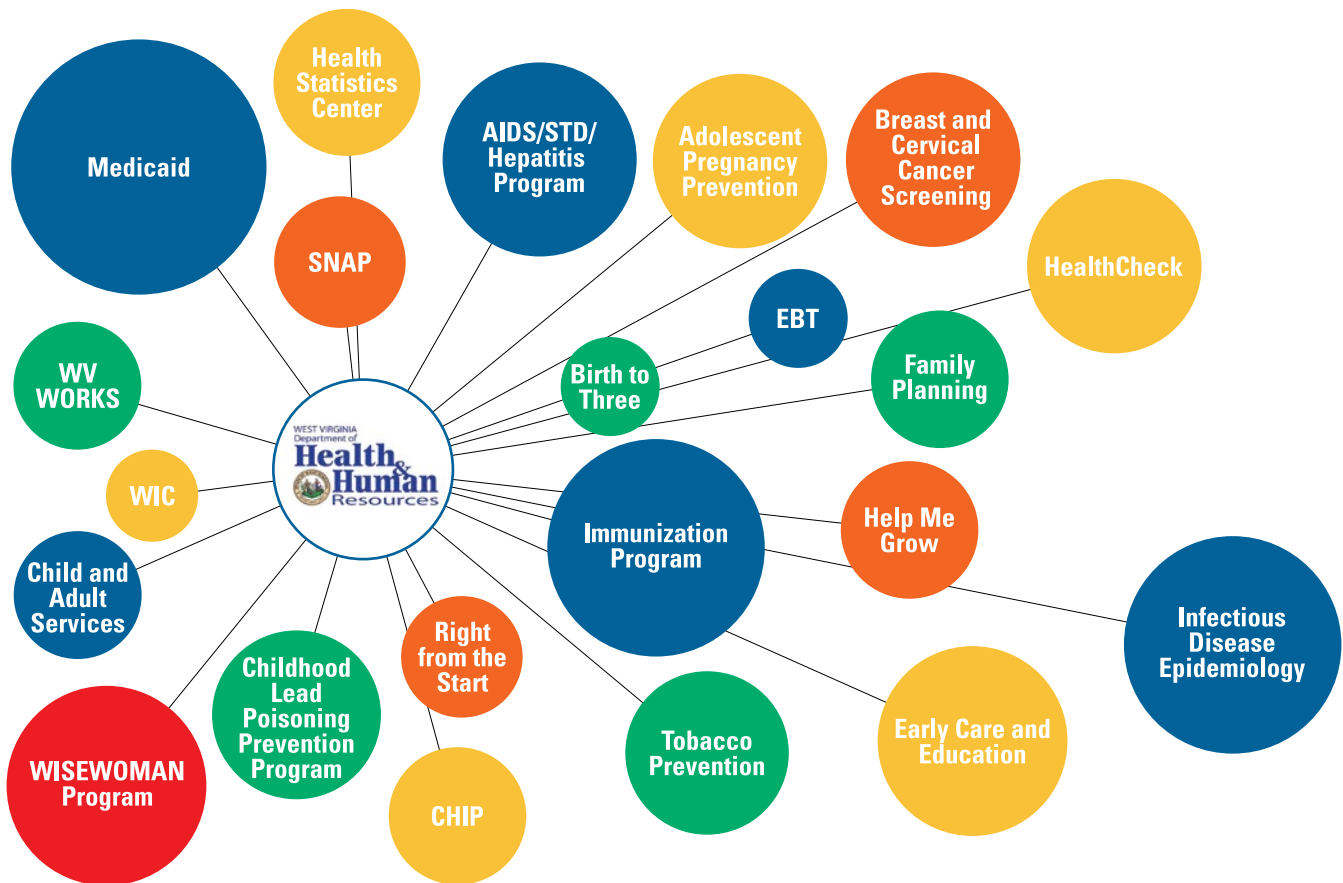
## Overview of the DHHR

The DHHR is the largest state agency in West Virginia. It oversees a broad range of services specifically designed to preserve and improve community health and wellness. While Medicaid is the most extensive program that the DHHR undertakes, serving one-third of the state population, it is one of several that interact to contribute to holistic health outcomes. As **Figure 1** indicates, the DHHR also helps connect vulnerable populations with essential services such as family planning, STI screening, food and nutrition, and more.

**Figure 1**

### The DHHR Plays Instrumental Role in Public Health in West Virginia

*Programs run by the DHHR, 2021*



Source: West Virginia Department of Health and Human Resources

Medicaid directs an average of over \$4.4 billion, including \$3.1 billion in federal dollars, annually to the state’s health care providers and economy while providing health coverage to 33 percent of West Virginians. Medicaid enrollment is also incredibly responsive to economic downturns and health crises and has grown throughout the pandemic, which this report primarily focuses on and will later examine. In FY 2022, the total budget of the DHHR is approximately \$6.4 billion. Federal funding accounts for nearly 75 percent of the FY 2022 DHHR budget, or \$4.7 billion. The state provided the remaining \$1.7 billion.<sup>2</sup> In the previous fiscal year, FY 2021, the DHHR had a budget of \$6.1 billion, representing a five percent change.<sup>3</sup>

<sup>2</sup> Department of Health and Human Resources, “Budget 86th Legislature.”

<sup>3</sup> Department of Health and Human Resources, “Department of Health and Human Resources Budget Presentation: 1<sup>st</sup> Session of the 85th Legislature” (January 2020).

As of 2019, the program covers over half of births across the state.<sup>4</sup> It also covers over half of children, indicating that most kids in West Virginia have health insurance via Medicaid (and the Children’s Health Insurance Program, or CHIP) throughout their childhoods. This coverage gives children critical access to routine checkups, immunization, and other services that ensure that they are not only born healthy but remain so into adulthood.<sup>5</sup> Additionally, recently extended postpartum legislation provides mothers coverage for up to a year after giving birth, helping ensure infant and parent wellness beyond their time in the hospital.<sup>6</sup>

Medicaid also provides long-term care for over 75 percent of all nursing home residents in West Virginia as of 2019, alleviating gaps in unpaid family care.<sup>7</sup> Further, it covers one-fifth of Medicare beneficiaries, helping people 65 and older as well as those with disabilities access long-term care and other services not covered by Medicare. Medicaid also covers three in eight younger individuals.

Medicaid’s interaction with nursing home and other long-term care services will become increasingly important as the population ages. The following section will outline how the federal-state partnership supports Medicaid patients across West Virginia.

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4 Kaiser Family Foundation, “Births Financed by Medicaid” (October 2019).

5 Kaiser Family Foundation, “Fact Sheet: Medicaid in West Virginia” (October 2019).

6 West Virginia Legislature, “2021 Regular Session: Enrolled Committee Substitute for House Bill 2266” (April 2021).

7 Kaiser Family Foundation, “Medicaid in WV”.

# Medicaid: A Federal-State Partnership

Medicaid is a federal and state health insurance program that helps low-income families and people with disabilities access affordable health care. As of January 2021, over 73 million people across the nation were enrolled in the program, including 584,000 West Virginians — a third of the total state population.<sup>8</sup> In FY 2022, the program will bring over \$4.2 billion to West Virginia’s economy via federal dollars alone.<sup>9</sup> It is a countercyclical program, meaning it expands to meet increasing need during economic recessions and public health emergencies, such as the COVID-19 pandemic and the subsequent economic downturn.

Medicaid provides a range of essential services that would otherwise be inaccessible to these populations, from primary care to nursing home care services. Since its expansion in West Virginia in 2014, more people have been able to receive these and other services that have proved invaluable to familial and community health. It has been one of the nation’s most powerful anti-poverty tools — and fundamental in improving public health outcomes — for over half a century.

The relationship between the federal and state governments is key to the Medicaid program’s success. While the federal government plays a significant role in providing states funding for Medicaid and in creating overall program requirements, the state also provides some funds, executes these requirements, devises additional functions relevant to state needs, and administers the program. This federal-state partnership universalizes basic requirements while allowing more localized applications that can aid pertinent community needs.

The share of the Medicaid program for which the federal government pays is called the Federal Medical Assistance Percentage, or FMAP. This rate derives from a formula and ranges based on overall poverty levels and other factors. Because West Virginia maintains one of the highest poverty rates nationally, at around 18 percent in 2021, the state has one of the most generous FMAP rates in the country, helping the state alleviate health disparities.<sup>10</sup> The regular FMAP in West Virginia is 75 percent, meaning that the federal government contributes three dollars for every one dollar the state spends on Medicaid. Medicaid expansion enrollees — who became eligible after the state expanded the program to include people up to 138 percent of the federal poverty level as part of the Affordable Care Act — have an even more generous match of 90 percent, with the federal government contributing nine dollars for every one dollar the state spends.<sup>11</sup>

## The Bureau for Medical Services — Medicaid

The Bureau for Medical Services (BMS), which administers Medicaid, is the largest bureau within the DHHR, making up over 75 percent of the department’s funding in FY 2022. The budget for the BMS is \$4.8 billion in FY 2022, roughly 5.6 percent higher than in FY 2021, when the budget was \$4.5 billion.<sup>12</sup> The next section of this report will outline how this increase was part of the broader response to increased hardship triggered by the COVID-19 pandemic.

Of the overall BMS budget in FY 2022, the federal government provided over four-fifths of the funding, equaling nearly \$4 billion. These dollars represent a seven percent positive change from FY 2021. Meanwhile, the state provided the remaining amount — about \$800 million — via several funding sources. **Figure 2** displays how each of these sources contributes to the total BMS budget in FY 2022. There was no change to the state contributions between FY 2021 and 2022, again indicating flat projections on the state-level.<sup>13</sup>

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8 Centers for Medicaid and Medicare Services, “January 2021 Medicaid and CHIP Enrollment Data Highlights” (January 2021).

9 Department of Health and Human Resources, “Budget 86<sup>th</sup> Legislature”.

10 World Population Review, “Poverty Rate by State 2021” (February 2021).

11 Department of Health and Human Resources, “Budget 85<sup>th</sup> Legislature”.

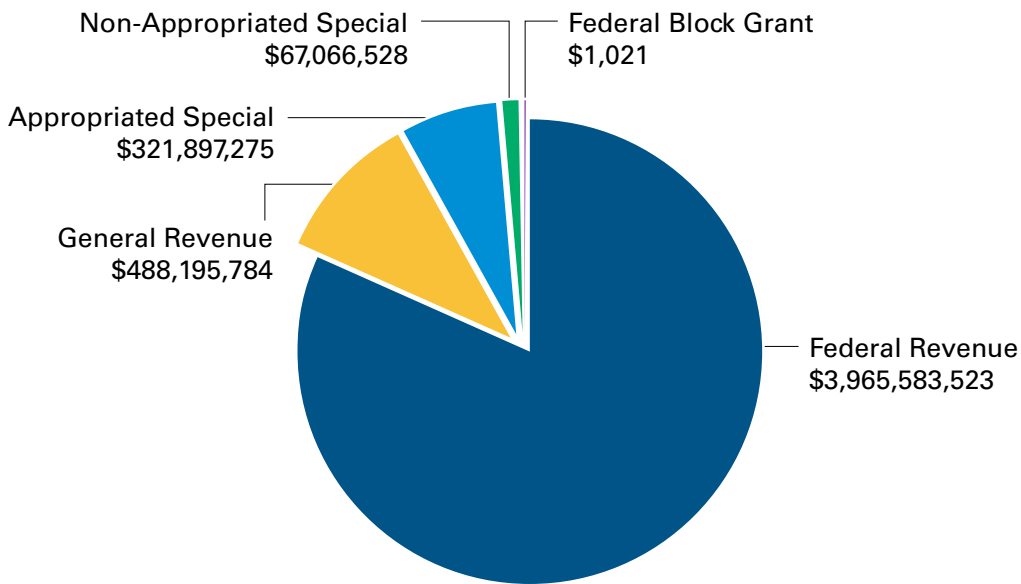
12 Department of Health and Human Resources, “Budget 85<sup>th</sup> Legislature”; Department of Health and Human Resources, “Budget 86<sup>th</sup> Legislature”.

13 Ibid.

**Figure 2**

## FY 2022 Bureau for Medical Services Budget — \$4.8 Billion

*Breakdown of BMS funding by source, FY 2022*



*Source: Department of Health and Human Resources Budget Presentation, FY 2022*

The state's contributions to Medicaid play a key role in determining how many federal dollars West Virginia's Medicaid program receives. This is because states must also contribute a state match (or some rate relative to the FMAP) to receive those federal funds. These contributions support the Medicaid program both directly (through services) and indirectly (administratively). West Virginia generates these funds via several streams: the medical services fund, the health care provider tax, and some reserve funds. The medical services fund, which pays all medical expenses for Medicaid-eligible clients, is the largest of these at \$225 million in FY 2022.<sup>14</sup> This figure remains relatively flat from FY 2021.<sup>15</sup>

The health care provider tax is the next most significant individual source of revenue supporting the DHHR. As the name suggests, the health care provider tax generates proceeds by taxing health care providers. These dollars then return to the state health care infrastructure by supporting the Medicaid program, both via contributing to the state match and more generally. This tax has become increasingly integral to the solvency of Medicaid programs across the nation as health care costs continue to rise. As of 2017, every state but Alaska had a health care provider tax.<sup>16</sup> In FY 2022, the West Virginia health care provider tax amounts to approximately \$214 million—one in eight dollars that the state spent on the DHHR.<sup>17</sup>

14 Department of Health and Human Resources, "Medical Services Fund Advisory Council," Department of Health and Human Resources <https://dhhr.wv.gov/bms/About%20Us/MSFAC/Pages/default.aspx>, accessed June 16, 2021; West Virginia Legislature, "2021 Regular Session: Enrolled Committee Substitute for House Bill 2022" (April 2021).

15 West Virginia Legislature, "2020 Regular Session: Enrolled Committee Substitute for Senate Bill 150" (March 2020).

16 Kaiser Family Foundation, "Fact Sheet: State and Medicaid Provider Taxes or Fees" (July 2017).

17 West Virginia Legislature, "Committee Substitute for House Bill 2022" (March 2021).

# Pandemic Response

As briefly mentioned in the section of this report analyzing federal policy changes in response to the COVID-19 pandemic, the Medicaid program has been responsive to changing health needs since the start of the pandemic in March 2020, when the federal government instated the public health emergency (PHE).

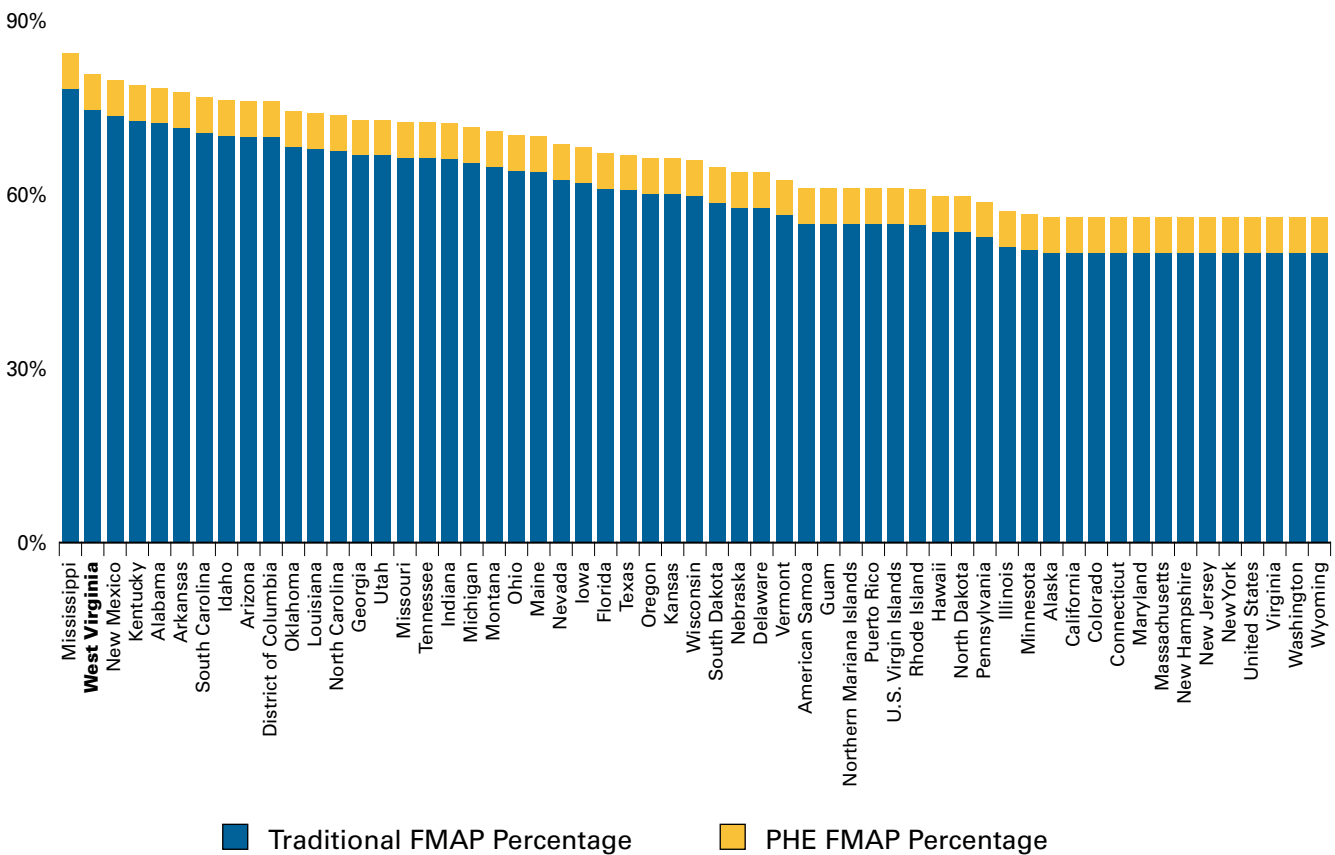
The PHE pushed federal lawmakers to pass the Families First Coronavirus Response Act. Among other provisions, this law increased the Medicaid FMAP by 6.2 percent, which added roughly \$200 million to the West Virginia Medicaid program in FY 2022 (or \$50 million per quarter). These funds bring the budget for the Medicaid program up to \$5.1 billion in FY 2022, allowing West Virginia to address short-term and long-standing health challenges, such as substance use disorders, more adequately.<sup>18</sup>

This FMAP increase is conditional on several terms, including state compliance with a maintenance of effort (MOE) requirement.<sup>19</sup> The MOE mandates that states keep individuals enrolled in Medicaid through the PHE, allowing enrollees to seek critical care throughout the emergency. **Figure 3** indicates that in FY 2021, West Virginia’s regular FMAP was around 75 percent, exceeded only by Mississippi.<sup>20</sup> The FMAP increase triggered by the pandemic then took the state’s FMAP to just over 80 percent.

**Figure 3**

## Public Health Emergency Moved West Virginia FMAP Rate Over 80 Percent

*State distribution of regular and PHE FMAP rates, FY 2022*



Source: Department of Health and Human Services

18 Bureau for Medical Services, “FY 2021-2022 Budget Update” (May 2021).

19 Dolan, Rachel et al., “Medicaid Maintenance of Eligibility (MOE) Requirements: Issues to Watch” (Washington, DC: Kaiser Family Foundation, December 2020).

20 Congressional Research Service, “Medicaid’s FMAP”



Two significant factors are impacting Medicaid enrollment, both of which officials predict will be relatively short-term considerations. First, as briefly discussed, the FMAP increase that the federal government tied to the MOE ensured that BMS has not disenrolled anyone from the state Medicaid program since the start of the pandemic. The MOE is the primary factor contributing to the temporarily increased number of people on Medicaid in West Virginia.<sup>21</sup> This policy has also proven an essential means of ensuring that low-income families across the state remain healthy, helping to mitigate cases and mortalities associated with COVID-19 and other related complications.

The second, smaller factor driving increased Medicaid numbers is that the COVID-19 crisis triggered an economic crisis. Almost overnight, thousands of people lost their jobs or otherwise worked fewer hours. In April 2020, the unemployment rate in West Virginia peaked at nearly 16 percent.<sup>22</sup> While it has since recovered, there is more to the narrative than immediately meets the eye. In May 2021, the unemployment rate was 5.5 percent, which is somewhat comparable to the six percent unemployment rate in March 2020.

However, a closer study finds that all is not well in our state economy. While the unemployment rate has been decreasing steadily since April 2020, where the rate peaked at nearly 16 percent, the state is yet to fully recover and is still down 36,000 jobs compared to February 2020. This figure represents an overall five percent loss in jobs across the state since the start of the pandemic. Notably, the unemployment rate only captures the number of people looking for jobs relative to the number of jobs available. And because some West Virginians have left the workforce altogether, largely driven by the number of jobs lost, the unemployment figures paint a particularly rosy image of recovery that is irreflective of lived experiences. Because Medicaid is incredibly responsive to increased hardship, more struggling families became eligible for the program as unemployment levels rose and job losses mounted.

Both the MOE and changes in labor force participation made more West Virginians eligible for Medicaid, helping them access necessary care. While the MOE allowed the DHHR to keep people already enrolled in Medicaid in the program, increased unemployment made the program accessible to more families during the pandemic. Together, these factors have contributed to the 17 percent change in the overall size of the program since February 2020. **Figure 4** highlights that Medicaid serves 584,000 people across West Virginia as of May 2021.<sup>23</sup> It covers one in two children in West Virginia, who represent one-third of the overall program.<sup>24</sup>

When comparing the costs of Medicaid for different populations against the cost of subsidizing enrollees to buy private insurance plans on the Marketplace, it becomes clear how efficient the Medicaid program is. While the average overall expenditure per Medicaid enrollee was \$7,200 in 2018, **Figure 5** indicates how that number varies based on the population. Of course, medical costs related to COVID-19 may have impacted these estimates more recently. Still, on average, subsidizing private insurance via the Marketplace is more costly than enrolling a person in the Medicaid program. Both the Marketplace and Medicaid insurance programs must adhere to regulations set by the Affordable Care Act, so differences in services do not account for these differences in costs.

However, as more people have enrolled in Medicaid, they have also utilized it less over the past year in response to the pandemic.<sup>25</sup> This decreased utilization of services, alongside increased funding, has mitigated some of the challenges facing the program. The last section of this report will detail the general economic outlook facing the Medicaid program in FY 2022 and beyond.

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21 Dolan, "MOE Requirements."

22 US Bureau of Labor Statistics, "Local Area Unemployment Statistics: West Virginia, 2011-2021" (June 2021).

23 Department of Health and Human Resources, "Bureau for Children and Families Monthly Secretary's Report" (January 2020 to April 2021).

24 Kaiser Family Foundation, "Medicaid in WV."

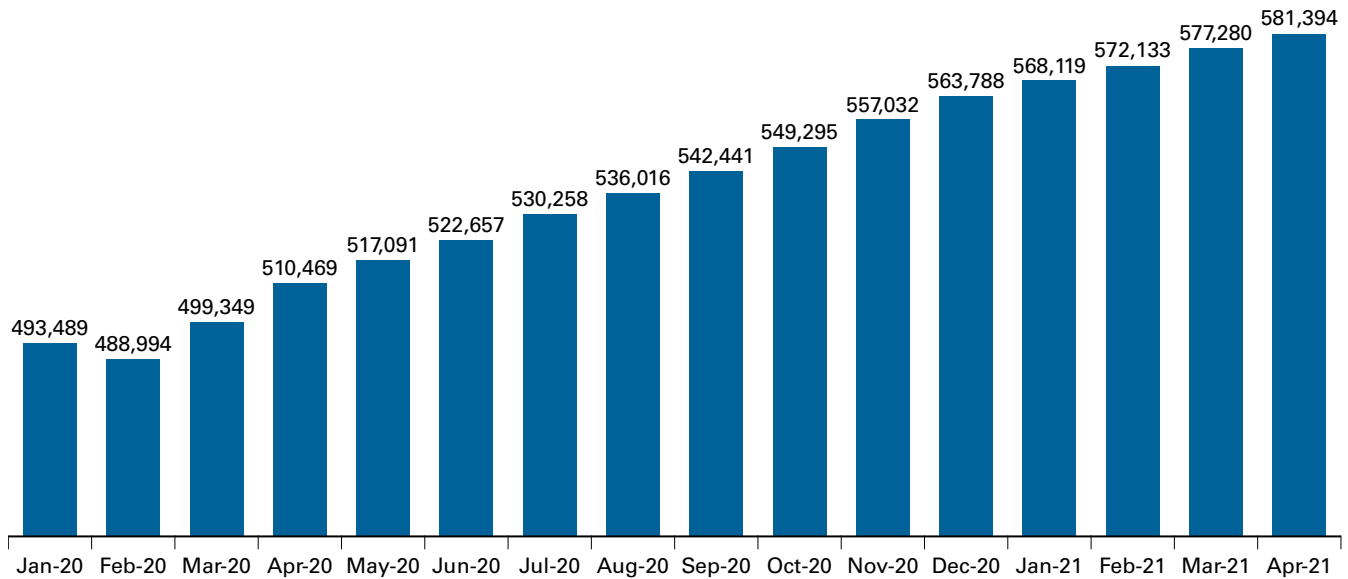
25 Department of Health and Human Resources, "Budget 86th Legislature."

Due to the COVID-19 crisis, West Virginia has also received additional funds from the federal government. Given that the DHHR directs many of the services pertinent to this pandemic, they have been one of the primary agencies administering these federal dollars. Several of the bureaus within the department have received enhanced funding since March 2020.

**Figure 4**

Medicaid Responsive to Increased Economic Hardship Over Pandemic

*West Virginia Medicaid enrollment, January 2020 to April 2021*



Source: West Virginia Bureau for Children and Families Monthly Secretary Report

**Figure 5**

Subsidizing Private Insurance More Costly than Enrolling in Medicaid on Average

*West Virginia Medicaid expenditures by demographic, 2018; Marketplace enrollee, 2020.*

Population	Average Expenditure
Overall	\$7,232
Children	\$2,869
Adult: Non-expansion, Non-disabled, under 65	\$4,698
Aged	\$23,013
People with Disabilities	\$13,983
Adult: ACA Medicaid Expansion	\$5,080
Marketplace Enrollee	\$9,766 (2020)

Source: Centers for Medicaid and Medicare Services

## Economic Impact of Medicaid

This report has uplifted the leading role that Medicaid plays in individual and communal health in West Virginia. And while this remains its central and most important objective, the program has significant economic implications as well. In the years following the Great Recession, when West Virginia's economic recovery was slower than that of many other states, the health care sector — significantly aided by public investment in Medicaid and other public health initiatives — was one of the only industries in West Virginia that experienced job growth. Social services, including Medicaid, made up about 12 percent of the state's gross domestic product (GDP) in 2019.<sup>26</sup>

For every dollar that the state invests in Medicaid, West Virginia receives it back fivefold via the FMAP. While traditional Medicaid pulls three dollars down from the federal government for every dollar spent on the state level, the Medicaid expansion population pulls down nine federal dollars. These figures average out to five federal dollars that West Virginia receives for every one dollar spent at the state level. Though temporary, the enhanced FMAP through calendar year 2021 has increased this ratio from five federal dollars to about 5.7 federal dollars per state dollar toward Medicaid.<sup>27</sup> This means that, while the state's share of Medicaid is a budget expenditure, Medicaid itself is a source of positive revenue for West Virginia, generating far more in federal dollars than the state spends on the program.

Of course, these funds have implications beyond the FMAP and impact the state in several ways, both within and outside of the health care sector. In FY 2019, the federal government invested \$3.1 billion in West Virginia's Medicaid program, which directly supported nearly 20,000 jobs across the state. A study from the West Virginia University Bureau for Economic Research found that a \$28.7 million reduction in federal Medicaid funding would result in a loss of \$49 million in economic output, loss of 520 jobs, and loss of \$22 million in compensation annually. This would imply that Medicaid's total annual federal impact indirectly supported an additional 19,000 jobs, bringing its total impact on employment to 39,000 jobs across West Virginia. This figure translates to about five percent of total jobs in West Virginia directly or indirectly supported by the Medicaid program in 2019.<sup>28</sup>

Further, the direct compensation to health care workers exceeded \$1.5 billion, which represented roughly two percent of the state GDP in 2019 from labor compensation alone. And of course, these dollars are not stagnant — most of the money these health care workers received then circulated around the state as they spent money on an array of goods and services, helping to support their local economies.

When accounting for both direct and indirect compensation generated or supported by Medicaid, economists found that the program's overall impact on total labor income was around \$2.4 billion in FY 2019 — or around 3.2 percent GDP. When estimating the total output of Medicaid in West Virginia, which includes indirect and direct payments to workers (as well as value added as these payments circulate around the economy via these workers spending money), they found that Medicaid had a whopping \$5.7 billion impact on the state economy overall. This figure equals roughly 7.2 percent of the state GDP in FY 2019. The additional funds triggered by the COVID-19 pandemic have only increased the overall economic benefits of Medicaid, especially as these funds continue to grow within a shrinking economy.

Given the enormous economic impact of investing in Medicaid, it is clear how tax cuts, flat spending projections, and other poor public health policies have negatively impacted not only Medicaid recipients and public health, but the state economy overall. Lawmakers and other decisionmakers who determine the Medicaid budget, as well as other key factors that impact it, make decisions about West Virginia's health and economic outcomes — whether they realize it or not.

26 Urban Institute, "State Fiscal Briefs: West Virginia" (April 2021).

27 Department of Health and Human Resources, "Budget 86th Legislature."

28 Methodology: WVCPB analysis and extrapolation of analysis utilized in WVU Bureau for Business and Economic Research report: "The Economic Impact of Medicaid on West Virginia's Economy."

This analysis underlines the economic importance of investing in Medicaid. Of course, these considerations are limited and cannot measure nonpecuniary factors, like to what degree Medicaid impacts the quality of life or how severe budget cuts would affect the quality of care. But the overwhelming amount of empirical evidence supporting Medicaid's necessity to West Virginia's economic and health outcomes confirms that the benefits associated with an investment in community health are enormous.

# Economic Outlook and Challenges

## Six-Year Economic Outlook

Each year, the DHHR releases a six-year economic outlook for the Medicaid program, as **Figure 6** highlights. This outlook helps the department anticipate future challenges and ensure that Medicaid is solvent in the coming years. As the table highlights, by FY 2025 and 2026, there will be some gaps that the state must mitigate to ensure that the program can still serve West Virginians to its most total capacity. In FY 2025, the state will need to provide Medicaid \$23 million in additional funding to ensure solvency. By the next fiscal year, FY 2026, the state will need to provide over six times that figure — \$153 million — to ensure that Medicaid does not become insolvent.<sup>29</sup>

**Figure 6**

### Medicaid Will Be Insolvent by FY 2026

*Medicaid budget outlook before and after state adjustment, FY 2021 to 2026*

	2021	2022	2023	2024	2025	2026
<b>Before State Budget Adjustment</b>	\$284M	\$342M	\$269M	\$174M	\$58M	-\$135M
<b>After State Budget Adjustment</b>	\$284M	\$210M	\$154M	\$76M	-\$23M	-\$153M

*Source: Department of Health and Human Resources Budget Presentation FY 2022*

The DHHR has always prioritized long-term budget management that has ensured that Medicaid meets federal and state requirements. Encompassing a range of strategies, this has been the primary way that the department has guaranteed continued benefits over the past several years. However, such planning cannot make up for structural budgetary problems that impact the entire state. In past years, Medicaid has relied on surpluses that will soon be exhausted, as they are not replenished at the same rate at which they are depleted.<sup>30</sup> While an influx of federal dollars and decreased utilization during much of the pandemic have helped forestall budgetary problems facing Medicaid and the DHHR, they do not address long-term fiscal constraints. Both these factors have contributed to the solvency of Medicaid by increasing funds available to the program and reducing costs, but it cannot be ignored that these factors are also covering up structural problems in the short-term.

This phenomenon is evidenced by changes to the six-year outlook between FYs 2021 and 2022. The previous six-year outlook from FY 2021 had indicated that the budgets in FYs 2022 and 2023 would be flat, with the Medicaid program becoming insolvent in FY 2025 if the state did not provide an additional \$23 million. While that shortfall is still present for FY 2025, as **Figure 6** indicates, the program will be sound through that year, with insolvency pushed out to FY 2026.<sup>31</sup> The federal dollars that made the state pandemic response possible are responsible for pushing insolvency out to FY 2026. Furthermore, rather than showing flat budgets, both FYs 2022 and 2023 now show some growth.<sup>32</sup>

One challenge plaguing the Medicaid program in West Virginia is that the state legislature consistently plans around flat projections. While there are less costly years than others, officials must look at long-term trends and realistic future forecasts, including increasing costs of health care that arise through new treatments

29 Department of Health and Human Resources, "Budget 86th Legislature."

30 Ibid.

31 Department of Health and Human Resources, "Budget 85<sup>th</sup> Legislature"; Department of Health and Human Resources, "Budget 86th Legislature."

32 Department of Health and Human Resources, "Budget 86<sup>th</sup> Legislature."

and drugs, instead of hoping suppressed numbers remain permanent. Indeed, before the pandemic, Medicaid savings often derived from short-term changes, such as decreased enrollment.<sup>33</sup> Without further investigation of the underlying factors, it is easy to assume that cyclical trends are the broader narrative.

In a state facing increased poverty and an ongoing opioid crisis, in addition to rising medical costs across the country, it is unreasonable to assume little to no growth within Medicaid and other public health initiatives. Such projections ultimately limit the DHHR by disallowing substantial investments in public health from happening to the capacity necessary to improve health outcomes meaningfully.

In recent years, the legislature has also tapped Medicaid reserve funds, which are intended to cover health care needs in future years, to balance the budget. In FY 2020 the legislature used \$150 million in Medicaid reserve funds to balance the budget and is using another \$150 million to balance the FY 2021 and FY 2022 budgets.

## Challenges Facing the Medicaid Program

Several fiscal challenges are facing West Virginia's Medicaid program. The COVID-19 pandemic has introduced an array of unforeseen trials that have impacted health outcomes across the country. It has also exposed and exacerbated long-standing inequities that have persistently hindered health and wellness in West Virginia. The temporary regulatory and financial mitigations executed on the federal and state levels have introduced several short-term solutions. Still, decisionmakers must conduct more robust investigations and analyses to adequately address long-standing problems, as well as advocate for the permanence of these changes. The following section will introduce some policy prescriptions that aim to address a few of these challenges.

The previous section analyzed the increased size of the Medicaid program in response to the pandemic. The PHE will presumably sunset at the end of 2021, and the DHHR will have at least six months to unwind the MOE and remove ineligible individuals from the program.<sup>34</sup> Such action will reduce the overall size of Medicaid. However, given the changes in labor force participation and lags in economic recovery, it is unlikely that the program will return to its pre-pandemic levels of enrollment and utilization in the short-term.

There have also been other health challenges in West Virginia exacerbated during or in association with COVID-19. These include HIV and hepatitis outbreaks in several parts of the state due to the opioid crisis that West Virginia has been at the epicenter of for years. Harmful policy choices on the state and local levels have worsened the opioid crisis, which the Medicaid program will respond to by offering impacted individuals necessary services and care.

The increased size of the Medicaid program in response to both crises — COVID-19 and opioid — may also eventually result in increased utilization. Thus far, the pandemic has contributed to decreased utilization. But the over year-long social distancing, mask mandates, and other efforts combined with vaccinations have contributed to significant decreases in daily case numbers and deaths across the country. And those decreases have manifested in return to many everyday activities — including routine visits to the doctor's office.

Besides increased enrollment and utilization, the DHHR also anticipates that the aging population will raise overall Medicaid costs. Earlier, this report cited that the average expenditures per Medicaid enrollee were roughly \$7,200 annually (**Figure 5**). However, the aged population had medical costs exceeding three times that figure — about \$23,000 in 2018 dollars. This population represents six percent of the Medicaid program and is expected to grow over the next several years, both in West Virginia generally and within Medicaid.

For these reasons, it will become more imperative than ever that there are caseworkers, caretakers, and other professionals to provide adequate care and administrative support to the program. However, for the past several years, the BMS and DHHR have been understaffed, making it difficult to fulfill this goal.

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33 Department of Health and Human Resources, "Budget 85<sup>th</sup> Legislature."

34 Center for Medicaid and Medicare Services, "RE: Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the COVID-19 Public Health Emergency," DHHS <https://dhhr.wv.gov/COVID-19/Pages/default.aspx>, accessed on May 1, 2021.

As of February 2021, the BMS had 21 vacant positions of 100 positions total.<sup>35</sup> **Figure 7** breaks down these vacancies by bureau. While this is a problem across the state, it is especially pertinent to the southern-most parts of the state and more populated areas such as Cabell and Jefferson Counties.

**Figure 7**

Nearly One-Fifth of Full-Time DHHR Positions Vacant

*Full-time vacancies within the DHHR by bureau, FY 2022*

Bureau	Vacant FTE	Filled FTE	Total FTE
Bureau for Behavioral Health	7.00	64.00	71.00
Bureau for Children and Families	289.00	2,448.75	2,737.75
Bureau for Child Support Enforcement	74.50	419.45	493.95
Bureau for Medical Services	21.00	79.00	100.00
Bureau for Public Health	162.48	507.00	669.48
Children’s Health Insurance Program	2.00	7.00	9.00
Office of Health Facilities	458.15	1,190.00	1,648.15
Health Care Authority	2.00	6.00	8.00
Human Rights Commission	8.00	19.00	27.00
Other	109.00	558.16	667.16
<b>Department of Health and Human Resources</b>	<b>1,133.13</b>	<b>5,298.36</b>	<b>6,431.49</b>

*Source: Department of Health and Human Resources Budget Presentation FY 2022*

One driver for these vacancies that the DHHR has indicated is related to wages. As outlined by **Figure 8** below, over half of the vacancies observed within the department were for full-time positions that paid less than \$32,000 annually, which equals about 15 dollars an hour — maximum. Alternatively, jobs paying at least \$64,000 annually comprise roughly three percent of overall vacancies.<sup>36</sup>

The last challenge that this section will discuss is related to funding from the federal government. The pandemic has triggered increased financing, grants, and policy flexibilities that West Virginia has utilized to combat the direct and indirect impacts of COVID-19, as well as long-standing health issues. These changes have allowed the state to address persistent issues such as substance use disorders and domestic violence. They have bolstered funding for programs like home and community-based services.<sup>37</sup> And they have resulted in many more people accessing Medicaid, as discussed throughout this report.

But many of these responses are temporary, and some will sunset as early as January 2022. Without pathways for extending these changes, such as FMAP increases for several programs, it is more difficult for the DHHR to implement long-term changes with fiscal implications. Therefore, the federal government must continue to provide states funding to address the long-term consequences of the pandemic and alleviate long-standing inequities illuminated by the COVID-19 crisis. The concluding section will further outline some policies that could benefit the Medicaid program in West Virginia.

35 Department of Health and Human Resources, “Budget 86<sup>th</sup> Legislature.”

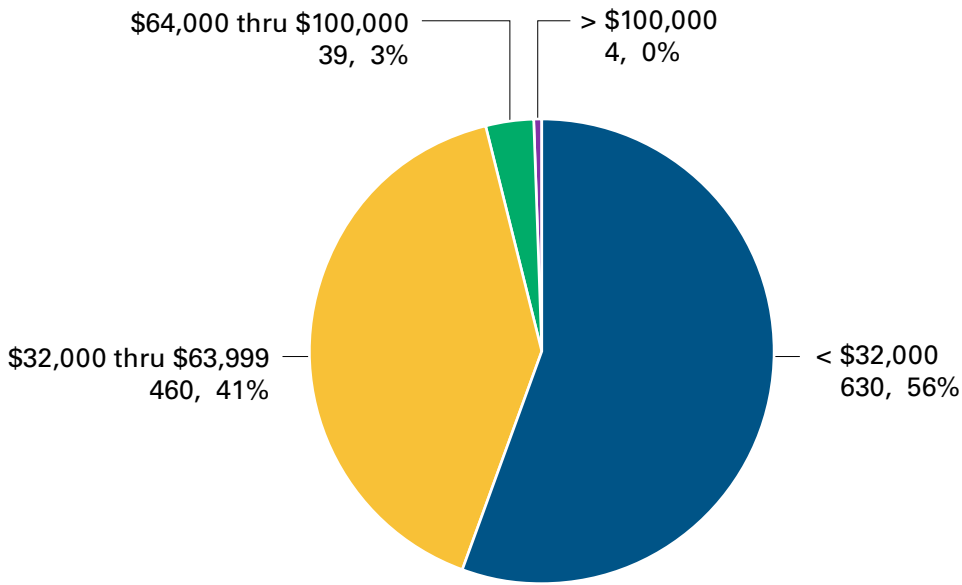
36 Ibid.

37 Ibid.

**Figure 8**

### Higher Wages Associated with Fewer Vacancies

*Vacancies within the DHHR by wage, FY 2022*



Source: Department of Health and Human Resources Budget Presentation FY 2022



## Policy Recommendations

Several policies can be implemented to help mitigate some of the challenges outlined in the previous section. Each of these policies aims to help make Medicaid more efficient, both in the short- and long-term.

### Data Transparency

The pandemic and its subsequent policy changes created a natural experiment of sorts, the impacts of which researchers have already begun to unwind. The information collected during this period has already proven crucial, especially when compared against pre-pandemic statistics. These data can precisely measure how various policies impacted people — and how their effects differ based on a variety of factors, including race, sex, age, and other demographics. By observing, collecting, and analyzing this information, researchers can better advocate for impacted communities. These studies are also critical for creating relevant, necessary, and nuanced policies; without empirical evidence, even the best of political intentions can waste valuable resources.

Therefore, having publicly available and detailed information about Medicaid — whether around demographics, utilization, or other key features — is critical to having a successful program and a healthy state. Collecting said data, though, is merely the first step. Data, whether quantitative or qualitative (or, ideally, a combination of both), must underscore every policy prescription, especially those with significant fiscal and community ramifications.

Of course, sending interested parties DHHR data manually requires a lot of time and resources. Depending on the information, datasets can take up to days or months to gather, organize, and redistribute. By automating this process and publicizing this data online as necessary and proper, the department can reduce the amount of time spent on redundant responses.

But even beyond publicizing data, transparency can allow outside researchers to perform robust analyses that state agencies otherwise do not have the capacity to prioritize. The costs associated with this policy would be negligible relative to the enormous benefits that can spur from the broad range of insight provided by various, research-driven third parties. The sheer number of policy solutions that would become more quickly and readily available to the DHHR, supported by the provided data, would offer nuanced solutions relevant to the state. Furthermore, transparency within government agencies is a best practice, both within public health and more broadly. It would foster collaboration between the department, advocates, researchers, interested parties, and, of course, impacted communities.

### Staffing

For the past several years, the state has had significant problems filling vacancies across its departments. This problem, of course, extends to the DHHR and BMS.<sup>38</sup> Understaffing has implications across the state, but these go beyond just being inconvenient within public health services. A lack of access to health care services can mean the difference between a routine checkup with a primary care physician and an expensive visit to the emergency room. By addressing understaffing, the DHHR can become more efficient while improving the Medicaid user experience.

Earlier, this report showed the number of vacancies within several bureaus in the DHHR (*Figure 7*). Such evidence uplifts the discrepancy between current resources and what the department needs to fulfill its core mandate to protect public health across West Virginia. But beyond the lack of personnel — although related — the DHHR also faces another issue: high turnover. *Figure 8* indicates that persistently low wages are a significant factor driving the department's difficulty in recruiting and retaining personnel, which, in turn, impacts the overall wellness of West Virginia residents.

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38 Ibid.

In the short-term, hiring and training more personnel can seem like a major cost. But the DHHR has already outlined their need for more caseworkers and other employees, making the case for more staff not only relevant but urgent. By hiring more people — and paying them fair wages — the department will experience lower turnover rates and higher morale amongst their staff. With higher wages, they will recruit and retain more talented and passionate individuals, lowering long-term training costs.

Beyond direct costs to the DHHR, filling all the current vacancies will also reduce medical expenses to the state and federal governments, which is currently the most significant expenditure facing both. For example, suppose the department can fill all their vacancies (and adequately pay their employees). In that case, these individuals can better help more West Virginians access Medicaid and other necessary public health services. By retaining passionate and talented individuals, the DHHR can help foster meaningful connections between caseworkers and their clients. These relationships can help destigmatize Medicaid, mitigate patients' distrust of the health care system, and increase engagement with health care services. With a fully staffed team, the DHHR can help clients more easily access preventive care and address health problems as they arise. Fewer people will forgo treatment that can inhibit minor ailments from progressing into chronic or otherwise relatively more expensive illnesses for both the patient and the Medicaid program to treat.

This strategy is one that the DHHR already champions but that other entities, including the state legislative and executive branches, must also support in order to make progress in this regard.

## Administrative Streamlining

In addition to addressing staffing shortages, the DHHR can also promote efficiency and user experiences by automating or otherwise streamlining time-consuming processes within Medicaid application and renewal. One such process is increasing the number of *ex parte* renewals, or renewals that employ existing data to automatically re-enroll eligible Medicaid enrollees. The state has access to income data for many Medicaid enrollees, through Workforce WV's unemployment portal, payroll data, and other means, and utilizing that data to automatically renew eligible enrollees would save time for the BMS staff and improve the Medicaid experience for users.

Despite this being an available tool, fewer than 25 percent of renewals in West Virginia utilize this streamlined option. Several states, including Alabama, Arkansas, and Ohio, have reported *ex parte* renewal rates exceeding 75 percent, resulting in fewer people losing coverage.<sup>39</sup>

Beyond helping individuals maintain coverage, such renewals also benefit the DHHR by reducing gaps that caseworkers would otherwise need to spend time closing. In addition, they can reduce costs to the state by automating renewals and reducing the number of reapplications from people who have lost coverage. *Ex parte* renewals may also reduce phone wait times, a pertinent problem in West Virginia, by reducing the number of notices enrollees must respond to, as well as other questions generated by the manual renewal process.

The state can also allow people to finalize their renewal forms via phone. Currently, 41 states allow Medicaid users to renew their enrollment over the phone through a process called a "telephonic signature."<sup>40</sup> While West Virginia allows users to report changes over the phone, enrollees must then wait for forms to arrive in the mail, sign them, and return them by mail or in-person to their local DHHR office to continue receiving Medicaid coverage.<sup>41</sup> This process is time-consuming and risks losses in the mail or late returns that may result in enrollees losing coverage and being forced to restart the enrollment process. Furthermore, in a state where access to the internet and reliable transportation are a major concern, allowing telephonic signatures can address these concerns while saving the department time.

39 Wagner, Jennifer, "Streamlining Medicaid Renewals Through the *Ex Parte* Process," (Washington, DC: Center on Budget and Policy Priorities, March 2021).

40 Kaiser Family Foundation, "Table 10: Medicaid Renewal Processes and Use of Periodic Data Matches Between Renewals for Children, Pregnant Women, Parents, and Expansion Adults, January 2020" (January 2020).

41 Wagner, "Ex Parte Process."

## Increasing and Generating Adequate Medicaid Funds

Overall, adequately planning the Medicaid budget, most of which is foreseeable, is one of the most important policy choices that West Virginia can implement — both for the economic and health well-being of our state and our people. Projecting a flat Medicaid budget while knowing that the state is facing unique challenges related to the opioid epidemic, income inequality, and other factors is short-sighted and contributes to systemic problems that will be more difficult to disentangle in the future. It is also fiscally unsound and irresponsible, making it that much more difficult for the DHHR to fulfill its core mission of promoting public health. Stifling and underfunding the department leaves people without access to a range of critical health care services. Serving West Virginia requires proactivity and realism, not hope that decreased funding will erase long-term systemic problems in the state.

The pandemic temporarily covered up some of these long-standing funding issues and inequities by creating several federal funding streams that helped West Virginia keep more of its residents healthy. However, some of these funding and policy changes will sunset as early as January 2022 — despite their clear relevance beyond the PHE. Combined with persistent elevated unemployment levels and poverty, the health disparities that so many West Virginians have experienced will return, at least to some degree, without further action. The COVID-19 pandemic confirmed what public health officials have been defending for years: adequately funding public health has significant implications for individual, familial, and community health outcomes far beyond its direct reach. Hence, officials at all levels of government must advocate for fully funded public health care systems.

One way that West Virginia can advocate for Medicaid in the long-term is to commit to maintaining a mutually exclusive relationship between Medicaid funds and other services. For years, the state has used surpluses in the Medicaid budget to fill gaps in other programs. While fully funding a range of services is critical, using a public health program already struggling to remain solvent to mitigate these gaps is a poor practice. Taking funds allocated for Medicaid and using them elsewhere in the budget makes planning for fiscal solvency for the six-year outlook and beyond nearly impossible.

While such funds would be imperative to the Medicaid program under any circumstance, the pandemic has further underscored the importance of these dollars. During the upcoming legislative session, lawmakers must prioritize bills that require that Medicaid have funds from which other programs cannot borrow. Such a structure would help ensure long-term solvency for the Medicaid program beyond the current 2026 sunset, offsetting the cost of future potential public health emergencies. It would also begin to alleviate deep-rooted health inequities across the state.

In addition to protecting existing Medicaid dollars, officials must also support the health care provider tax and other revenue sources that can help the Medicaid program better serve all West Virginians who qualify. On every level of government, officials have abundant opportunities to advocate for increased funding on behalf of their constituents, whose lives depend on it.

The policies described in this section of the report are by no means exhaustive, and many other fiscally sound prescriptions could help improve Medicaid's long-term outlook and help the program maximize its ability to reach those who it intends to assist. Transparency can help better define the problems facing Medicaid and those who use it, while fully staffing and funding the program can help create and execute more nuanced and personalized solutions both now and in the future. These can help the program be more efficient, allowing it to work as intended to its total capacity. Over time, these and other solutions will bolster the DHHR's ability to positively impact community health outcomes and help West Virginia become a healthier place to live.

