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COMMITTEE OF THE WHOLE

SENATE PRESIDENT – HONORABLE NOVELLE E. FRANCIS, JR

Monday, June 24, 2024

VIRGIN ISLANDS DEPARTMENT OF HUMAN SERVICES

Good Morning Honorable Novelle E. Francis, Jr., President of the 35th Legislature, members of the 35th Legislature, fellow testifiers, and to the viewing and listening audience. I am Averil E. George, Commissioner of the Virgin Islands Department of Human Services. With me today is Denelle Baptiste, Assistant Commissioner, Gary Smith, Medicaid Director and Roberto Tirado, Federal Grants Financial Analyst. We appreciate the opportunity to be here today to provide testimony on Bill Number 35-0291, an act appropriating the sum of $3,000,000 from the General Fund of the Treasury of the Government of the Virgin Islands to the Department of Human Services to pay providers and vendors that participate in the Medicaid program and for other related purposes.

The Virgin Islands Department of Human Services is the state agency who administers the Medicaid program in the territory. Currently the program has 21,463 members enrolled and there are 1,506 providers enrolled in the program to provide services, of which 440 are on-island and 1066 are off-island. During the Covid-19 Pandemic, the territory saw its highest enrollment of members reaching a peak of 38,489 members in June 2023. This increase was attributed to waivers granted by the Center for Medicare and Medicaid Services (CMS) which mandated that any member found eligible during the pandemic remain enrolled in the program throughout the Public Health Emergency in exchange for a higher Federal Matching Assistance Percentage (FMAP). With the Public Health Emergency ending on May 11, 2023, the VI Medicaid's unwind process began in June 2023, requiring all members to be recertified and since then, enrollment has reduced by 44%.

DHS is in need of additional funds to support a shortfall in the Medicaid local match for claims to pay past due expenses to providers and to support the continued operation of the Medicaid Program. To date the program has expended $109,221,830 for Medicaid and Children Health Insurance Program (CHIP) claims of which $98,827,870 is the federal share and $10,393,960 is the local match. For Fiscal Year 2024 (FY24), $9,005,275 was budgeted between Medicaid and CHIP for local match. An additional $710,000 was reallocated within the department to address

some of the shortfall. The program currently has a local account deficit of $678,248 with an additional $2,430,133.55 in current local match obligations waiting to be processed.

In Fiscal Year 2023 (FY23), the program expended $142,969,337 for Medicaid and CHIP claims of which $133,312,344 is the federal share and $9,656,994 is the local match. During the previous fiscal years, due to the waivers granted by CMS for the COVID-19 Pandemic, the territory operated with a higher Federal Medical Assistance Percentage (FMAP) which required a lower local match obligation until Q1 of Fiscal Year 2024, when it returned to the statutory 83% requiring a 17% local match. Please note that there are variable FMAPs that apply to sub-populations within the Medicaid member groups but this represents the largest population within the program.

Even with a significant decrease in members, contrary to the department's anticipation, the program's claims expenditures have not reduced accordingly. For FY24, claim cycles average $8.6M per month while in FY23 claim cycles averaged $9.3M in expenditures. At almost three quarters of the year, the department has spent 81% of what it spent in all of FY23 for claims and at the end of Q2 had spent 9% more on claims than it did in Q2 of FY23. This can mostly be attributed to the FMAP increase in the previous fiscal year, however the program expected to see expenditures level off due to the significant decrease in membership as well. The department is working closely with its contractors to gather insights into the trends and projections of spending as it relates to members and claims being incurred as well as with peers to understand how other state Medicaid programs are performing during the unwind. Thus far, here are a few suspected causes for the sustained or increased costs even with a reduced member population:

- Return of the local match to 17% after lower variable matches as low as 10.2% in immediate previous years as previously mentioned.
- High Utilizers - There are a few members that incur most of the costs paid by the program that continue to remain on the program through the unwind. A study conducted in 2023 showed that between 2020 and 2022, 2% of the program's members drove 29% of the costs. See Appendix for more details.

- Time to submit claims – Providers have one year to submit claims after services are rendered. The program continues to receive claims from points in time with higher member volumes. As mentioned, June 2023 saw the highest count of members so most of these claims should be submitted by the end of this month.
- Additional providers enrolled in the program which correlates to additional services being rendered. Services like Personal Care Attendants have seen an uptick in enrolled providers and services offered.
- Relaxed pre-authorization process – Due to services being bottlenecked at the Federally Qualified Health Centers and Department of Health Clinics the pre-authorization/referral process for private and specialty providers were relaxed as to not be a barrier to care. As a result, members are going directly to on-island providers for services allowing for less control over spending by the program.

The above are some of the insights that have been determined thus far which contributes to the program's need for additional local funds to cover obligations. As the medical needs of the community continue to grow and Medicaid approved services expands, the need for additional local match that supports maximizing the federal allotment is needed. Concurrently, the program must find ways to reduce spending as well as fraud, waste, and abuse to allow for the best use of available funds and to ensure sustainability of the program.

In response to the funding shortfall, there are short-term and long-term measures the program is taking to reduce costs. These include:

<u>Short-Term</u>

- Onboard additional clinical staff to assist with vetting referrals and to provide prior authorization for procedures – this allows for more control within the program of what and how much of a service is rendered.
- Temporarily pause CMS identified "optional" services such as Adult Dental, Durable Medical Equipment, Medical Escort travel, etc.

- Place limits on total spend per member for select services – This would entail placing funding caps on particular service categories such as Dental and Personal Care Attendant services.
- Reduce percentage of costs covered for select services – This pertains to offering some services at a reduced percentage such as 50% or 75% vs 100% of costs. This may apply to more mandatory services which must be offered.
- Re-institute pre-authorizations for most services

Long-Term

- Enroll eligible members in Medicare Part D for prescription costs – Through its Pharmacy Benefits Manager (PBM), the program has identified approximately 2000 members with active prescriptions who are eligible for dual-enrollment in Medicaid and Medicare Part D. The program will enroll those members and pay the Part D premium which will allow the program to see an almost 50% reduction in drug costs for those members.
- Implement comprehensive policies for high spending areas such as travel, dental services, PCA services, etc. – The VI Medicaid program is very expansive and requires guardrails to be placed around spending to ensure sustainability of the program
- Continue to build Medicaid Program Integrity Unit – The program onboarded a Program Integrity Director in August 2023 and is currently working to hire one Fraud Investigator and one Quality Control Reviewer in each district. DHS has already made a significant effort to address fraud within the program and will continue to increase those efforts to the extent possible.
- Conduct actuarial study to better predict and anticipate Medicaid population needs and trends.
- Implement technology to better track and manage service delivery and mine data for on-demand insights into utilization and spending.

In general, in the short term, the team will be faced with determining on a case by-case basis what services can be performed with the highest priority being placed on emergency and life-threatening services and procedures as well as mandatory services such as those for children. In this vein, the department sent out a notice to the public regarding temporary service adjustments effective July 1, 2024, which temporarily limits or in some instances pauses services such as Adult Dental, Medical Escort Travel, Personal Care Attendant, Durable Medical Equipment and non-emergent Prescriptions. DHS is diligently working to ensure that critical (i.e. life or death) services are not impacted. The team has put together an extensive communication plan to include individual correspondences to members and providers and will be facilitating targeted meetings with providers to share additional information around process changes. The Bryan-Roach Administration and the DHS team understand the impact these changes may have on our community, particularly on those who heavily rely on these services. Our goal is to ensure that services are available for those who most critically need them and that the program is sustainable for many years to come.

I would like to thank the hardworking staff of the Medicaid Program and the department for their dedication and hard work in tirelessly supporting the most vulnerable populations in our community. DHS is grateful for the support of Governor Albert Bryan, Jr and Lt. Governor, Tregenza Roach and looks forward to the favorable consideration of this body to provide the much-needed financial support the Medicaid Program requires.

Mr. Chairman, this concludes my testimony. My staff and I remain available for any questions this body may have.