

# Update on the Virginia Health Reform Initiative

*Presented by Cindi B. Jones  
Director  
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## Virginia Health Reform Initiative (VHRI)

### Opportunity

- ▶ Offer an alternative state model for health system reform
- ▶ Meet the needs of Virginia's citizens and government
- ▶ Create a health system that contributes to Virginia's economy

Support for this Initiative came from the Virginia Health Care Foundation and the Robert Wood Johnson Foundation. Health policy support was provided by Dr. Len Nichols, Director of the Center for Health Policy Research and Ethics at George Mason University

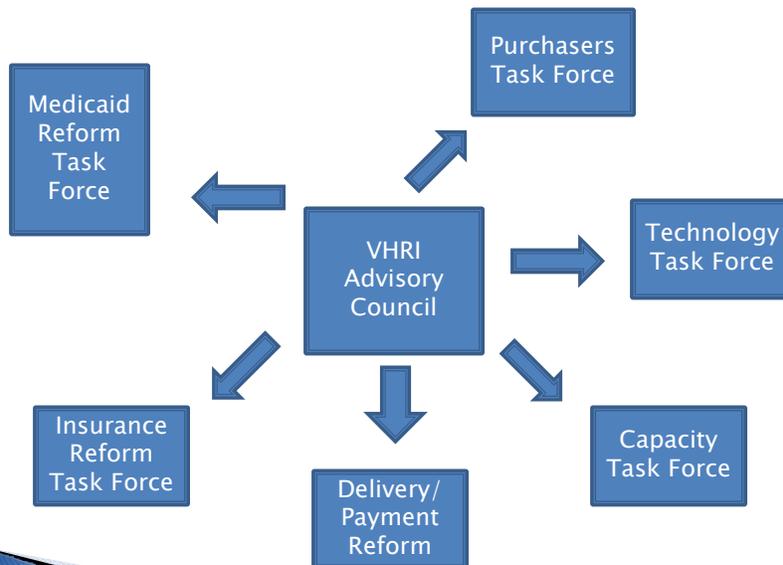
## VHRI Advisory Council

(24 Members, Secretary Bill Hazel is Chair)  
(6 taskforces, additional 46 members, including  
consumer representatives)

- From August to December 2010, the Advisory Council met three times; the six task forces met 18 times
- Developed a strategic plan for how to reform the health care delivery system in Virginia; 28 recommendations in final report

*Vision: Virginia should aspire to have the healthiest individuals, the healthiest communities, the best health care system and the strongest economy in the nation.*

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## **Delivery and Payment Reform Co-Chairs : Scott Burnette, Steve Horan**

### **What do we know?**

- ▶ Health care spending is on an unsustainable path
- ▶ Health care access, quality and health status are inadequate for large numbers of Virginians
- ▶ Service delivery and payment reform is essential for achieving the triple aim of better health, higher quality of health care, and a lower cost trajectory
- ▶ There is no single, “one size fits all” model of delivery and payment which is universally best for every population and setting of care
- ▶ Some states, communities, and providers are achieving positive change by systematically testing and reproducing models that work

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## **Delivery and Payment Reform: Recommendations**

### **The Commonwealth should:**

1. Articulate a vision for excellence in health, health care, and economic strength for all Virginians, which includes service delivery and payment models
2. Convene multiple stakeholders in collaborative efforts to identify, pilot, and spread effective models of delivery and payment reform
3. Leverage its purchasing power to support improvement in delivery and payment models in state-funded programs
4. Implement policies and regulations to support care delivery models that emerge from 2 and 3

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## **Delivery and Payment Reform: Recommendations**

**The Commonwealth should:**

5. Protect existing health care safety net providers to ensure its continued existence and adjustment to its potentially new patient populations
6. Leverage federal funding (when appropriate) for service delivery and payment initiatives
7. Advocate to federal government for state flexibility to test and spread improvements in service delivery and payment reform

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## **Technology Chair: Geoff Brown**

**What do we know?**

- ▶ Health information is a tool, not an end unto itself
- ▶ Focused on five key health information technology tools: Electronic health record, health information exchange, telemedicine, broadband, and an all payer claims database
- ▶ Virginia is already a leader in Health Information Technology

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## **Technology: Recommendations**

**The Commonwealth should:**

8. Apply to be a Medicare Demonstration site for telemedicine in areas with underserved populations
9. Expand its telemedicine coverage
10. Consider an all payer claims data base via JCHC study
11. Take results of the “mapping” survey and target investments to expand broadband infrastructure and telemedicine
12. Investigate ways for physicians to qualify for loans for HIT capacity

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## **Capacity Co-Chairs :**

**Dr. Dixie Tooke–Rawlins and Shirley Gibson, RN**

**What do we know?**

- ▶ Virginia is projected to have shortages of many health professions prior to the impending coverage expansion under federal health reform
- ▶ The geographic distribution of many health professions is less in rural and some poor urban areas
- ▶ There is considerable interest in the “team concept” of care to help leverage scarce health professionals and improve outcomes and patient satisfaction, while lowering costs
- ▶ State scope of practice laws vary considerably but many are more restrictive than other states and may limit the ability to fully expand the “team concept” in service delivery

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# Capacity

## What do we know?

- ▶ Technology, such as telemedicine and electronic health records, can help with the geographic issues and limited capacity of health professionals.
- ▶ There are not enough nursing faculty and clinical training sites to keep pace with the demand for nurses, especially advanced practice nurses
- ▶ Post-graduate training slots for all professionals and preceptors to mentor them are limited

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## Capacity Recommendations

13. Health workforce capacity will have to be increased to improve access to affordable, high quality care. Recommended at least four pathways:
  - Reorganize care delivery practices into “teams”
  - Change scope of practice laws to permit health professionals to practice up to the evidence-based limit of their training
  - Expand use of information technologies
  - Increase supply of health professionals
14. Secretary of Health and Human Resources should work with private and public organizations to fund studies of collaborative teams

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## Capacity Recommendations

15. The Secretary should develop recommendations on evidenced-based scope of practice changes, expansion of clinical training sites, scholarship and loan forgiveness programs, and how best to attract health care professionals to certain communities
16. The Secretary should designate an agency or entity to serve as a clearinghouse and technical assistance partner for demonstration project applications to the Center for Medicare and Medicaid Services

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## Medicaid Reform Co-Chairs : William Fralin, Scott Johnson

### What do we know?

- ▶ Medicaid/CHIP spending and spending growth is a major strain on the state budget in spite of a lean program in terms of eligibility levels and provider payments
- ▶ The current program covers children, pregnant women, seniors, and individuals with disabilities
- ▶ DMAS has implemented best practices for quality, service delivery, and cost saving strategies

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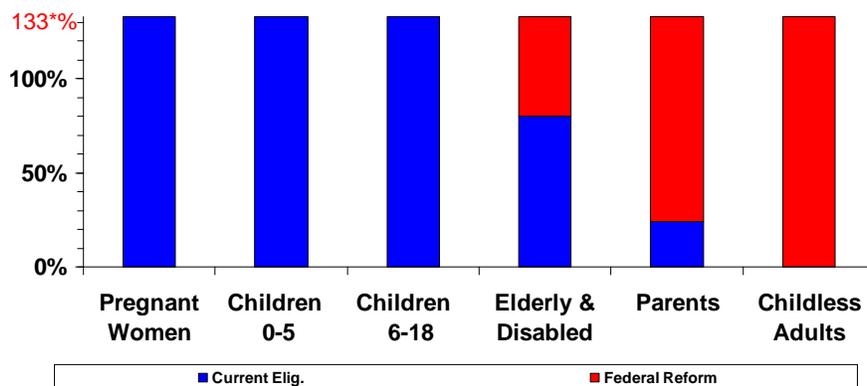
## Medicaid Reform

### What do we know?

- ▶ Medicaid serves a majority of its clients through a managed care model
- ▶ However, the most costly Medicaid patients and services are being served outside a coordinated care delivery model. Seniors and individuals with disabilities make up 30% of enrollees but 70% of the costs
- ▶ The federal health care reform will require more state expenditures in exchange for more insurance coverage

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## Federal Health Reform: Impact on Medicaid Eligibility



\*Does not include 5% income disregard;  
133% of federal poverty is \$14,404 for an individual and \$29,327 for family of four (in 2010)

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## Preliminary Fiscal Impact Estimate of Health Reform on Medicaid/CHIP

Estimate Component	Lower Bound Enrollment Increase	Upper Bound Enrollment Increase
Assumed Enrollment Increase	271,047	425,930
Expansion Cost	\$2,089,443,970	\$2,784,506,651
Reform Savings	\$625,860,262	\$625,860,262
<b>Net Estimated STATE Cost of Reform (SFYs 2010-2022)</b>	<b>\$1,463,583,708</b>	<b>\$2,158,646,389</b>

Note: these costs do not include potential costs associated with reversing eligibility changes prohibited by health reform as contained in the 2010 Appropriations Act

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## Medicaid Reform: Recommendations

17. The Commonwealth should continue to pursue additional care coordination models for geographic areas, clients, and services, including but not limited to behavioral health and long term care services
18. DMAS should work with nursing facilities, hospitals, and physicians to improve the acute medical care needs of nursing facility residents
19. DMAS should continue to evaluate demonstration projects, grants, and state plan options under federal health care reform

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## **Medicaid Reform: Recommendations**

20. DMAS should require fee for service providers to submit electronic claims submissions and receive electronic funds transfers
21. The Medicaid Task Force supports funding and implementation of the Virginia Gateway project, which is the automation of an eligibility system across health and human services agencies
22. DMAS should evaluate the incentives and cost sharing opportunities for the current and expanded Medicaid populations

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## **Insurance Reform Co-Chairs : Dr. Clarion Johnson, Dr. Richard Hamrick**

### **What do we know?**

- ▶ The current state of the insurance market in Virginia, especially for small employers, is unsustainable
- ▶ Many Virginians cannot afford private health insurance and are not eligible for Medicaid; some go without needed care
- ▶ The Bureau of Insurance will need new statutory authority to enforce provisions of the federal health reform law
- ▶ The federal law gives the states many choices regarding the new insurance market place, including the development of a Health Benefit Exchange

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## **Insurance Reform: Recommendations**

23. Virginia should create and operate its own health benefit exchange to preserve and enhance competition
24. Whatever form the Virginia Health Benefit Exchange (HBE) ultimately takes, the task force provided ten factors that should be considered.
25. The General Assembly should amend the statutes to enable the Bureau of Insurance to implement and enforce the immediate market reforms and other applicable provisions of federal health reform
26. The Secretary should obtain grant funding to establish and implement the HBE

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## **Purchaser Perspectives** **Co-Chairs : Monty Dise, Ned Massee (for John Luke)**

### **What do we know?**

- ▶ Employers, combined, pay for more health care than any other single payer
- ▶ Health care costs so much more here than in other countries that US employers are having a difficult time competing with global firms
- ▶ Individuals and families, through out of pocket payments, reduced wages, and taxes, ultimately pay for all of health care, and therefore are purchasers too
- ▶ An unhealthy workforce is less productive and more costly to employers

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## Purchaser Perspectives

### What do we know?

- ▶ Most Virginia employers have fewer than 100 workers. These firms are less likely to offer health insurance.
- ▶ Health care costs are higher—28-50 % higher depending on the measure—in the US because we pay higher prices, perform more invasive procedures, and concern for medical mal-practice lawsuits
- ▶ Far more of the health dollar is spent on hospital and clinicians than on insurance administration but 15% of our higher than expected spending is in that category
- ▶ Costs and premiums are growing faster in Virginia and US and have outstripped state GDP and personal income per capita growth

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## Purchaser Perspectives

### What do we know?

- ▶ Cost growth is driven by 4 main factors: technological changes, reduced cost sharing, the rise in prevalence of chronic conditions, and the aging of the population
- ▶ The return on investment from wellness and prevention activities is beginning to be understood; the federal health reform law supports employer-based wellness and prevention programs
- ▶ According to a Virginia Hospital and Healthcare Association study, health reform's net spending and tax effects would increase the GDP and jobs in Virginia, and the net positive impact would be almost tripled if health care cost growth slows by a little as 0.75% per year

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## **Purchaser Perspectives: Recommendation**

27. The Secretary should work with business leaders, researchers, and private foundations to commission and conduct a representative sampling of Virginia employer opinions about what feature they want in a Health Benefit Exchange and from health care reform generally.

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## **Concluding Recommendation**

28. The Advisory Council should continue its role as fact-finder and sounding board for the Virginia Health Reform Initiative and the Secretary as he works with the Governor and the legislature to implement the recommended steps and develop subsequent proposals throughout 2011.

THE FULL REPORT OF THE ADVISORY COUNCIL CAN BE FOUND AT:  
<http://www.hhr.virginia.gov/Initiatives/HealthReform/docs/VHRIFINAL122010.pdf>

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