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**Report of the  
Advisory Council  
*to the*  
Chairman of the Virginia  
Health Reform Initiative**

**DRAFT**

**December 14, 2010**

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The Virginia Health Reform Initiative would like to acknowledge the Virginia Health Care Foundation for providing start up support towards the work of the Initiative. The continued work has been sustained through the generous funding of the Robert Wood Johnson Foundation. Tremendous thanks to the George Mason University Center for Health Policy Research and Ethics for their overwhelming support and commitment to the success of the Virginia Health Reform Initiative.

## **Executive Summary**

### **Background**

In August of 2010, Governor Bob McDonnell appointed 24 political, health system, civic and business leaders to the Virginia Health Reform Initiative (VHRI) Advisory Council, with these words:

Every Virginian needs access to affordable health care. The challenge is how to provide that access in an economically responsible manner. The recommendations of the Council will help create an improved health system that is an economic driver for Virginia while allowing for more effective and efficient delivery of high quality health care at lower cost.

The VHRI and Advisory Council is chaired and led by Secretary of Health and Human Resources, Bill Hazel, MD. The Advisory Council was asked to develop recommendations about implementing health reform in Virginia, and to seek innovative solutions that meet the needs of Virginia's citizens and its government in 2011 and beyond.

After the Advisory Council's initial retreat, the Governor created six task forces to focus within the six domains that the Advisory Council identified as critical to the success of meeting the Governor's charge: Medicaid Reform, Capacity, Service Delivery and Payment Reform, Technology, Insurance Reform, and Purchaser Perspectives.

### **Vision**

The Advisory Council concluded that the health of Virginians, health system quality/performance, and economic strength are all deeply related. Therefore, the council unanimously supported the following vision for Virginia health reform:

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

The best health care system means not only outstanding quality, superb patient experience, and highly efficient resource use, but also a system in which clinicians want to practice and insurers want to compete. The economic effects of a health care system delivering this kind of value include small employers thriving while providing affordable health insurance and large employers gaining market share against global competition. In short, an excellent health care system would be a competitive advantage for Virginia business of the first order.

Specifically, within 10 years, Virginia should be ranked in the top 10 states in terms of health of the population and the overall quality of its health care system, and in the bottom 10 states in terms of per capita costs and private insurance premiums. Virginia should also be in the top 10 in terms of patient experience and retain well over half of the physicians it trains.

## **Motivation**

A long-standing axiom in engineering is that each system will yield the results it is designed to deliver. As Secretary Hazel asked the Advisory Council in his presentation at the initial Roanoke retreat, “If we keep doing things the same way, how can we expect different results?” Surprising to some and embarrassing to all, Virginia’s overall health system performance is actually quite mediocre. To be sure, there are excellent hospitals, physicians, health centers, and innovative health plans that are working hard to effectuate local and state-wide improvement. Still, it is hard to be proud of a system in which nearly 1 million Virginians – and 150,000 children – lack health insurance and the timely access to quality care that only it can ensure. Something is wrong with a system in which only 37% of small employers offer health insurance to their workers, down from 48% ten years ago. Virginia’s overall quality of care is average, with strengths in cardiac care, hospital care generally, and home health. Weaknesses in Virginia’s quality rankings include nursing home care, diabetes care and maternal and child health. Specifically, Virginia ranks 41<sup>st</sup> in the nation in breast cancer death rates, and 35<sup>th</sup> in infant mortality. None of these statistics measure up to Virginia’s #6 ranking in median family income.

Cost is the main driver of the reform conversation nationally and in the Commonwealth. While overall and hospital spending per capita are lower than the national average, premiums are higher, and both health care cost and premium growth in Virginia have exceeded national averages for more than a decade. Most troubling, health care cost and premium growth continue to outstrip personal income growth by 2 – 3 percentage points a year, so that both care and coverage require greater and greater sacrifice from families and employers, especially small employers, year after year after year. Medicaid is both the largest and the fastest growing state budget item. Health care cost growth in Virginia, as in the nation, is simply unsustainable. So Virginia should be discussing health reform options, independent of federal law changing or staying the same.

## **Findings and Recommendations**

The Advisory Council used the Task Forces to focus on the six domains independently, to allow as deep a dive as time and existing knowledge allowed. Of course some elements are shared by more than one domain. We report the salient findings and recommendations from each Task Force in order.

### **Service Delivery and Payment Reform**

Health care spending is on an unsustainable path. Health care access, quality, and health status are inadequate for large numbers of Virginians. Delivery and payment reform – incentive realignment – is essential for achieving the triple aim of better health (which also requires better access and patient engagement), high quality 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. Promising ones include patient centered medical homes, bundled payments across silos of care, performance and case management bonuses tied to traditional fee for service, and accountable care organizations. Collaborative efforts by providers and communities in Virginia and around the country are demonstrating the transformational potential of the types of delivery system innovations being discussed.

Primary care “teams” hold great promise for better care coordination, better outcomes, more patient engagement and satisfaction, and lower overall system costs. Still, there is not a lot of specificity yet about how best to configure the new models of care for different populations, communities, and organizations. Pilots, demonstration and collaborative learning projects are definitely in order.

Key recommendations for service delivery and payment reform are, the Commonwealth should: define its vision to include service delivery and payment reform models; convene stakeholders, leverage its purchasing power, and implement regulations and laws to play catalytic roles in spreading promising new models of care delivery and system transformation; protect safety net providers, leverage private and federal funds and initiative to advance Virginia goals health system performance.

## **Technology**

Health information technology (HIT) is a tool, not an end. The Council and Task Force focused on five key HIT tools. An electronic health record (EHR) is an electronic version of the traditional patient health record which can be stored and recalled, edited and supplemented with decision support tools like reminders and best practice information, with specific subsets of the record being securely transmittable to those who need it (other clinicians, health plans, the patient) in real time. A Health Information Exchange (HIE) is a clearing house for relevant clinical information from the electronic health record to be shared in real time among patients, their clinicians and hospitals on an as-needed and confidential basis. Telemedicine is the use of medical information, exchanged from one site to another via electronic means, to support medical diagnosis, ongoing patient care, remote patient monitoring. Broadband, a telecommunications signaling method that, with the right infrastructure on both ends and in between, permits the delivery of very large amounts of digital audio and visual information, precisely, instantaneously or in real time. An all payer claims database (APCD), a database that could be constructed from medical, eligibility, hospital, pharmacy, dental, and other provider files and would support analysis of use and spending patterns in specific communities or with specific providers and could also greatly facilitate price and cost transparency for health care consumers.

Virginia is already a leader in many ways in the pursuit and application of information technologies in general and of HIT in particular. The Commonwealth has three regional Health Information Exchanges (HIEs) now and is coordinating federal grants to create a statewide HIE and to coordinate technical assistance so that smaller primary care practices can achieve meaningful use of electronic health records. The Commonwealth may be #1 in the nation in mapping its health providers' access to broadband signals, and will soon be able to target investments in key infrastructure elements very precisely. Statewide broadband access will empower telemedicine, which will also help reduce disparities in access and health as well as leverage scarce and geographically mal-distributed clinical specialists.

Central recommendations for technology are, the Commonwealth should: become a Medicare demonstration site for the use of telemedicine in urban areas; cover telescreening for diabetic retinopathy under Medicaid; construct an all payer claims data base; take the results of the mapping survey and target investments to build and promote the growth of access to broadband and telemedicine services; help small primary care practices acquire small business loans to invest in new technology.

### **Capacity**

Of all the many capacity dimensions, workforce was quickly determined to be the most central to the real time access and coverage expansion challenges (if PPACA is implemented as currently written). Virginia has some professional shortages now that are expected to worsen over time, even without coverage expansion. Geographic mal-distribution may actually be a large problem than overall supply per se. The shortage problem is serious but will be much worse if PPACA's coverage expansion starts on or around 2014.

"Team" delivery of health services was of great interest to the Task Force, though again no single model appeared ideal for all patients. Care teams, especially primary care teams and prospects of more efficient coordination and utilization also raised the contentious but necessary issue of scope of practice limits on the ability of all clinicians to practice to the limit of their own professional capacities. Considerable clinical evidence and a recent Institute of Medicine report supports relaxing some of Virginia's more restrictive scope laws. However, there is not unanimity on this point among Task Force and Advisory Council members nor among the Commonwealth's professional societies. Telemedicine and broadband access will also empower and leverage scarce professionals of many kinds. Limits on nursing faculty and clinical training slots severely hurt the Commonwealth's ability to retain the health professionals it educates.

Key recommendations include acknowledging that health workforce capacity will have to be increased if all citizens of the Commonwealth are to have access to affordable high quality care, now and even more so in 2014 if planned coverage expansions occur. Capacity can be increased in four ways, and Virginia will likely need some version of them all: (1) re-organizing care delivery practices into "teams" that could leverage scarce physician capacity by more extensive

use of non-physicians in ways that are more consistent with their education and training than many current practices permit; (2) changing scope of practice laws to permit more health professionals to practice up to the evidence-based limit of their training; (3) expanding the use of information technologies, like telemedicine, electronic health records and health information exchanges to extend the geographic reach of existing health professionals and enable many to be more productive per unit of time; (4) increasing the supply of health professionals. Additional specific recommendations include: increasing clinical training slots and re-activating loan forgiveness and other programs to increase retention of health professionals educated in Virginia.

## **Medicaid**

The Medicaid Task force heard several key themes throughout the presentations provided at their meetings, including: (1) the Virginia Medicaid program, which served more than one million low-income beneficiaries in 2010 at a cost of more than \$6.6 billion dollars, is a lean program in terms of eligibility levels and provider payments; (2) the Program is well managed and has implemented many best practices for quality, service delivery, and cost saving strategies; (3) in spite of this, the Medicaid program is the second largest budget in the Commonwealth and there are serious concerns about its sustainability, (4) the expansion of the Medicaid program under PPACA will increase the Medicaid enrollment by more than 270,000 new enrollees at a cost to the state of more than \$1.5 billion dollars by 2022, (5) the implementation of PPACA is complex and there are still many unknowns due to lack of federal regulations; and (6) the Virginia Medicaid program must continue to implement reforms in the area of care coordination for the populations and services that are the most costly in the Medicaid program.

Based on the presentations and public comment, the Medicaid Task Force made six recommendations in the areas of care coordination and chronic care management, administration simplification, and eligibility and benefits. The Task Force recommended that the Department of Medical Assistance Services pursue additional care coordination models; work with nursing facilities, hospitals, and physicians on strategies for caring for nursing facility residents; evaluate and pursue potential federal reforms for chronic disease management and care coordination; require providers to submit claims and receive payments electronically; and explore cost sharing opportunities for the expanded Medicaid population. In addition, the Task Force supported the funding and implementation of a streamlined eligibility system across all publicly funded health and human services.

## **Insurance Reform**

The current state of the insurance market in Virginia, especially for small businesses, is unsustainable. Many Virginians cannot afford private health insurance and are not eligible for Medicaid, and despite the best efforts of those in Virginia's elaborate safety net, some go without needed services as a result. The Virginia Bureau of Insurance (BOI) will need new statutory authority to enforce some elements of the new federal reform law that went into effect

September 23, 2010. No one thinks the regulation of insurance carriers should be taken out of the BOI and put in any new Health Benefits Exchange (HBE). The HBE that the new federal law requires to be operational by 2014 is for those without employer offers of insurance and for those in small firms (less than 50 full-time workers in 2014 and less than 100 in 2016) that choose to use the HBE rather than health plans that will be sold outside the HBE.

According to the best data available, roughly 2.6 million people are likely to be theoretically eligible to enter the exchange in VA in 2014, or 56% of the current private insurance market. The HBE and Medicaid will have to coordinate eligibility and enrollment determination very closely, since many will be eligible for both at different times.

Designing a HBE requires many decisions, the most important of which are: Whether to have a state or federal HBE? (assuming state, as the Task Force and the Advisory Council as a whole have already recommended) Will it be a government entity or a non-profit? If government, will it be a new or within an existing agency? If non-profit or independent, how will it be governed? Will individual and small group markets in the HBE be combined or kept separate? How small will “small” be in 2014, and after 2016 (when firms larger than 100 could come in with state permission) Will the HBE be state-wide, a set of contiguous sub-state HBEs, or one large multi-state HBE? Will the HBE be an “active” or a “passive” purchaser or setter of competitive rules within the HBE? What other actions might the state choose to take to minimize the risk of adverse selection into the HBE ? (i.e., to avoid the HBE becoming a dumping ground for poor health risks).

The Task Force recommended that Virginia create and operate its own HBE to preserve and enhance competition. The Governor and legislature should work together to create a process to work through the various issues in detail, with broad stakeholder input, in time for implementation to satisfy the timing requirements of the federal law. Whatever specific form the Virginia HBE ultimately takes, there was broad agreement about what the HBE should achieve in practice, about what would be considered a successful HBE: Provide small employers with an opportunity to be financially successful while providing health insurance to their workers; Provide a marketplace that works well for those without insurance today; Provide a marketplace that facilitates the transformation of the delivery system to produce more value per dollar spent, by focusing on quality and transparency; Transparency in all things should promote choice, stability and innovation; The HBE must address the cost of health care and the competitive disadvantage that small firms and ultimately all US firms labor under now. We should not miss an opportunity to explore how the HBE can help on the cost front; The HBE should help educate employees and employers through a user-friendly website; Individuals and employees should be engaged in their own care as well as in regular wellness and prevention activities; Maximizing effective competition and number of competitors with qualified health plans should be the goal, with absolute transparency about the implications of consumer choices in cost and quality

dimensions. Access to a robust all payer claims database may help us all become smarter consumers together.

Above all: remember to keep it simple, so that small employers and average citizens can understand how to use and benefit from the HBE marketplace

### **Purchaser Perspectives**

The Purchaser Perspectives Task Force was created to enable employers and consumers of health insurance and health care to have their own seat at the table in discussing reform options. Their purview was so broad as to be unlimited, to encourage the free flow of ideas and curiosities. Nevertheless, group discussions led to a coherent set of fact findings and then to a focus on four major questions:

- (1) What is driving high health costs and cost growth?
- (2) What tools are available, existing or in recent legislation, for employers big and small to promote wellness and prevention?
- (3) What is likely to be the impact of health spending and reform on jobs and the economy?
- (4) What insurance options will be available inside and outside the Health Benefit Exchange (HBE) after reform takes place?

Employers, combined, pay for more health care than any other single payer, including Medicare or Medicaid. Health care costs so much more here than in other countries that US employers are having a more difficult time competing with global firms than they used to. Individuals and families, through out-of-pocket payments, reduced wages, and taxes, ultimately pay for all of health care, and therefore individuals are purchasers, too. An unhealthy workforce is less productive and more costly to employers than a healthy workforce, whether they provide health insurance or not.

The following statements or facts are part of the important context of the underlying knowledge base and values of the Task Force on Purchaser Perspectives and the Advisory Council:

- Employers want choice, honest dealings in negotiating premiums, and transparency in price and quality when buying health insurance and health care.
- Employers often lack actionable data from insurers (e.g., on chronic disease prevalence).
- Individuals want choice, fair value and transparency in insurance and care. Some also need subsidies to afford insurance and appropriate care.

- Personal responsibility for health and health care choices must be part of any reformed system.
- The insurance reforms, new taxes, and employer requirements in PPACA will likely increase premium costs, somewhat, for most sponsoring firms in the next few years. Tax credits would lower costs for certain small, lower wage firms. The big unknowns are whether delivery reforms and health benefit exchanges will help lower costs vs. baseline in the long run.

Now to answer their questions, costs are higher – 28-50% higher depending on the measure -- in the US mostly because we pay higher prices than other countries, because we perform more invasive procedures and advanced imaging, and because clinicians here are more worried about medical mal-practice lawsuits for not “doing enough” for a patient. Specific and complex procedures, like transplants, are very expensive, but we still spend most of our health dollar on chronic conditions like heart disease and hypertension, cancer, mental health, and lung diseases. Cost growth is widely believed to be driven by four main factors, listed in order of estimated importance: technological change, reduced cost sharing, the rise in prevalence of chronic conditions, the aging of the population. The return on investment from wellness and prevention activities is beginning to be understood more precisely and promising examples are starting to spread, including in Virginia. The new federal health reform law has a number of provisions that aim to support employer-based wellness and prevention programs. Health reform’s net spending and tax effects would increase GDP and jobs in Virginia, and the net positive impact would be almost tripled if health care cost growth slows by as little as 0.75% per annum. Options for purchasing health insurance inside and outside the Health Benefits Exchange are not clear at this point. Details of these options cannot be known, until the rules of competition within the HBE and outside the HBE are clarified in the next two years, and not until insurers decide what to offer in each market and at what prices, given those as yet undefined rules.

The Purchaser Perspective Task Force concluded its work with one recommendation: that the Secretary of the Department of Health and Human Resources work with small business leaders, researchers and private foundations to commission and conduct a representative survey of Virginia employer opinions about what features they want in a Health Benefits Exchange and what they want from health reform generally. Much of the point and focus of reform is to make health insurance and health care more affordable for small employers and their workers and their families. Therefore policy makers need to listen to the business voice in what they really want HBEs, and reform generally, to accomplish. We note however, it is not easy to obtain a representative sample of business views, especially small business views, for most owners are often too busy running their business to participate in public policy discussions and processes.

## Conclusions

Health reform is a process, and successful health reform is a participation sport. The Advisory Council and Task Forces were created to ensure that the VHRI reflects the values, wisdom, and experience that only a broad array of private citizens, acting in deliberative concert around a common purpose, possess. When coupled with the leadership exhibited by Secretary Hazel, in 4 months the effort has identified 25 specific and evidence-based steps that would move Virginia toward the vision of healthier people, healthier communities, a better health care system, and a stronger economy. The vast majority of these suggested actions are independent of the new federal law. This accentuates the fundamental point that health system reform can be in the Commonwealth's interest regardless of federal actions or inactions.

This report and these observations suggest two broad conclusions.

One, the Advisory Council should continue its role as fact-finder and sounding board for the VHRI and the Secretary as he works with the Governor and the legislature to implement the recommended steps and develop subsequent proposals. Quarterly meetings throughout 2011, wherein the Secretary and others report on progress and findings as they develop, might be the right interval.

Two, given that "health reform Virginia's way" is worth doing regardless of federal law, there should be no unnecessary delay in beginning implementation. Since so many recommendations hold promise to improve quality, lower cost, or make insurance and care more affordable and accessible, opportunities for "early adoption" should be prudently explored and acted upon. For example, the Health Benefits Exchange could be created before 2014 and thereby designed and shaped to fit Virginia's goals and values more than the contours of PPACA as passed in 2010. There would still need to be study and much stakeholder input, but the need to make a more effective marketplace for small employers, their workers and their workers' families has rarely been more self-evident.

## Background

On August 16, 2010, Governor Bob McDonnell appointed 24 political, health system, civic and business leaders to the Virginia Health Reform Initiative (VHRI) Advisory Council, with these words:<sup>1</sup>

Every Virginian needs access to affordable health care. The challenge is how to provide that access in an economically responsible manner. The recommendations of the Council will help create an improved health system that is an economic driver for Virginia while allowing for more effective and efficient delivery of high quality health care at lower cost.

That same day the Governor asked Secretary of Health and Human Resources, Bill Hazel, MD, to chair and lead the VHRI Advisory Council in providing recommendations towards a comprehensive strategy for implementing health reform in Virginia. The VHRI is expected to go beyond federal health reform and recommend innovative healthcare solutions that meet the needs of both Virginia's citizens and government in 2011 and beyond.

On August 20-21, 2010, the Advisory Council held their first meeting in Roanoke. Following the initial meeting, the Governor announced the creation of six task forces, chaired or co-chaired by members of the Advisory Council. The taskforces were created to work within the six domains that the Advisory Council identified as critical to the success of meeting the Governor's charge: Medicaid Reform, Capacity, Service Delivery and Payment Reform, Technology, Insurance Reform, and Purchaser Perspectives.<sup>2</sup>

The Advisory Council issued charges to each task force,<sup>3</sup> and each task force then had an initial conference call, two three-hour face-to-face meetings in Richmond, and each set of co-chairs reported out the recommendations to the Advisory Council at the subsequent retreats in Chantilly, Virginia October 26-27 and in Charlottesville, Virginia December 13-14. All of these activities were open to the public. The deliberations of the Task Forces, as well as of the Advisory Council, benefited from the public comments that were offered at each meeting.

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<sup>1</sup> Johnson, S. "Governor Bob McDonnell Announces Members of the Virginia Health Reform Initiative Advisory Council" August 16, 2010, Available as Appendix A and from:  
<http://www.hhr.virginia.gov/News/viewRelease.cfm?id=315>

<sup>2</sup> Johnson, S. "Governor Bob McDonnell Announces Taskforce Membership of Virginia Health Reform Initiative", September 14, 2010, Available in Appendix B and from:  
<http://www.governor.virginia.gov/news/viewRelease.cfm?id=373>

<sup>3</sup> Links to charges from the Advisory Council to each of the taskforces are available in Appendix B and from:  
<http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

Additionally, many comments came in through VHRI's web portal, were duly noted, and reported out by VHRI staff. This report describes the findings and recommendations of the Advisory Council to the VHRI chair, Secretary Hazel, who will deliver the final report to Governor Robert F. McDonnell.

## **Overarching Vision**

The Advisory Council concluded that the health of Virginians, health system quality/performance, and economic strength are all deeply related. Therefore, the council unanimously supported the following vision for Virginia health reform.:

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

The best health care system means not only outstanding quality, superb patient experience, and highly efficient resource use, but also a system in which clinicians want to practice and insurers want to compete. The economic effects of a health care system delivering this kind of value include small employers thriving while providing affordable health insurance and large employers gaining market share against global competition. In short, an excellent health care system would be a competitive advantage for Virginia business of the first order.

Specifically, within 10 years, Virginia should be ranked in the top 10 states in terms of health of the population and the overall quality of its health care system, and in the bottom 10 states in terms of per capita costs and private insurance premiums. Virginia also should be in the top 10 in terms of patient experience and retain well over half of the physicians it trains.

While many Virginia communities' have strong health systems, several of which are exemplary, significant geographic and socioeconomic disparities exist in health, quality of care, and affordable access. Compounding this reality is the fact that throughout the Commonwealth, health costs are growing faster than business revenue, tax revenue, productivity and household incomes. This mediocre health *system* performance threatens the economic strength of Virginia. Achieving the Advisory Council's vision will require a greater focus on systemic efficiency. Considerable research and concrete examples provided to the VHRI<sup>4</sup> support the conclusion that the keys to improving efficiency, performance, and health over time are: focusing on quality and

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<sup>4</sup> See the presentations made by Len M. Nichols and by Chris Bailey to the Delivery System and Payment Reform Task Force on October 22, 2010, Nichols, L.M., "Delivery and Payment Reform: Examples from Around the Country" Available from:

<http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/DeliveryandPaymentExamples.pdf>

Bailey, C., "System Reform in Virginia: Virginia Context and Experiences" Available from

<http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/SystemReformInVA10-22.pdf>

improving information and incentives for providers, payers and patient alike. Every recommendation of the Advisory Council, as detailed in this report, is designed to further the goal of making high quality care and overall good health affordable and accessible for all Virginians. These two outcomes are directly attributable to a healthier workforce that enables our economy to increase its competitiveness and growth potential.

## **Motivation**

Regardless of the fate of federal legislation, Virginia must examine and determine what can be done to help achieve the charge put forth by Governor McDonnell and the vision of the Advisory Council. There is broad recognition that past and existing government policies, at both the federal and the state levels, have led to or perpetuated the distorted incentives that have produced the inefficient system we have today. It is important to note that despite these perverse incentives, Virginia has several high quality hospitals, physicians, health centers, and innovative health plans that are working hard to effectuate local and state-wide improvement. This report describes some of these more fully below.

Even with impressive examples, it is hard to defend a system when nearly 1 million Virginians – and 150,000 children – lack health insurance and the timely access to high quality care that insurance helps enable. It is also hard to argue a system needs no change when only 37% of small firms (those with fewer than 50 workers) offer their workers health insurance, compared to 48% ten years ago. Virginia’s quality of care rankings are right about the US average, yet Virginia should not be satisfied with a system in which our public insurance programs chronically underpay for services relative to costs, when administrative and regulatory burdens are growing, when fears of medical liability lawsuits are not abating, and when Virginia health care costs and premiums are growing faster than Virginia incomes and faster than health care costs in the rest of the nation. It is hard to square this set of widespread dissatisfactions and mediocre performance measures with Virginia’s median family income ranking of #6 in the nation. It is time for Virginia to lead the nation and not be satisfied with average or below average performance; as the “average” performance of the United States (US) health care system is also unsustainable.<sup>5</sup>

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<sup>5</sup> Uninsured statistics and state median income ranking are taken from <http://www.statehealthfacts.org/profileglance.jsp?rgn=48>, Small firm offer rates are from AHRQ, MEPS-IC tables, state comparison quality rankings are from AHRQ <http://statesnapshots.ahrq.gov/snaps09/dashboard.jsp?menuId=4&state=VA&level=0>, growth rates of health care costs and premiums are computed from CMS and AHRQ data and are reported in “blanket” memo, presented to Purchaser Task Force on November 9, available at VHRI website link. US system being unsustainable can be taken from any number of published statements, including Secretary Hazel’s presentation in Roanoke.

Few would dispute that the main reason health reform has become such a focus of attention is because of seemingly unstoppable health cost growth. Key cost growth statistics for Virginia are reported in the table below.

**Average Annual Growth Rates, over most recent 10 years of data**

Geographic unit	Item	Compound annual growth rate
US	Health care costs per capita	5.5%
VA	Health care costs per capita	6.0%
VA	Personal income per capita	4.1%
VA	Average premium, single employee policies (for small firms only in parentheses)	7.6% (8.0%)
VA	Average premium, family policies in the employer market (for small firm only in parentheses)	7.8% (8.2%)
VA	Average employee premium amount, family policies in the employer market	9.6%
VA	Average family deductible	9.7%

Sources: CMS and AHRQ data. Compound annual growth rates computed from 10 years of data, 1999-2009 for premiums, 1994-2004 for costs, the most recent available at the state level.

This table makes clear that health cost growth has exceeded income growth by over 35% over a ten year period, that premium growth has exceeded health care cost growth consistently, and that premium growth is outstripping economic growth in general. This all leaves employees with compounding problems of lower income growth relative to their out-of-pocket premium costs *and* increasing cost-sharing at the point of service. At the same time, this is exactly why the VHRI was created. Virginia is searching for reform options that show the most promise toward making quality health care affordable for the citizens and taxpayers of the Commonwealth.

**Recommendations of the Task Forces to the Advisory Council**

The narrative and the recommendations are organized by task force. As many Advisory Council members noted repeatedly, many issues are cross-cutting and what is decided or is true in one domain will affect the policy choices and the implications of the choices other domains. Given this, the order of the presentation is somewhat arbitrary. This report begins with Service Delivery and Payment Reform, since all agree that success in that domain is essential for quality health care to be affordable for those who have health insurance now, and even more so for those who are currently uninsured. It will be followed by Technology and then Capacity, for these

three domains are naturally linked, as information systems can leverage any health workforce configuration and thereby improve the potential of the delivery system to enable more health to be enjoyed at lower cost. These sections will be followed by Medicaid and then Insurance Reform, also inexorably linked, as the new federal law's focus on coverage and new eligibility and market rules significantly increases the importance of close enrollment cooperation and financial information sharing between public agencies and private insurance entities. Finally, Purchaser Perspectives offers a cross-cutting set of employer and consumer observations on the entire field of health reform issues and options for the Commonwealth, as VHRI recognizes and supports the administration's focus on job creation and elevating Virginia's ability to compete in a global market economy.

Each section is divided into three parts, to facilitate focus on the bottom lines:

1. What do we, the Advisory Council as informed by the Task Forces, know?
2. What do we still need to know ?
3. What do we recommend for next steps for 2011?

## Service Delivery and Payment Reform

### *What do we know?*

*Health care spending is on an unsustainable path.*

The data in Table 1 make the fundamental point: health care and insurance costs rise each year relative to incomes, and therefore more and more Virginia citizens and businesses, especially small businesses, find it unaffordable. Ever-rising premiums are pushing more and more small employers into the “do not offer” category, and many that have historically offered report they are near the breaking point. Excess cost and premium growth also reduces the competitiveness of large Virginia businesses vis a vis international firms, just as our economy is ever more open and vulnerable to cross-border cost differences. The weaker economy has increased enrollment in Virginia Medicaid and Family Access to Medical Insurance Security (FAMIS). This along with excess cost growth in the Medicare program (which reflects cost growth in the national health care system), explain why public insurance program spending is the main source of structural budget deficits at both the federal and state levels. The status quo spending trajectories are simply unsustainable.<sup>6</sup> Virginia has the opportunity to facilitate a paradigm shift in health system performance if policy makers, health system leaders and business leaders grapple with underlying causes (which this document will address later) and potential remedies.

*Health care access, quality and health status are inadequate for large numbers of Virginians.*

Thirteen percent of Virginia residents, 988,000 people, are uninsured, and despite a vibrant safety net, in 2009 eleven percent of adults reported needing to see a doctor but could not because of cost. Virginia ranks 31<sup>st</sup> in percent of children 19-35 months old who received all doses of five key vaccines, with 80%. Compare that to the estimated 92% of Virginia children who have insurance coverage, and it becomes clear that having insurance alone does not guarantee access to appropriate care.<sup>7</sup>

The Agency for Healthcare Research and Quality (AHRQ) compiles many different measures of quality for its annual national quality report, and overall Virginia’s system appears to deliver

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<sup>6</sup>The President’s Deficit Commission report makes the point clearly.

[http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/CoChair\\_Draft.pdf](http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/CoChair_Draft.pdf)

<sup>7</sup>The facts in this paragraph are from the Kaiser Family Foundation’s analysis of the Current Population Survey available from: <http://www.statehealthfacts.org/profileglance.jsp?rgn=48> and from the Commonwealth Fund C reports of Centers for Disease Control and Prevention/National Center for Health Statistics/ Behavioral Risk Factor Surveillance Survey and National Immunology survey, respectively available here:

<http://www.commonwealthfund.org/Maps-and-Data/State-Scorecard-2009/DataByState/State.aspx?state=VA>.

care on par with national averages. Virginia's measures for hospital care and home health care are strong, as are measures for heart disease. On the other hand, nursing home care, along with diabetes and maternal and child care, are rated as weak.

Areas of strength are:

- certain kinds of cancer screenings,
- appropriate drugs prescribed for certain heart patients at discharge, and
- low rates of hospital-acquired pneumonia.

Areas of specific weakness are:

- pneumonia vaccination rates,
- low percent of Medicare fee-for-service patients who report their most recent doctor visit manifested "best" care experience,
- and high percentages of long-term nursing home residents who lose mobility.

Of particular concern are Virginia's 41<sup>st</sup> state ranking both in deaths from breast cancer and in the percent of diabetics who get a flu shot each year.<sup>8</sup>

In terms of health status and healthy behaviors compared to other states, Virginia ranks 29<sup>th</sup> in mortality amenable to health care, 35<sup>th</sup> in infant mortality, 17<sup>th</sup> in teen birth rate, 27<sup>th</sup> in percent of children who are overweight or obese, right at the national average for overweight or obese adults, 20<sup>th</sup> in suicide death rate, 17<sup>th</sup> in percent of adults who eat fruit two times a day, (at 33%), and 18<sup>th</sup> in percent of adults who smoke. We do rank 7<sup>th</sup> in percent of adults who eat vegetables 3 times a day, but clearly much improvement is possible and necessary in the Commonwealth.<sup>9</sup>

In some ways, the cause for greatest concern to Virginia policy makers is in the large intra-state variation in access to quality care. An overall health and outcomes barometer of the scale of the problem is (combined) years of potential life lost before age 75. This measure averages 6,872 years per 100,000 Virginia residents, about 1% higher than the national average. In Fairfax, this measure is only 3,693, or less than half the state and national average. In Henrico County, the years of potential life lost is within 2% of the national average, at 6,667 days per 100,000, whereas in Emporia County, that measure is 17,212, or more than twice the state and national average, and almost 5 times the rate in Fairfax County.

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<sup>8</sup> <http://statesnapshots.ahrq.gov/snaps09/dashboard.jsp?menuId=4&state=VA&level=0>

<sup>9</sup> All health status data are from Health United States, CDC/NCHS. Will get url in next draft.

A concrete outcome measure that reflects disparities in access to and use of appropriate and coordinated care (including well-informed self-care), is preventable hospital stays among Medicare beneficiaries. The latest available data for Virginia as a whole put that measure at 68 per 1000 beneficiaries, but it varies from 49 in Fairfax, 52 in Henrico, all the way up to 224 per 1000 in Buchanan County. These data suggest that improving access to quality care and health outcomes in the lowest-performing regions of Virginia will increase overall population health and lower the costs of care, two main goals of health reform in general and service delivery and payment reform in particular.<sup>10</sup>

*Service delivery and payment reform is essential for achieving the triple aim of better health (which also requires better access and patient engagement), higher quality health care, and a lower cost trajectory.*

A long-standing axiom in engineering is that each system will yield the results it is designed to deliver. As Secretary Hazel asked the Advisory Council in his presentation at the initial Roanoke retreat, “If we keep doing things the same way, how can we expect different results?” In order for Virginia to achieve real and lasting performance improvement, incentives *and* information about patients and best practices have to be improved, for providers, payers, and patients alike. A laser-like focus on the quality of patient care should always remain paramount, and incentive realignments and information system innovations that are consistent with that focus will be more likely to be successful in Virginia.

*There is no single, ‘one-size-fits-all’ model of delivery and payment which is universally best for every population and setting of care.*

There is considerable interest in examples of interdisciplinary team models that are emerging in Virginia and around the country, but there is an equally intense interest in making sure any new model best fits the population being served. Dual eligibles (for both Medicare and Medicaid, who are the lowest income Medicare beneficiaries) are likely to need a different “team” and types of cross-site coordination than children, high-risk pregnant women, or adult-onset diabetics with heart problems. New models of care delivery that have been identified as worthy of study and tailoring to those specific populations, that is, those with incentives that would support more coordinated and higher quality patient care, include:<sup>11</sup>

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<sup>10</sup> All data in this paragraph come from [www.countyhealthrankings.org](http://www.countyhealthrankings.org).

<sup>11</sup> A good reference document for an introduction to payment reform is (that Harold Miller doc we sent to DS&P reform task force and will soon put on VHRI website?)

Miller, H, “*Network for Regional Healthcare Improvement: (2006, January) From Volume to Value Transforming healthcare payment and Delivery Systems to Improve Quality and Reduce Costs*”, available here: <http://www.nrhi.org/downloads/NRHI-PaymentReformPrimer.pdf>

- variants of the original chronic care model developed long ago by Ed Wagner and his team at Group Health of Puget Sound for managing diabetics and patients with congestive heart failure, hypertension, or chronic obstructive pulmonary disease;
- patient centered medical homes utilizing teams of professionals and focused on primary care;
- integrating primary care with behavioral health;
- accountable care organizations or sets of providers that assume responsibility for the complete continuum of care a defined population might need; community support or collaboration models where best practices are shared in continual improvement environments;<sup>12</sup>
- diverse hospital and specialty care models for specific chronic conditions;
- adding a performance-based case-management fee to regular service fees;
- bundled payments across traditional silos of care (to align the incentives for hospitals and physicians to coordinate the care of complicated patients in the most appropriate settings);
- global payment (a lump sum payment, adjusted for each patient's condition, to provide high quality care to a patient for a specified length of time);
- pay for performance (generally linking payment amounts to quality, patient experience, and total resource use);
- value-based insurance design (i.e., tailoring covered benefits and cost-sharing to maximize the likelihood that consumers and clinicians will make utilization and behavioral choices that are most likely to improve health with minimum necessary resource cost).

*With engagement from multiple stakeholders, some states, communities and providers are achieving positive change by systematically testing and reproducing models that work.*

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<sup>12</sup> For example, Grand Junction Colorado referenced in Nichols presentation to DS&PR, and CCNC, also on VHRI website. Nichols, L.M., "Delivery and Payment Reform: Examples from Around the Country" Available from: <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/DeliveryandPaymentExamples.pdf>

Landcaster, M., "Community Care of North Carolina" Presented to the VHRI Advisory Council, October 26, 2010 in Chantilly, Virginia.

An impressive array of innovations are occurring within Virginia and nationwide. Several national examples include: the Network for Regional Health Improvement Collaboratives, which is focused on improving the quality of care; the Beacon Communities, (selected by the Office of the National Coordinator of Health Information Technology), are producing examples of how to leverage information technology to improve patient care and health; the Institute for Healthcare Improvement's 'How Will We Do That' communities are committed to sharing best practices across the country for communities in pursuit of the Triple Aim; and a collaborative series of state and local multi-payer pilots centered around the Patient Centered Primary Care Medical Home are all pursuing community-based efforts to improve the quality of care delivery, patient experience and health outcomes as well as lower costs. The Robert Wood Johnson Foundation's Aligning Forces for Quality program has these goals as well as that of reducing racial and ethnic disparities in its 17 participating communities. All of these efforts intend to provide examples to drive system improvement that can be replicated and spread. To date, no Virginia community is participating in these efforts.<sup>13</sup>

There are exemplary efforts within Virginia,<sup>14</sup> including ProjectCARE, a joint effort of Greater Virginia Peninsula medical societies, health centers and free clinics, foundations, health departments, and large hospital systems. This model has improved not only access to care but also care quality and lowered system costs through a two-pronged approach. The model focuses on engaging the uninsured in a more patient-centered medical home environment while sharing the burden of uncompensated specialist and hospital care more equitably. Virginia Commonwealth University's Virginia Coordinated Care for the Uninsured (VCC) project has a similar aim and method in the Richmond-Tri-Cities area. The program is connecting the uninsured with regular primary care and thus improving the quality of their care while reducing emergency department use and preventable admissions as well. As a final example, the Carilion Clinic based in Roanoke, an integrated health system with multiple hospitals, clinics, a large medical staff and many collaborating community physicians, is actively engaged in becoming an accountable care organization (ACO). An ACO is a collaboration of physicians, hospitals and

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<sup>13</sup> Further information on these efforts can be found at <http://www.nrhi.org/index.html> , <http://healthit.hhs.gov/portal/server.pt?open=512&objID=1805&parentname=CommunityPage&parentid=2&mode=2&cached=true> , <http://www.ihl.org/IHI/Programs/StrategicInitiatives/HowWillWeDoThat.htm>, <http://www.pcpcc.net/> , <http://www.forces4quality.org/welcome>.

<sup>14</sup> The examples in this paragraph were compiled by Chris Bailey and included in his October 22, 2010 presentation, c.

Bailey, C., "System Reform in Virginia: Virginia Context and Experiences" presented to the VHRI Service Delivery and Payment Reform Task Force, October 22, 2010. Available here: <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/SystemReformInVA10-22.pdf>, Additional information can be found at: <http://projectcareva.org/>, and Brookings-Dartmouth <https://xteam.brookings.edu/bdacoln/Pages/home.aspx>

other health care professionals who are re-organizing care delivery around improving health and reducing overall costs for a defined population. ACOs use quality and cost measurement techniques as well as shared incentives to drive organization-wide improvement. Collaboratives of organizations aspiring to become ACOs are springing up around the country, and Carilion was a charter member this movement.

In addition, Anthem Blue Cross and Blue Shield has implemented a voluntary, but nationally recognized and spreading, performance based payment program for hospitals (Q-HIP). This innovative project has improved patient care and lowered costs and now covers 73 facilities and 95% of Anthem's inpatient admissions in the Commonwealth. They have also instituted an analogous program for cardiology (Q-P3), and now have participating cardiologists who treat 84% of Anthem's heart patients in Virginia. Kaiser Permanente's core delivery model is an example of the "team" concept that so many now find attractive. It leverages a strong focus on primary care health professionals' skills and time through the use of information technology, decision support, and patient education. Another example of the primary care "team" concept was described to the task force by Professor Anton Kuzel of VCU who showed how more effective use of non-physicians can improve primary care practice bottom lines and improve patient care and satisfaction.

Care First of Maryland, DC, and Northern Virginia just unveiled both a primary care medical home method of compensating physicians – which enables primary care physicians to earn more for coordinating care and engaging more with patient care plans -- and a new insurance product – Healthy Blue -- that incentivizes patients to join the new primary care medical homes. Additionally, Community Health Solutions has been coordinating a collaborative effort among community health centers, the Greater Richmond Patient Centered Medical Home project, which has focused on real time quality innovations while spreading best practices. The Medical Society of Virginia has begun an innovative small practice collaborative project that uses the American Board of Family Medicine's recertification process to support individual practices' self-identification of opportunities for systems and patient outcomes improvement. As a final example, Sentara Health System has developed an integrated model of patient care that dovetails with a wellness and prevention program that proved to be so successful with Sentara's own employees they have added it to their commercial offerings for large and small employers alike through their Optima Health insurance product.<sup>15</sup>

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<sup>15</sup> Anthem presentation, "Quality Insights Hospital Incentive Program;" L. Gilbert, "Aligning Hospital and Physician Performance Incentives," *Joint Commission Journal on Quality and Patient Safety* 34(12) (December 2008); Kaiser Permanente presentation, "Kaiser Permanente's Integrated Care Model;" T. Kuzel's presentation to Service Delivery and Payment Reform Task Force; Care First, "Primary Care Medical Home: Program Description and Guidelines;" Community Health Solutions, <http://pcmh.webexone.com/login.asp?loc=&link=>; Medical Society of Virginia <http://foundation.msv.org//Foundation/ChronicDisease/TO-GOAL-Phase-I-CVD.aspx>; Sentara presentation to Purchaser Task Force.

It is important to note that all of these efforts were underway before the new federal health reform law was passed and signed. They signify a growing awareness that transforming care delivery is necessary and possible and should not become a partisan issue. The Advisory Council has tasked the Department of Health and Human Resources with identifying opportunities in the Patient Protection and Affordability Act (PPACA) that could possibly speed the transformation of care delivery in ways that are complementary to the efforts described above, *if* they are implemented wisely and in consultation with states, local communities, and providers on the ground.

### ***What Do We Still Need to Know?***

*How are these innovative models actually going to work?*

While instructive and in some ways inspiring, the nearly overwhelming amount of information presented about care delivery and payment reform possibilities raised as many questions as it answered. The following set of questions are illustrative of those related to some key practicalities that must be addressed before widespread adoption will occur:

- Will the models be administratively simple enough to be adopted and implemented by practicing physicians rather than just by academics or already integrated delivery systems?
- Will the models actually reduce cost growth over time?
- Will the models actually improve health outcomes?
- Will the models reward patient-centered care better than today's system does?
- Will the models reward real value over unproductive volume?<sup>16</sup>
- Will the models reward quality, patient safety, and efficiency?
- Will the models reward continuity and coordination of care across multiple providers?
- Will the models engage patients as informed and responsible partners in their care?
- Will the models engage environmental and community health partners?
- Will the models perform outreach to vulnerable populations?

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<sup>16</sup> Some reformers have defined value as quality / cost. This is a convenient way of working both concepts into focus, but health practitioners notice and worry that a significant *reduction* in quality, if outweighed by a larger reduction in cost, would be interpreted as an *increase* in value by that definition. Therefore they reject this simple definition of value and warn against its widespread use.

- Will the models appropriately incorporate risk (or patient acuity) adjustment?
- Will the models ensure reasonable time frames for implementing practice improvements?
- Will the models provide sufficient payment to support sustained participation by reasonably efficient providers?
- Will the models require provider accountability for quality, cost, and patient experience performance?
- Will the models provide actionable data and feedback to providers?
- Will the models allow providers to share in system-wide savings?
- Will the models recognize and reward best practices while encouraging health care improvement and continual innovation?
- Will the models avoid adverse impacts on the health care safety net?
- Will the models avoid adverse impacts on health professions' training programs?
- Will the models promote equitable access to quality care for all patients with similar conditions?
- Will the models demonstrate potential for dissemination to additional settings?
- Will the models recognize geographic and socio-economic factors in establishing payment and delivery reform systems?

*What is the optimal configuration of care teams and organizational partners?*

Beyond emphasizing primary care, coordinated care across traditional 'silos' or sites of care (e.g., hospitals, physician offices, pharmacies, labs, nursing homes, etc), information systems, and utilizing a wide range of health professionals in multi-disciplinary care teams wherein they can all practice up to the limit of their competence, there is not a lot of specificity about how best to configure new models of care for different populations, communities, and organizations. This uncertainty is one reason so many collaboratives have formed around the country, to spread knowledge faster than traditional research demonstration projects. Virginia communities and health system stakeholders may want to consider joining some of the efforts listed above or to create parallel efforts on their own. The fluidity in the range of models suggests that federal and foundation-funded research and demonstration projects are likely to be forthcoming in the near future.

*What opportunities for advancing the vision of the Advisory Council are embedded in the delivery system pieces of the federal reform law?*

There are many specific delivery and payment reform pilots and demonstration projects that are called for in the new federal law. These reforms include medical homes, bundled payments, and accountable care organizations, many of which can be targeted to specific geographic or patient populations that might have particular appeal in Virginia. Most of these new opportunities have not been fully defined, as they will be directed by the new Center for Medicare and Medicaid Innovation (CMMI) within CMS. CMMI was required by law to be created by January 2011. Because of intense interest in these projects and the time it takes to plan participation in them, an Interim Director was announced November 16, though the office is not expected to be fully staffed and operational until 2011. One of its first projects will be implementing the Medicare shared savings ACO as specified in the federal law (there will be other variants of ACOs piloted later). One of the first tasks of CMMI will be defining the specifications and variants of all the new payment and delivery models. This will be an iterative process with ample opportunities for public comment over the next two plus years. Therefore, there is still time to help shape delivery and payment reform pilots that might be attractive to providers and payers in the Commonwealth, including the state government itself, not only as purchaser for Medicaid and state employees, but also as steward of the quality and efficiency performance of the health care system as a whole.

### ***Recommendations***

*#1. The Commonwealth should articulate a vision, which includes service delivery and payment models, for excellence in health, health care and economic strength for all Virginians that includes service delivery and payment models.*

Ideally, delivery and payment reform efforts should be:

- (a) population based, focused on the measureable health of individual patients and the community in which they live;
- (b) patient centered, from enrollment to care delivery;
- (c) inclusive of mental and dental care as well as medical and nursing care;
- (d) value-driven, emphasizing health outcomes and resource use;
- (e) demanding of personal responsibility even as they promote prevention and wellness;
- (f) informed by stakeholders;
- (g) transferable to other settings and communities;
- (h) engaging of multiple payers;

- (i) aligned across public and private sectors;
- (j) measureable.

*#2. The Commonwealth should convene multiple stakeholders in collaborative efforts to identify, pilot test, and spread effective models of delivery and payment reform. The state should clarify that system-wide costs, not the costs of a particular segment, is the proper cost-metric for evaluation. The Commonwealth should also ensure that the same performance metrics be used to evaluate all models, including the status quo.*

Employers and consumers/patients are particularly important stakeholder voices that need to be at the table. Coordinating, facilitating, and evaluating the collaborative efforts could be a catalytic role that could spread best practices quicker than traditional mechanisms.

*#3. The Commonwealth should leverage its purchasing power to support improvement of delivery and payment models in state-funded programs.*

Between Medicaid, FAMIS, and the state employee benefits program, Virginia state government is the largest single buyer of health care and health insurance in the Commonwealth. Therefore, it should be an active innovator and user, not a passive observer, of incentive realignment and information system tools, whether they are developed by health plans, providers, or researchers.

*#4. The Commonwealth should implement policies and regulations as necessary and provide prudent support of care delivery models that emerge from recommendations #2 and #3.*

This could include but should not be limited to scope of practice, anti-trust, and malpractice laws.

*#5. The Commonwealth should protect the existing health care safety net to ensure its continued existence and adjustment to its potentially new patient populations of focus through the transition period to 2014 and beyond..*

Some of highest performing elements of the current system in Virginia are some of its federally qualified health centers (FQHCs) and free clinics. They have long served much of the population that is most likely to gain coverage as a result of the new federal law. FQHC's and free clinics may continue to better serve these individuals with more purchasing power in their current patients' hands. It is also likely that there will be many who remain without coverage and will need a safety net.

*#6. Where appropriate, the Commonwealth should leverage federal funding and policy initiatives to advance Virginia initiatives for service delivery and payment reform.*

The state may be uniquely able to serve or to designate some other entity to serve as a catalytic clearinghouse for grant or collaborative opportunities that would advance the vision of the

Advisory Council.

*#7. The Commonwealth should advocate to federal policy makers for state flexibility to test and spread improvements in delivery system and payment reform.*

In order to make forthcoming pilot opportunities more attractive to Commonwealth providers and the state government, appropriate flexibility is needed from the Federal government. Virginia needs to be able to tailor delivery and payment reform pilots to fit conditions that are relevant to the diversity of the health systems across the Commonwealth and the nation. The federal government is not likely to incorporate optimal flexibility unless it is educated about the implications of diverse local conditions by knowledgeable and interested parties. The Commonwealth itself may be among the most knowledgeable and interested party in this potential conversation.

DRAFT: CONFIDENTIAL

## Technology

There are many forms of health technology. For the purposes of the VHRI, the Advisory Council felt that the most salient is health *information* technology (HIT).

### *What do we know?*

*Health information technology is a tool, not an end in itself.*<sup>17</sup>

Health information technology is a wonderful thing, but technology alone is not going to help patients. Health information technology is in fact a potentially powerful set of tools. The purpose of the tools is to enable citizens, providers and health plans to improve health, health care, the efficiency of care delivery, and the efficiency of insurance enrollment and administration, so that delivery system efficiency can help the Commonwealth's economy thrive. One fundamental idea is to reduce unnecessary information processing and reduce wasteful activities so that everyone involved can focus on the patient's health, and therefore spend less time waiting for, looking for or tediously re-producing data and information, or what may be worse, acting without full but available information.

The goal of a robust health information technology platform is to enable every clinician-patient encounter in the Commonwealth to be informed by the combination of complete, up-to-date patient records and best practice information for that condition and type of patient. This will increase the likelihood that the joint decisions made by patients and their clinicians are the absolute best that can be made for that patient at a specified point in time. The ultimate vision is to enable significant and measureable improvement in population health, including reductions in socio-economic and geographic disparities, through a transformed health care delivery system while ensuring privacy and security protections.

Based on what is happening in some parts of the country and what the spread of meaningful use of HIT could bring, the Office of the National Coordinator of Health Information Technology (ONCHIT) has laid out an "achievable vision" for 2015:

- a million heart attacks and strokes prevented, so that heart disease is no longer the #1 killer in the US;
- a 50% reduction in medication errors, one of the major reasons for preventable deaths;

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<sup>17</sup> This statement and much of this section is liberally drawn from Geoff Brown's presentation in Roanoke.

Brown, Geoff, "Vision for Meaningful Use/HITECH Act" presented to the VHRI Advisory Council, August 20, 2010, Roanoke, Virginia. Available from:

<http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/technology.pdf>

- the racial and ethnic gap in diabetes control halved; preventable hospitalizations and readmissions cut by 50%;
- all patients have constant access to all of their own patient information, and patient's end of life preferences will be followed more often;
- all public health departments have real time situational awareness of disease outbreaks.

These achievements will go a long way toward realizing the potential of HIT.

Health information tools will need to be shared among patients, clinicians, and payers. Individual patient records, medical claims, and decision support tools based on aggregated data and research all have important roles to play in informing individuals, clinicians, payers and policy makers about choices they all have to make.

#### *Focus Areas and the Relationships Among Them*

The Technology Task Force and Advisory Council focused on five key HIT tools.

1. Electronic health record (EHR), an electronic version of the traditional patient health record which can be stored efficiently and recalled, edited and supplemented with patient-centric decision support tools like reminders and best practice information, with specific subsets of the record being securely transmittable to those who need it (other clinicians, health plans, the patient) in real time;
2. Health Information Exchange (HIE), a clearing and storehouse for relevant clinical information from the electronic health record to be shared in real time among patients, their clinicians and hospitals on an as-needed and confidential basis;
3. Telemedicine, the use of medical information, exchanged from one site to another via electronic means, to support medical diagnosis, ongoing patient care, remote patient monitoring;
4. Broadband, a telecommunications signaling method that, with the right infrastructure on both ends and in between, permits the delivery of very large amounts of digital audio and visual information, precisely, instantaneously or in real time; and
5. All payer claims database (APCD), a database that could be constructed from medical, eligibility, hospital, pharmacy, dental, and other provider files and would support analysis of use and spending patterns in specific communities or with specific providers and could also greatly facilitate price and cost transparency for health care consumers.

These tools are interrelated. For example, access to broadband instantly increases the geographic reach and clinical scope of telemedicine. This access provides rural and traditionally

underserved populations much easier and lower cost access to high quality specialty care. (The spread of broadband and telemedicine in turn has implications for delivery and payment reform as well as for optimal patient care teams and strategic investments in health workforce training, as will be discussed in the Capacity section). A state- or nationwide network of health information exchanges would permit clinicians in any location to access key items from a patient's electronic health record that might save his or her life or otherwise vastly improve patient care in an emergency or real time situation. Additionally, the ability to access patient records will be helpful in enhancing the effectiveness of patient office visits since it is common for patients to be referred to specialists or other providers. The use of HIEs to share patient records can also be helpful for a primary care physician to see what other providers the patient has seen.

Broadband access can also expand the reach of HIEs as HIEs provide telemedicine practitioners with access to the patient record. This enables improvement of patient care in real time and thus increases both the efficacy and efficiency of our overall health care system. Finally, analysis of all payer claims data might show regional (sub-state) variation in health service use or pricing patterns that could indicate areas for focus for local patients, provider stakeholders, and payers alike.

#### *Mapping Broadband in Virginia*

*Virginia is already a leader in many ways in the pursuit and application of information technologies in general and of HIT in particular.*

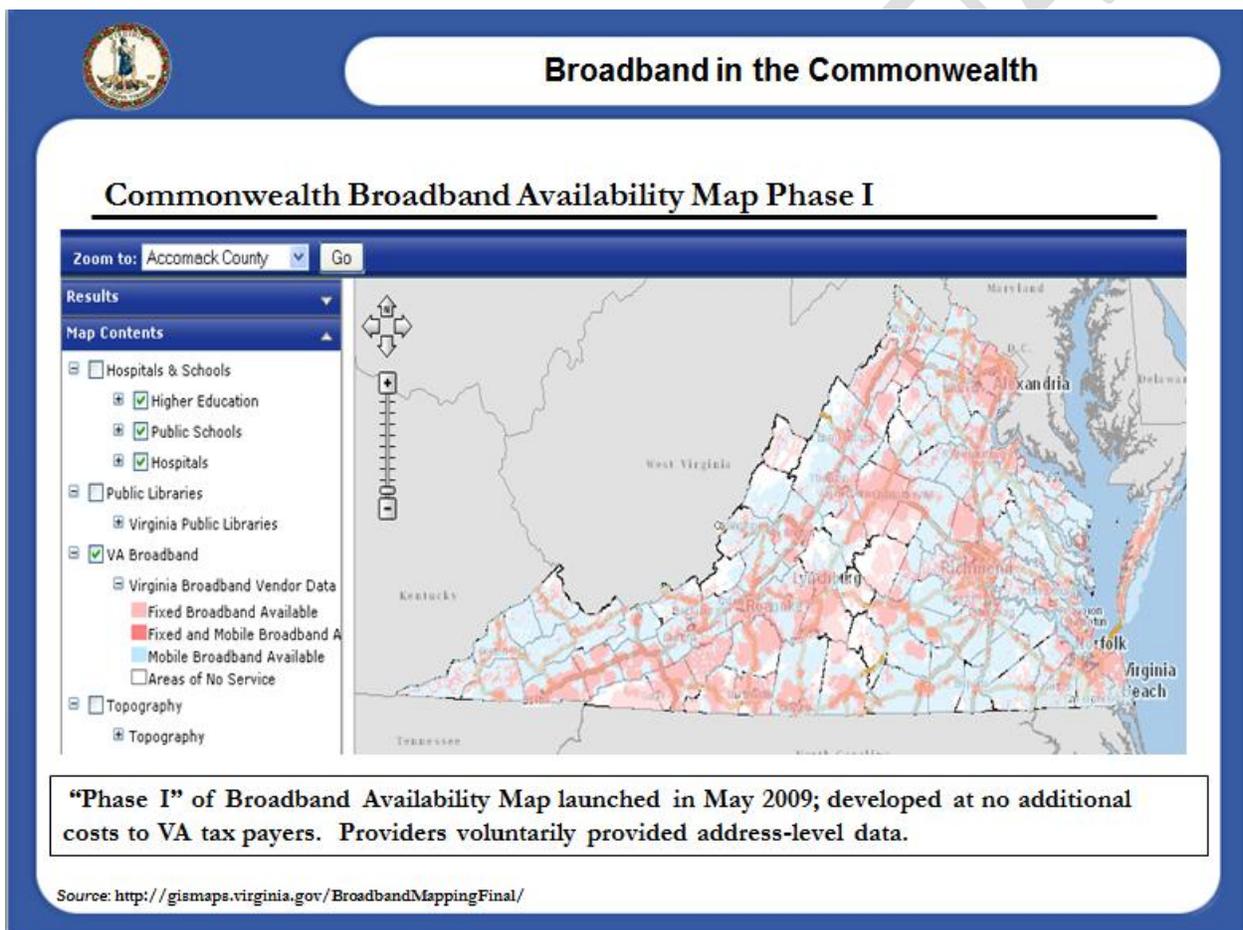
Access to broadband is highly important as the type of connectivity to the HIE effects the speed and ability of the system to receive information from and provide information to the system. For example, dial up, dsl, and T-1 lines all function at different speeds, and can handle different amounts of data, both factors affect the experience of the user. Therefore it is important to learn where broadband infrastructure is available and what areas lack access in order to find out where we need to expand Virginia's infrastructure. When planning the expansion of broadband, it will be useful for both the organization installing the lines as well as for hospitals and physician offices to be included in the routes<sup>18</sup>

In 2009 Virginia undertook a project to create a detailed map of the broadband infrastructure in the Commonwealth. The broadband map, released in May 2009, was the first in the nation and was created by overlaying a number of community organizations where broadband access is

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<sup>18</sup> Jackson, Karen, "Broadband, Virginia Style" Presentation to the Technology Task Force, Virginia Health Reform Initiative, October 22, 2010, Richmond Virginia. Available from:  
<http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

highly useful. The organizations are categorized by symbols as displayed on the map key and include: hospitals, K-12 schools, institutions of higher learning, and libraries. The project was conducted with existing resources with data collected through voluntary corporation of broadband service providers. The state released a web-based version of the map with interactive features to overlay the specific community organizations above as well as the ability to focus in on any county or city in the state in order to get a better view of the status of a specific community. It is important to note, that building out broadband infrastructure is a continuing process and therefore the map is already outdated, however, it is helpful in determining access to broadband services. Below is a snapshot view of the Virginia Broadband Map from 2009. The interactive map can be found at: <http://gismaps.virginia.gov/BroadbandMappingfinal><sup>19</sup>



<sup>19</sup> Map is taken from: Jackson, Karen, “Broadband, Virginia Style” Presentation to the Technology Task Force, Virginia Health Reform Initiative, October 22, 2010, Richmond Virginia slide 6. Available from: <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

The Commonwealth is in the process of updating the map with a grant from the National Telecommunications and Information Administration (NTIA). These updates will allow the Commonwealth to continue studying and mapping broadband access in Virginia. The project and grant are being coordinated by the Office of the Secretary of Technology (OST) for the Commonwealth.

The American Recovery and Reinvestment Act of January 2009 (ARRA) tasked the Federal Communications Commission with developing a national broadband plan which “Shall seek to ensure that all people of the United States have access to broadband capability.” The OST is partnering with the Virginia Center for Innovative Technology, the Virginia Geographic Information Network, and Virginia Tech to use federal funds for a statewide broadband access survey for the purpose of creating a current map, for planning for broadband use, and for technical assistance to communities and users. In fact, the NTIA is so impressed with Virginia’s broadband mapping activities to date they have made Virginia’s survey and methods a template for other states to use as the broadband mapping work proceeds across the country.

### *Electronic Health Records and Electronic Health Exchange*

Some physician offices, federally qualified health centers, hospitals, and pharmacies use electronic prescribing and computer-assisted physician order entry, a smaller number use full electronic health records, and a much smaller number have interoperable health records that can be shared with most other health professionals if certain patient needs arise. There are a variety of current activities to encourage and assist physicians and hospitals to purchase and adopt Electronic Health Record (EHR) systems. Some of these activities will be discussed in this section.

Virginia already has three regional HIEs – CareSpark, which spans parts of southwest Virginia and eastern Tennessee and enables physician offices, hospitals, public health departments, pharmacies, laboratories, and imaging centers to communicate electronically to improve patient care and safety while reducing costs; MedVirginia Solution, a Richmond area and community-based HIE which provides the technical infrastructure to collect hospital, physician, lab, and pharmacy data and organize into one single electronic chart that authorized users can access from a user-friendly and secure web portal; and Nova RHIO (Northern Virginia Health Information Organization), which just launched the connecting hospital emergency departments with the patient’s medication history to minimize confusion and avoidable medication errors patients.<sup>20</sup>

The HIE is a method of connecting separate electronic health record systems together in order to allow providers to access their patients records which have been produced by other physicians or

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<sup>20</sup> Current HIT Initiatives in the Commonwealth of Virginia, Health IT Efforts in Virginia, provided to the Technology Task Force and Advisory Council, Excerpt from “COV-HIE Strategic and Operational Plan, July 30, 2010, Full Report available from: <http://www.hits.virginia.gov/> .

providers. The Commonwealth of Virginia HIE will have standards by which smaller HIE's will be certified to link to the statewide network. The pathway to creating access to patient's multiple EHRs created by multiple clinicians in Virginia is different than at least some other states such as our neighbor Maryland. While Virginia currently has three Regional HIE's, Maryland has taken a statewide approach from the beginning of their HIE.<sup>21</sup> Maryland has a single statewide HIE used to connect the individual physicians, hospitals, and other clinical providers to the available records of their patients. However, despite differences in overall design, the goals are similar, to allow access to patients health information in real time. As in Virginia, physicians, hospitals, etc. are free to use a variety of electronic health record programs and vendors. In Virginia, it is likely that the current regional HIEs will continue to be important and therefore Virginia may have regional HIEs feeding into the overall statewide HIE. In addition to the regional multi-player RHIO systems, Virginia may also have Enterprise HIE networks which will feed into the statewide network. An Enterprise HIE is a network within a health system with a fully developed EHR system, which may already be linking hospitals with physician offices, or hospitals with other hospitals and/or outpatient facilities within their organization.<sup>22</sup> Virginia health systems and hospitals are currently at different stages of development and implementation of EHR systems. Sentara, a large health system mostly in Eastern Virginia has one of the most comprehensive hospital EHR systems in the nation.

Although our pathway and ultimate HIE network will likely have a different structure than Maryland, we can learn from the Maryland information exchange some of the useful tools that an HIE can provide. The Maryland system utilizes three major methods for sharing and receiving information on patients. These include: the ability to push, query, and subscribe for alerts. These three components are all designed to allow authorized physicians and clinicians easy and timely access to a patient's healthcare record. The components help clinicians to communicate with each other through the push method, for example; a clinician can send a particular patient's record to another physician to which s/he is referring. The original physician can then subscribe

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<sup>21</sup> Horrocks, David, "Chesapeake Regional Information System for our Patients (CRISP)", Presentation to the Task Force on Technology, Virginia Health Reform Initiative, October 22, 2010, Richmond, Virginia Available from: <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/crisp.pdf>

<sup>22</sup> Barnes, Kim, Discussion of the COV-HIE, Task Force on Technology, Virginia Health Reform Initiative, October 22, 2010, Richmond Virginia

"Current HIT Initiatives in the Commonwealth of Virginia, Health IT Efforts in Virginia", provided to the Technology Task Force and Advisory Council, Excerpt from "COV-HIE Strategic and Operational Plan, July 30, 2010, Full Report available from: <http://www.hits.virginia>.

to the patients record to receive notice when new records are added to the patient's record and then retrieve the notes posted by the consulting physician.<sup>23</sup>

Over a year before federal health reform legislation passed the Congress, the ONCHIT decided to use the incentives embedded in the ARRA to jumpstart both HIEs and Regional Expansion Centers. RECs are being funded and created to provide HIT technical assistance to primary care physician practices. In addition, the US Center for Medicare and Medicaid Services (CMS) immediately began using ARRA incentives to link ONCHIT's definitions of "meaningful use" to provider incentives to adopt interoperable EHRs. Most anticipate that eventually, demonstrated meaningful use will be necessary to be paid full price by Medicare.

Meaningful use standards are criteria which are designed to, "realize the true potential of eHRs to improve the safety, quality, and efficiencies of care."<sup>24</sup> The Meaningful Use Standards can be phased in by an eligible provider over two years. The phase in is designed to encourage implementation of EHRs by Physicians by helping them reach the minimum requirements for the additional reimbursement for use of electronic health records. The phase in requirements include mandatory core features and a set of optional features. In order to qualify for certification to receive the incentive payments, the provider must meet all core features and a minimum of five of the optional features. Examples of core requirements include:

- Recording patient demographics, vital signs and chart changes,
- Maintain up-to-date problem list of current and active diagnoses,
- Maintain active Medication list,
- Maintain smoking status for those over age 13,
- electronic prescribing of medications,
- ability to provide patients with an electronic copy of their health information (including diagnostic-test results, medication list, problem list),
- implement drug-drug interaction checks,

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<sup>23</sup> Horrocks, D., "CRISP" presentation to the Technology Task Force, Virginia Health Reform Initiative, October 22, 2010, Richmond, Virginia. Available from:  
<http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/crisp.pdf>

<sup>24</sup>Both Quotes and information in this paragraph from: Blumenthal, D, Tavenner, M., "The "Meaningful Use" Regulation for Electronic Health Records", The New England Journal of Medicine" August 5, 2010; 363;6 p.501-504.

- ability to electronically exchange key clinical information among providers and patient-authorized entities.

Additionally each EHR system must utilize at least five capabilities from a list of ten items. Examples of capabilities include the ability to:

- generate list of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach,
- use EHR to identify patient-specific education resources and provide as appropriate,
- Provide summary of care record for patients referred or transitioned to another provider or setting,
- submit electronic immunization data to immunization registries or immunization information systems,
- send reminders to patients for preventive and follow-up care.

The state secured and is coordinating \$24 million in HIE and REC grants from the federal government in order to create a statewide HIE and provide technical assistance so that smaller, primary care physician practices can achieve meaningful use of EHRs within the time frame envisioned by ONCHIT and CMS. (The standards for meaningful use rise over time, from capturing and sharing data in 2011 to improved patient outcomes by 2015).

Virginia's Health Information Technology Advisory Commission (HITAC), supported by the Office of Health Information Technology, a joint initiative of the Secretaries of Health and Human Resources and of Technology, is responsible for building trust and support for a statewide approach to HIE, for ensuring that an effective model for HIE governance and accountability is in place, for encouraging the proliferation of telemedicine, and for monitoring the support of activities associated with REC grants in Virginia. The Medical Society of Virginia, the Virginia Hospital and Healthcare Association, and the Virginia Community Healthcare Association are active and supportive of EHR, HIE and 'meaningful use' activities, which is a major advantage for Virginia. Both the University of Virginia and Virginia Commonwealth University have telemedicine programs that together serve about 37,000 patient encounters each year. The UVA program alone saved patients 5.6 million miles of travel.

### *Price Transparency*

Finally, Virginia has already created a non-profit entity to facilitate price transparency, Virginia Health Information (VHI). VHI is a contractor to the Department of Health in fulfilling legislative mandates to pursue transparency in health care cost and quality, and the state supplies about half of its budget (the rest comes from sales of data products and services). The VHI, with

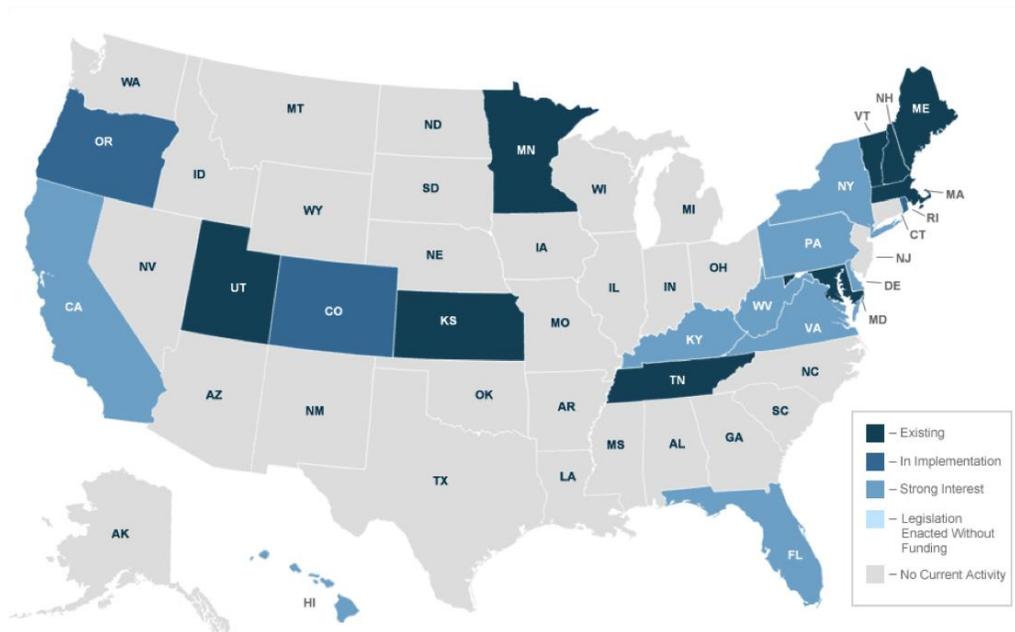
limited authority to compel private providers to supply data, supplements what it can collect with data compiled and analyzed by national organizations (e.g., AHRQ, NCQA), and provides some convenient “comparison shopping” opportunities, in both price and quality dimensions, for patients choosing hospitals, ambulatory surgery centers, certain physicians, nursing homes and assisted living facilities. It also supplies average allowed charges for common procedures by commercial carriers in Virginia, to help consumers benchmark against prices they are quoted or charged.

Several states have developed an All Payer Claims Database, APCD, which is derived from data provided to states from a variety of third party payers of healthcare services.<sup>25</sup> Most APCD’s are state run and can mandate that the payers provide certain data. The data comes directly from the payers existing databases for receiving and processing health care claims. A few states have voluntary databases, however, these are not as comprehensive and generally are more restrictive in sharing the information with the public. Below is a map which shows states with operating APCD as well as states in some stage of the process from studying the idea to full implementation.

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<sup>25</sup> Prysunka, A. M., “All-Payer Claims Databases” presentation to the Technology Task Force, Virginia Health Reform Initiative, November 16, 2010 Richmond, Virginia. Available from:  
<http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

# Status of State Government Administered All Payer / All Provider Claims Databases



11

As the map above shows, states which have mandatory APCD are spread around the country and include diverse states such as Maine, Utah, Kansas, Tennessee, Minnesota, Vermont and New Hampshire. Many states which have APCD are finding them very useful and recommend them to other states. Understanding the value of such, the VHRI acknowledges that an APCD would allow Virginia to build on our current VHI system and enhance the knowledge of our health care system for better understanding, transparency of cost, and service performance. This will allow consumers the ability to have informed choice when choosing their healthcare providers and facilities. This information will also help health care providers, insurance companies, self funded plans, and others to identify areas for improvement and better know how they are competing in the market-place. Below is an example from the Maine APCD. The example compares charges with payments for a variety of healthcare services in Maine<sup>26</sup>

<sup>26</sup> Prysunka, Alan M., "All-Payer Claims Databases" slide 33 , Presentation to the Technology Task Force, Virginia Health Reform Initiative, November 16, 2010 Richmond, Virginia. Available from: <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

Maine HealthCost Maine Health Data Organization

Home    Definitions/Methodology    Statewide Prices    Procedure Prices    Providers/Procedures



## STATEWIDE PROCEDURE PAYMENTS

**Description:** The chart below contains statewide pricing information across all insurance carriers and all medical providers. The chart provides average total charge and payment information, and the individual professional and facility components.

**Data used for report:** 12/01/2005 through 12/27/2007

Procedure Description	CPT-4 Procedure Code	Average Professional Charges	Average Professional Payments	Average Facility Charges	Average Facility Payments	Average Total Charges	Average Total Payments
Arthroscopic Knee Surgery (Outpatient) <a href="#">View Histogram</a>	29881	\$2,998	\$1,493	\$4,221	\$3,698	\$7,219	\$5,191
Biopsy - Breast (Auto Vacuum) <a href="#">View Histogram</a>	19103	\$1,475	\$671	\$2,502	\$2,190	\$3,977	\$2,861
Bronchoscopy <a href="#">View Histogram</a>	31622	\$4,338	\$2,203	\$7,304	\$6,559	\$11,643	\$8,762
Carpal Tunnel Release <a href="#">View Histogram</a>	64721	\$1,729	\$898	\$2,341	\$2,034	\$4,070	\$2,932
Colonoscopy <a href="#">View Histogram</a>	45378	\$751	\$349	\$1,223	\$1,054	\$1,974	\$1,403
Colposcopy With Biopsy <a href="#">View Histogram</a>	57454	\$618	\$355	\$271	\$258	\$889	\$613
CT - Abdomen <a href="#">View Histogram</a>	74160	\$288	\$101	\$1,164	\$951	\$1,452	\$1,053
CT - Chest <a href="#">View Histogram</a>	71260	\$289	\$93	\$1,140	\$968	\$1,429	\$1,061
CT - Head (Without Contrast Material) <a href="#">View Histogram</a>	70450	\$178	\$66	\$797	\$652	\$974	\$718
CT - Pelvis <a href="#">View Histogram</a>	72193	\$251	\$90	\$1,042	\$852	\$1,293	\$942
Gallbladder Removal <a href="#">View Histogram</a>	47562	\$3,442	\$1,907	\$7,573	\$6,643	\$11,016	\$8,551
Hernia Repair (Outpatient) <a href="#">View Histogram</a>	49505	\$2,117	\$1,323	\$4,998	\$4,358	\$7,115	\$5,681
Kidney Stone Removal <a href="#">View Histogram</a>	50590	\$3,053	\$1,466	\$6,566	\$5,578	\$9,619	\$7,044
Mammogram (Screening) <a href="#">View Histogram</a>	76092, 77057, 60202	\$81	\$50	\$140	\$127	\$221	\$177
MRI - Back <a href="#">View Histogram</a>	72148	\$318	\$117	\$1,288	\$1,048	\$1,606	\$1,166
MRI - Knee <a href="#">View Histogram</a>	73721	\$253	\$109	\$1,162	\$973	\$1,416	\$1,083

Source: ME Health Data Organization

Copyright 2009-2010 APCD Council, NAHDO, UNH



APCD's allow data analysis of significant numbers of claims from multiple payers which can be used to identify service use rates in general and by specific diagnosis, as well as the actual prices paid for services. The data can often support sub-state analysis, which is very useful since almost all health care markets are local, not statewide. APCDs can be useful tools in tracking the performance of local delivery systems and in helping communities – providers, payers, and patients alike -- decide where they would like to focus improvement efforts in care delivery and efficiency.

The main national APCD organization is now conducting a study to determine what data each state is collecting, with the goal of creating a standardized data set that will maximize value to consumers and minimize the burden on payers and providers. This will be helpful to data contributors as the number of states using APCD continues to rise. The experience of other states shows that APCDs can help to answer many questions that health policy makers and consumers have about local health systems' relative performance.

### ***What do we still need to know?***

*How “wired” are Virginia health care providers and patients at the present time?*

The broadband “mapping” survey being conducted by the OTS will answer this question by early 2011. Knowing what fraction of physicians, clinics, and hospitals have EHRs and web-access now will help stakeholder and policy makers assess the pace at which care delivery processes can change more accurately than they can at the present time.

*What is the current extent and quality of broadband access?*

The broadband “mapping” survey being conducted by the OTS will answer this question by early 2011. This is extremely important information to leverage ongoing private investment and to guide limited public funds in laying more broadband cable infrastructure for maximum strategic advantage to the Commonwealth.

*How fast will EHRs and HIEs spread with existing federal subsidies and incentives for adoption and with the current highly active state facilitation roles being played by OTS and DHHR?*

This is a key question, for the transformational possibilities of HIT on care delivery are not possible if most providers are not using interoperable EHRs that can transmit information through HIEs.

*How might expanded broadband and telemedicine capabilities affect the configurations of optimal care delivery teams in different geographic regions and for different patient populations?*

There are chicken-egg issues here that require simultaneous analysis with full information among the entire range of possibilities.

*How much would an APCD cost the state and the private sector? How might it complement or strengthen the VHI and benefit the Commonwealth specifically?*

These questions in a slightly different form have led to a request for a study by the Joint Commission on Health Care staff, which is now underway. The due date is November 2011. Nine states already have APCDs and three more are implementing at this time. Reports from individuals heavily involved with the the APCDs in Maine and Utah, to different task forces, indicated that employers and purchasers in both states find the APCDs helpful in providing more transparency for consumers and in developing provider contracting and benefit design strategies.

***Recommendations:***

(Note: There were 7 recommendations under Delivery System and Payment Reform.)

*#8 The Commonwealth should apply to become a Medicare Demonstration site for the use of telemedicine in urban areas.*

Some urban residents also have trouble accessing certain specialists, and this program could significantly reduce barriers to that access. Virginia has a strong and successful network for

telemedicine and this could be expanded into urban areas. IT is relatively inexpensive to set up an exam room with telemedicine equipment, as little as \$5,000 for a tele- psychiatry /tele-psychotherapy suite, to \$20,000 for a exam room with equipment for more detailed viewing and communication for physical exams. For underserved populations with limited transportation access and other issues, telemedicine may be an efficient solution to meet many health care service needs.<sup>27</sup>

*#9 The Department of Medical Assistance Services should expand its telemedicine coverage to include telescreening for diabetic retinopathy.*

Diabetic retinopathy is the leading cause of blindness for adult diabetics. Currently, diabetic patients at some community health centers have their retinas electronically scanned and the images transmitted to the University of Virginia ophthalmologists for evaluation. However, Medicaid recipients have to physically visit an ophthalmologist. With this expansion, this scan would be covered for Medicaid recipients under the telemedicine coverage.

*#10 The Commonwealth should move forward with the consideration of an all payer claims data base, through and perhaps in addition to the Joint Commission study.*

The November 2011 deadline for the Joint Commission study is rather a long way off, especially since so many states are already doing or considering similar activities. The Secretary, affiliated state agencies, and partner non-profit groups should work to push forward with the establishment of an APCD in Virginia.

*#11 The Commonwealth should take the results of the “mapping” survey and target investments to build and promote the growth of access to broadband infrastructure and telemedicine services.*

Relatively few investments would appear to have more potential payoff than infrastructure that could improve the quality of care, lower costs, and reduce the need for more investments in health professionals.

*#12 The Commonwealth should investigate and communicate ways for physicians to qualify for small business loans, either from federal or state source, to be used to acquire HIT capacity – hardware and software -- in their offices.*

One of the biggest burdens for small physician practices working to install a HIT infrastructure is the up-front cost as a share of operating margins. Although there are opportunities for physicians to receive reimbursement incentives through Medicare or Medicaid for utilizing electronic health

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<sup>27</sup> Rheuban, Karen S., “Telehealth in the Commonwealth” presentation to the Technology Task Force, Virginia Health Reform initiative, November 16, 2010. Available from:  
<http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

records which meet specific criteria of meaningful use, the physician must already have the hardware and systems in place before the reimbursements begins. This is particularly difficult for smaller practices and for primary care physician offices, which typically have lower revenue and lack economics of scale. It is difficult for physicians to get low interest loans from banks because physicians are excluded from obtaining loans through the small business administration programs. A bill to allow physicians to obtain loans through the small business administration passed the US House of Representatives in 2009, but has not yet been taken up by the U.S. Senate.<sup>28</sup> If this bill does not pass the Senate by the time Congress adjourns later this month, the process will have to begin again in the new Congress, which could lead to critical delays in small practice physician participation.

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<sup>28</sup> Ransone, Sterling, N. Jr. comments during the Technology Task Force, Virginia Health Reform Initiative , November 16, 2010, Richmond, Virginia

## Capacity

While there is more to capacity than workforce, health professional workforce needs are already very acute. If coverage expands as envisioned in the PPACA, there will be a critical need to identify ways to address workforce shortages. Therefore, Task Force deliberations focused almost exclusively on workforce issues.

### *What do we know?*

*By conventional measures of current workforce needs, demographic trends, retirement patterns and predicted replacement rates, Virginia is projected to soon have shortages of many health professionals on average, even without the impending coverage expansions expected from federal health reform. The scale of the projected coverage expansions will render all projected health professional supplies inadequate. We are therefore not likely to be able to provide care in the exact same ways we do now, for much longer.*

Virginia has about the same physician and dentist population ratio, on average, as the US in general, and actually has more RNs, LPNs, PA s and NPs.

### Illustrative Health Professionals' Supply, in Virginia and the US<sup>29</sup>

Practitioner	Virginia Total	Virginia Per 100,000 Residents	National Total	Per 100,000 Residents National	Projected Employment Growth, 2008-2018 (BLS)
<b>Healthcare Workforce Data Center</b>					
Physicians	20,778	267 (2008)	817,440	276 (2005) <sup>1</sup>	21.8%
Registered Nurse	78,812	1,011(2008)	3,063,163	854 (2008) <sup>2</sup>	22.2%
Licensed Practical Nurse	26,193	336 (2008)	889,027	211 (2000) <sup>3</sup>	20.7%
<b>Kaiser Family Foundation—statehealthfacts.org</b>					
Physician Assistants	1,611	21 (2008)	73,893	24 (2008)	39.0%
Nurse Practitioners	5,821	74 (2009)	157,782	51 (2009)	NA
Dentists	5,847	80 (2008)	233,104	80 (2008)	15.3%
Total Healthcare Employment	258,030	3,310 (2008)	1,1178,720	3,673 (2008)	22%*

<sup>29</sup> Reynolds-Cane, D. "Capacity Reform" Presentation to the Advisory Council in Roanoke, Virginia, August 21, 2010. Complete presentation available from <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/capacity.pdf>

However, even with the robust growth rates as projected in the last column, most experts expect shortages in virtually every category. Comparable projections for Virginia do not exist, but are expected to be commensurate.

**Projected shortages for selected health professionals, nationally**

Profession	Projected Shortfall	By Year	Source of projection
Physicians	124,400	2025	AAMC
Nursing	260,000	2025	Buerhaus et al
Public Health Workers	250,000	2020	ASPH
Pharmacists	38,000	2030	HRSA
Geriatricians	28,000	2030	IOM
Direct-Care Workers <sup>30</sup>	“serious” or “very serious” in 28 of 39 states surveyed	2005	IOM

And it is important to note that these shortage estimates all predate the passage of federal health reform and the possible health insurance coverage expansion of 30 million or more Americans.

*The geographic distribution of many health professionals – including primary care physicians, specialists, advanced practice nurses, physician’s assistants, mental health professionals, and dentists – is skewed away from rural areas but also some poor urban areas as well. These pockets of shortages are already acute, and will get worse with the coverage expansions envisioned from federal health reform.*

This point could be made with as many maps as there are types of health professionals.<sup>31</sup> For brevity’s sake we include two. Practice patterns across the state are similar for the following health professions: allopathic and osteopathic physicians, audiologists, physician assistants, advanced practice nurses (this includes certified registered nurse anesthetist, nurse practitioners,

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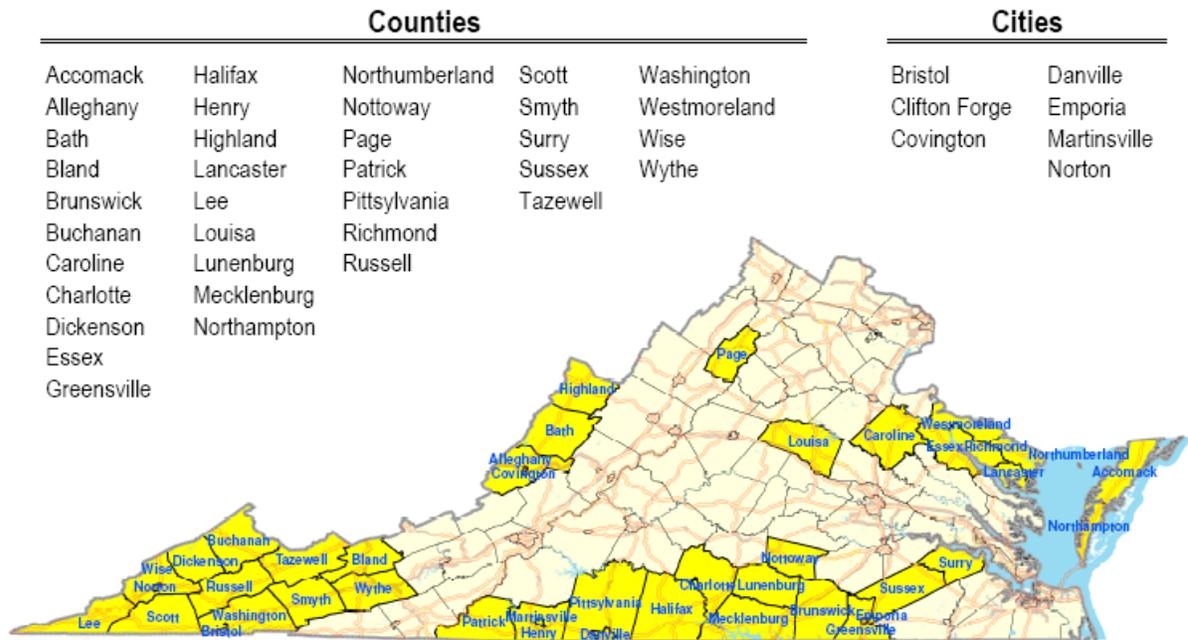
<sup>30</sup> Definition of direct care workers is taken from HRSA include certified nurse aides, orderlies, attendants, home health aides, personal care aides, home care aides, personal care attendants, psychiatric aides, medication aides, community health workers, direct services associates, and paraprofessionals.

<sup>31</sup> The presentation by Dr. Dixie Tooke-Rawlings to the Task Force in October has many illustrative maps of this nature, and is available on the VHRI website at <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

certified nurse midwives, and clinical nurse specialists) chiropractors, dentists, dental hygienists, pharmacists, podiatrists, psychologists, psychiatrists.<sup>32</sup>

# Virginia Medically Underserved Areas VMUAs

Updated 09/01/2006

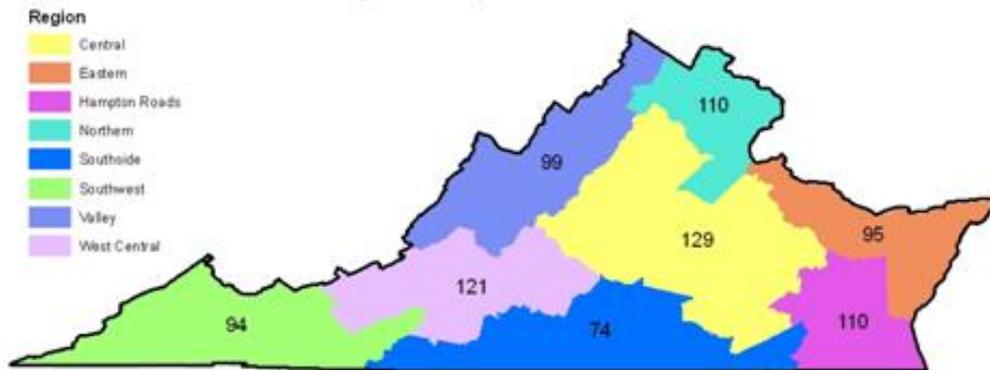


A medically underserved area has fewer health professionals than is considered adequate by the Health Resources and Services Administration, the nation's health workforce think tank. These are mostly rural areas but also include some cities.<sup>33</sup>

<sup>32</sup> Rawlins, Dixie T. The Current Status of the Healthcare Workforce in Virginia. Presented at the Virginia Health Reform Initiative on October 19, 2010.

<sup>33</sup> Map was taken from <http://www.vdh.state.va.us/healthpolicy/primarycare/shortagedesignations/documents/VMUA.pdf>

### Distribution of Primary Care Physicians in Virginia: Physicians per 100,000



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The distribution of primary care physicians per 100,000 varies as much as 25% of the state average. This clearly affects access to quality care. The specialist distribution is far more skewed, especially for mental health and dental professionals. Many urban neighborhoods lack adequate specialist and primary care professionals as well.

*The first two observations help explain why there is so much interest, in various task forces and in the Advisory Committee as a whole, in the concept of “team” delivery of care. Not only could “team” re-organization help leverage scarce -- and expensive to train and retain – health professionals, there is also growing evidence that some forms of “team” care delivery are improving outcomes and patient satisfaction while lowering cost.*

Some of the more promising models are variations on the theme of primary care-focused medical homes, as described above in the Delivery System and Payment Reform section. In addition, presentations and public comments suggested that Federally Qualified Health Centers (FQHCs)<sup>35</sup>, free clinics, Community Service Boards (CSBs), and the Program for the All-Inclusive Care for the Elderly (PACE) program all have potential lessons for workforce planners and delivery system re-designers, for more integrated and coordinated care will likely be better care.

*State scope of practice laws vary considerably, and for some health professionals, like nurse practitioners, Virginia’s are among the more restrictive. Scope of practice restrictions may limit the ability to fully expand capacity as much as optimal “team” care delivery might allow.*

<sup>34</sup> Reynolds-Cane, D. Healthcare Workforce. Presented at the Virginia Health Reform Initiative on October 19, 2010.

<sup>35</sup> Chapman, Howard. An Overview of Southwest Virginia Community Health Systems, Inc. Presented to the Advisory Council at the Virginia Health Reform Initiative on November 16, 2010 available from <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

*Similarly, knowledgeable professionals like pharmacists may be underutilized by existing care delivery patterns, especially for pharmacy-related consults to reduce confusion and increase patient compliance among those taking more than one medication. These consults should be properly compensated and considered part of what well-functioning primary care teams do.*

Considerable clinical and practical evidence suggests that some scope of practice restrictions and supervisory plus care delivery norms in Virginia may no longer be necessary to protect the health and safety of the public and may indeed contribute to inefficient and even ineffective care delivery and thereby raise costs unnecessarily.<sup>36</sup> At the same time, feelings are strong on both sides of this issue, and for some the evidence base is “new,” appropriate supervision questions have not been resolved, and therefore there is not yet consensus on the best way forward.

For some professionals, including nurses, “norms” of practice may be as limiting as scope of practice laws. For example, consider pharmacists. They are accessible in a community setting, their location positions them well to meet the needs of patients with chronic disease. They can counsel patients (help alleviate the stress on primary care to attend to these patients) and as a result help reduce costs and visits to the physician which may require more travel and increase expenses for both the patient and the payer. Expanding the use of medication therapy management will enable pharmacists to reach their full potential/capacity, improve patient understanding of compliance needs and potentially improve patient outcomes and lower costs from unnecessary doctor visits and hospitalizations. Some of the patients who could benefit include those with diabetes, heart failure, hypertension, dyslipidemia, chronic obstructive pulmonary disease, asthma, rheumatoid arthritis, depression, osteoporosis and osteoarthritis. These patients are often taking multiple drugs and often any one physician even does not know all the drugs they are prescribed, whereas pharmacy data may actually be more complete at the present time. To date, this expanded use of pharmacists’ potential is rare.<sup>37,38</sup>

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<sup>36</sup> The Institute of Medicine just issued a report with a clarion call for removal of state scope of practice barriers to practicing to the level of training for advanced practice nurses, *The Future of Nursing: Leading Change, Advancing Health*. Institute of Medicine, October 2010 (<http://iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>). Pohl, J., Hanson, C., Newland, J. and Cronewett, L. Analysis & Commentary: Unleashing Nurse Practitioners’ Potential to Deliver Primary Care and Lead Teams. *Health Affairs* 29: No. 5 (2010): p. 900-905. DOI: 10.1377/hlthaff.2010.0374 . Scope of practice and other barriers for other professions may merit re-examination as well.

<sup>37</sup> Articles in this paragraph from: Guglielmo, Joseph, B. A Prescription for Improved Chronic Disease Management: Have Community Pharmacists Function at the top of their Training. *Archives of Internal Medicine*. Vol. 170. No. 18: 1646-1647 and Cranor, C., Bunting, B., Christensen, D. The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program. *Journal of the American Pharmaceutical Association*. Vol. 43, No. 2. March 2003. P. 173-184.

<sup>38</sup> Another example of pharmacy engagement and Diabetes management on a national level is the 10 city Challenge, and information regarding the program can be retrieved from: <http://www.diabetestencitychallenge.com/>

*Technologies – especially telemedicine but also electronic health records and health information exchanges – can help address geographic mal-distribution of access to services and leverage existing and future limited capacity in health professionals.*

The potential for telemedicine in conjunction with team care delivery methods to reduce the magnitude of potential shortages and improve the average quality of patient care across the Commonwealth seems large relative to the necessary cost and relative to the outsized cost of simply “growing” enough professionals to serve all Virginians in existing care delivery patterns. An HD screen and hookup to enable telemedicine costs about \$20,000, whereas training a new physician costs more than \$400,000.<sup>39</sup>

*There are not enough nursing faculty and clinical training sites to keep pace with the growing demand for nurses, especially advanced practice nurses.*

Nursing faculty are retiring faster than they are being replaced all over the country. This will be a very serious problem very soon. The average age of nursing faculty is 53, compared to 47 for RNs as a whole. Part of the problem is pay differential, as faculty salaries average \$10,000-15,000 below what nurses working in hospitals and other setting can earn. Yet, to maintain accreditation, nursing programs must maintain a student-faculty ration no higher than 10:1. In addition, there is a shortage of clinical training sites which adds to the “shortfall” between the number of students Virginia Nursing programs can currently educate each year and the level of interest of students pursuing a career as a RN.<sup>40</sup> By 2014, 50% of Virginia RN’s will reach the age of 65, which means they will reduce the amount of hours they work, about 20% will stop working as they approach retirement in the next five years. Starting in 2015, the number of RN’s leaving the workforce will be greater than those entering the workforce,<sup>41</sup> unless something major occurs to change these trends.

*Post-graduate training slots for all professionals and preceptors to mentor them are limited relative to our educational system output in Virginia.*

There are 198 medical resident slots in 19 locations throughout Virginia. This would appear to be a major reason why Virginia retains less than half of the physicians educated in the Commonwealth; they literally must go somewhere else to complete their residencies. Only 30%

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<sup>39</sup> Check cost of undergrad physician ed, from Reynolds-cane early presentation slides, or from report on workforce by commonwealth from 2005 or so.

<sup>40</sup> Health Reform Commission. November 2006. The Nursing Shortage: Workforce Subcommittee Meeting. Richmond, VA.commission. .

<sup>41</sup> Registered Nurses: Highlights from the 2007-2008 DHP Licensure Renewal Survey. Department of Health Professions: Healthcare Workforce Data Center. July 2010. Retrieved from: [http://www.dhp.virginia.gov/hwdc/docs/RNFactSheet\\_08.pdf](http://www.dhp.virginia.gov/hwdc/docs/RNFactSheet_08.pdf)

of medical school graduates in Virginia completed residencies in state.<sup>42</sup> In terms of retention rates, the Commonwealth of Virginia only retains 35% of its medical school graduates and 39% of the residents that they train.<sup>43</sup> To address the physician shortage, Virginia must increase their retention of graduates and residents by 15% over the next ten years, especially in primary care.<sup>44</sup>

Current retention and recruitment efforts in Virginia are few but are focused on attracting physicians to serve in rural areas. There are three family practice residency programs (VCU, EVMS, UVA) that received \$8.8 million in state funding and they retain 68% of the participants to practice in Virginia.

The Virginia Recruitment and Retention Collaborative includes state agencies and organizations, including medical schools and Virginia's primary care association to encourage and increase retention in Virginia, especially in underserved areas. Also the Primary Care Practice Opportunities of Virginia maintains an online site to advertise opportunities. The Virginia Area Health Education Center (AHEC) is also a source to attract primary care health professionals to provide care in for those in medically underserved populations through community and academic partnerships.<sup>45</sup>

### ***What do we still need to know?***

*More detail is needed concerning different types of health care teams that might be best for different kinds of patients in the Commonwealth.*

The research work pursuant to what the Delivery System and Payment Reform task force asked for will be highly relevant to Capacity issues as well. The Task Force noted that health professionals may also need training in cultural competence to understand patients' cultural backgrounds in order to meet the need of the patient in underserved populations.

*How much telemedicine and Health Information Exchanges (HIEs) can reduce disparities in access and the need for more professionals of specific types and thereby lessen, but not eliminate, the shortages faced in Virginia?*

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<sup>42</sup> 2008 Virginia Physician Workforce Survey Findings and Recommendations. Virginia Department of Health Professions: healthcare Workforce Data Center. July 2010. Retrieved from: <http://www.dhp.virginia.gov/hwdc/docs/Physician2008/2008PhysicianFindings8-6-2010.pdf>

<sup>43</sup> Reynolds-Cane, D. "Capacity Reform" Presentation to the Advisory Council in Roanoke, Virginia, August 21, 2010. Complete presentation available from <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/capacity.pdf>

<sup>44</sup> Rawlins, Dixie T. Presentation to the Advisory Council on November 16, 2010, available from <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>.

<sup>45</sup> More information can be found on the AHEC at : <http://www.ahec.vcu.edu/>

The research work pursuant to what the Technology task force asked for will also be highly relevant to Capacity issues.

*What scope of practice rules would be optimal and what changes might the professional societies negotiate on their own?*

This research remains to be done in a comprehensive way for all professions simultaneously.

**Recommendations:**

Unlike the other Task Forces, the Capacity Task Force was not able to vote on its recommendations. What follows are the recommendations that were put forward in various forms at the second face-to-face meeting, and the individual task force members will comment upon them via email with VHRI staff (by law they are not allowed to vote by email), which will in turn report those comments to the Advisory Committee during the final retreat in Charlottesville.

{Note: Delivery System and Payment + Technology had 12 recommendations between them}.

*#13 Health workforce capacity will have to be increased if all citizens of the Commonwealth are to have access to affordable, high quality care. Effective capacity can be increased in at least four ways: (1) re-organizing care delivery practices into “teams” that could leverage scarce physician capacity by more extensive use of non-physicians in ways that are more consistent with their education and training than many current practices permit; (2) changing scope of practice laws to permit more health professionals to practice up to the evidence-based limit of their training; (3) expanding the use of information technologies, like telemedicine, electronic health records and health information exchanges to extend the geographic reach of existing health professionals and enable many to be more productive per unit of time; (4) increasing the supply of health professionals. We recommend the Commonwealth consider all four pathways to greater capacity, for all will likely be necessary, and they are, of course, inter-related.*

*# 14 The Secretary of Health and Human Resources should work with private foundations to commission and fund multi-dimensional studies of the highly promising collaborative “team” concept of care delivery for primary care for the purpose of informing future legislative considerations. Teams could include physicians, nurses, physicians’ assistants, pharmacists, dentists, dental hygienists, mental health professionals, case managers, and others. The elements of the study should include, at a minimum:*

- a. Identification of existing best practice teams, and with attention to alternative teams which may be most appropriate for specific patient populations (e.g., socioeconomic status, geographic area, unique health care needs (e.g., mentally ill, elderly, pregnant)). Models to investigate should include but not be limited to: medical homes, certain physician practices and health systems within Virginia, FQHCs, free*

*clinics, PACE, and CSB mental health teams.*

- b. How current scope of practice limits restrict the Commonwealth's ability to take full advantage of the "best practice" team models of care delivery. We believe it would be ideal if the relevant professional societies could reach modification agreements and present joint recommendations to the legislature in an expeditious manner. We are encouraged to note that some physician and nursing groups have entered into discussions of late, and we encourage other groups to join or start their own new talks. At the same time, our capacity shortages are too severe to permit undue delay in the face of good evidence, as will be assembled in this comprehensive study.*
- c. Review how practicing in team based care models and integrated primary care is now and should be taught in health professional schools and in post-graduate practice settings throughout the Commonwealth. Particular attention should be paid to ways in which FQHCs could play enhanced educational roles as ambulatory residency sites using new federal grant moneys going forward, since many are already using successful team concepts. Successful team models in general should become clinical training sites as well.*
- d. Explore how DHHR could best facilitate the creation of a collaboration process to share knowledge of evolving best team delivery practices across the Commonwealth.*
- e. Examine how the widespread application of team delivery, scope of practice changes, and the expected expansion of telemedicine and health information exchange capacities could impact currently projected health professional shortages in the Commonwealth.*

*# 15 In light of the findings of the study, the Secretary should develop recommendations in the following areas.*

- a. First, while the Secretary should consult with all relevant professional societies and take into account any voluntary and legislative progress made, the Secretary should also be prepared to provide the legislature with evidence-based, recommended scope of practice changes. These recommendations should take into account the scale of anticipated coverage expansions in 2014 or beyond.*

*If the recommended scope of practice changes are not made expeditiously, then the Secretary should seek private or public funding for demonstration projects in which expanded scope and more advanced team concepts would be implemented and evaluated in the dimensions of quality, patient experience, and cost against existing*

*care models in the Commonwealth.*

- b. Encourage the expansion of clinical training sites to increase retention of clinicians educated in Virginia. These and existing training sites should be as multidisciplinary as possible.*
- c. Restart and target state scholarship and loan forgiveness programs to specialties, residency choices, and geographic areas with the greatest unmet need. We expect these to be in primary care, but the results of the study may reveal additional areas of focus.*
- d. How to get local communities involved in providing incentives to attract needed health care professionals. This could significantly reduce the effects of the current and likely future geographic mal-distribution of health professionals. There are likely to be fruitful areas of collaboration with the Governor's Job Commission, which is also investigating how to attract certain kinds of professionals and employers to Virginia's communities.*

*#16 The Secretary of Health and Human Resources should designate an agency or entity to serve as a clearing house for demonstration project applications to CMS, whether they are public, non-profit, or for profit entities applying. This agency would also be responsible for tracking types of funding opportunities, deadlines for applying, and serve as a technical assistance partner with other state agencies and private sector parties to help make applications and awarded projects successful.*

## **Medicaid**

In August 2010, the Virginia Health Reform Initiative Advisory Council established the following facts and shared judgments for the Medicaid Task Force:

- Medicaid/CHIP spending and spending growth is a major strain on the Commonwealth of Virginia's budget. At the same time, it is a relatively lean program (compared to other states) that provides access to essential care for a large number of low-income Virginians.
- The Patient Protection and Affordable Care Act (PPACA) will require Virginia to spend considerably more money each year, in exchange for more coverage and an even larger infusion of federal and state dollars.
- The Medicaid program should not be thought of or reformed independently of the system as a whole. In particular, important interactions occur today between Medicaid and Medicare, private insurance, the behavioral health system, which includes Community Service Boards and state inpatient facilities, community health centers, free clinics, and public hospitals, including Veterans' Administration facilities.
- In Virginia, some of the more costly Medicaid patients and services are being served outside of a coordinated care delivery model. Medicaid seniors and individuals with disabilities make up 30 percent of the enrollees, yet they account for 70 percent of the expenditures.

The Advisory Council members also had numerous questions about the current Medicaid program in order to better understand the potential for administrative simplification and innovative solutions. In response to the charge from the Advisory Council, the Medicaid Task Force held three meetings during the fall of 2010. These meetings provided an overview of Virginia's Medicaid program, recent and potential innovation models for the Medicaid program, administration simplification and program integrity processes, and the eligibility and benefit options under the federal health care reform.

The Medicaid Reform Task Force came up with six recommendations for the full Advisory Council to consider on the topics of care coordination and chronic care management, administrative simplification, and eligibility and benefits.

### ***What do we know? Background on Virginia's Current Medicaid Program***

The mission of the Virginia Department of Medical Assistance Services is "to provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians." Medicaid is the nation's largest public health insurance program and a critical

safety net program for low-income Americans. It is the second largest program in Virginia's state general fund budget. In state fiscal year 2012, the Medicaid budget is 20.7 percent of the state only portion of budget of \$16.0 billion; 18.8 percent of the total budget of \$37.9 billion. In state fiscal year 2010, the total Medicaid expenditures were \$6.55 billion (both state and federal funds) which provided health care to an average monthly 764,000 Virginians and more than one million individuals over the entire year.

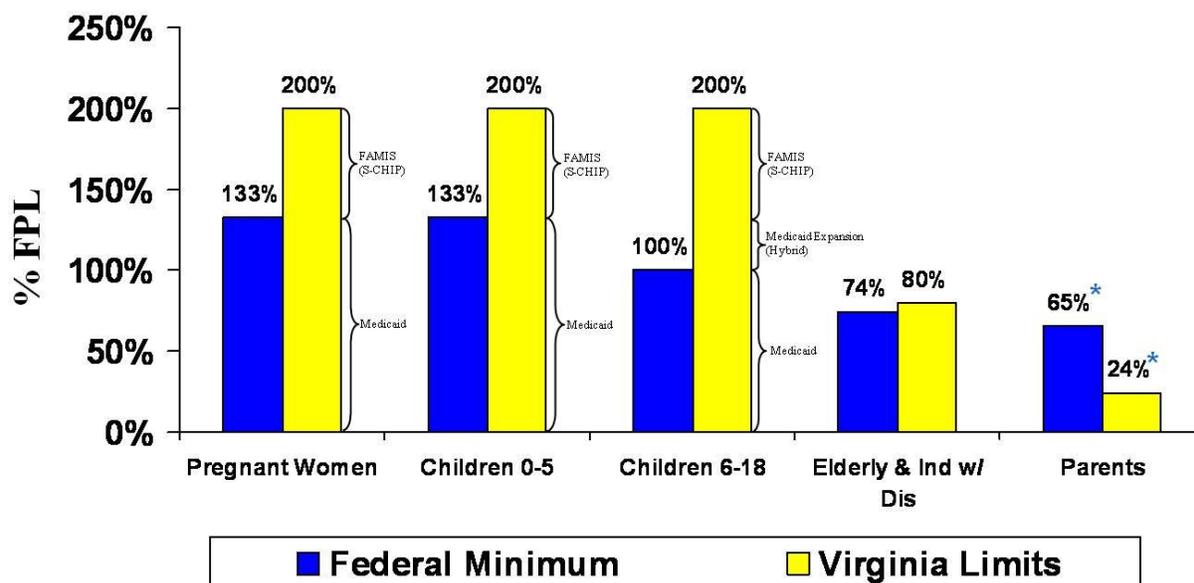
Medicaid is a means-tested entitlement program authorized under Title XIX of the Social Security Act that provides coverage of medical services for certain disabled and low income individuals. Medicaid is financed jointly by the state and federal governments and administered by the states, within guidelines established and approved at the federal level. Federal financial assistance is provided to states and the federal match rate is based on the state's per capita income. The non-stimulus federal match rate for Virginia is 50 percent, meaning that for every dollar expended in the Medicaid program, 50 cents is from the federal government and 50 cents is from the state's general fund (this match rate goes back into effect on July 1, 2011).

*Medicaid mainly covers children, pregnant women, seniors, and individuals with disabilities.*

While Medicaid was created to assist individuals with low incomes, coverage is dependent upon other criteria as well. Eligibility is primarily for people who fall into particular groups such as low-income children, pregnant women, and the elderly, individuals with disabilities, and parents or caretaker relatives of dependent children. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid, which results in a large variation among the states as to who is eligible. In Virginia, income and resource requirements vary by category. Virginia historically has had the low eligibility levels (shown in the Figure 1 below).

Despite Virginia's relative affluence (7<sup>th</sup> in the nation in per capita income), Virginia remains ranked near the bottom among states in terms of the number of Medicaid recipients as a percentage of the population (48<sup>th</sup> in the nation) and the Medicaid expenditure per capita (48<sup>th</sup> in the nation, Kaiser Commission). Based on these and other statistics, Virginia's Medicaid program has long been described as a very lean program with very strict eligibility criteria and modest payment rates for services.

## Medicaid/FAMIS in Virginia



\* National median Medicaid income eligibility level (2007) – Virginia statistic is a weighted average

Source: Kaiser Commission on Medicaid and the Uninsured; DMAS

### *Medicaid covers a broad range of primary, acute, and long term care services*

As permitted under federal law, the Virginia Medicaid program covers a broad range of services, with nominal cost sharing for some of the beneficiaries. Based on federal terminology, services are divided into “mandatory” and “optional” services. This terminology is outdated because prescription drugs, for example, are included in the “optional” category. In addition, if many optional services were eliminated, the state would end up paying higher costs for the mandatory services. The Virginia Medicaid program covers all of the federally mandated services, such as inpatient and outpatient hospital, physician, nursing facility, and Early and Periodic Screening, Diagnosis, and Treatment program for children (“EPSDT”). Virginia Medicaid also covers several optional services, such as dental care for persons under age 21, prescription drugs, rehabilitation services, home health, hospice, and mental health services.

Certain Medicaid beneficiaries may receive coverage through home and community-based “waiver” programs. These waivers provide community-based long-term care services as an alternative to institutionalization. In 2008, Virginia Medicaid spent 43 percent of its total long term care expenditures on community long term care services. The following community waiver programs are available to low-income seniors and individuals with disabilities who also meet the institutional level of care criteria: AIDS, Alzheimer’s, Day Support for Persons with Intellectual Disabilities, Intellectual Disabilities, Elderly or Disabled with Consumer-Direction, Technology Assisted, and Individual and Family Developmental Disabilities Support.

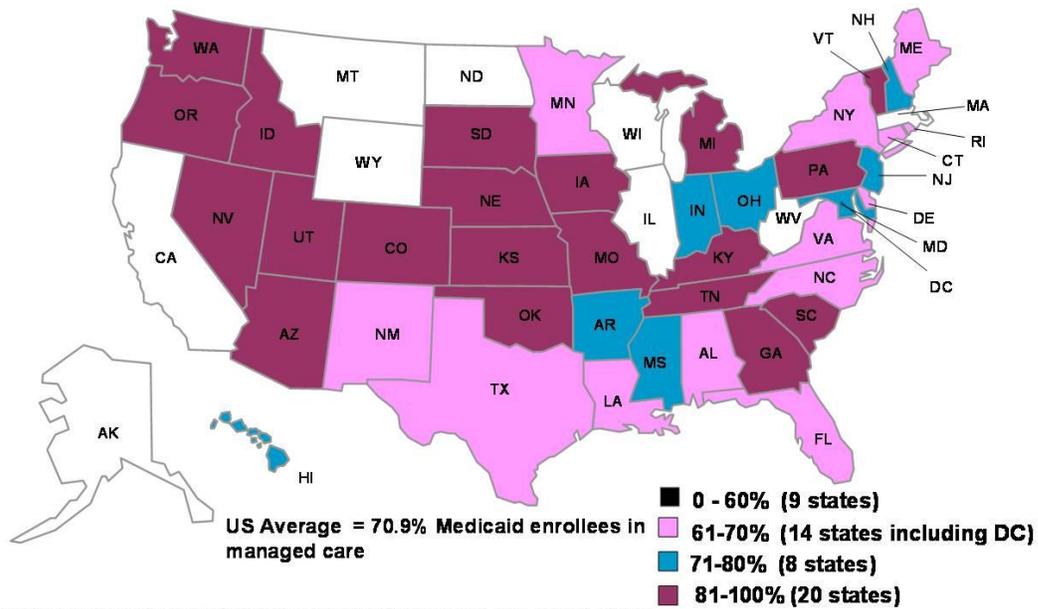
*Medicaid serves a majority of its clients through a managed care delivery model.*

The Department of Medical Assistance Services provides Medicaid to individuals through two delivery models: a managed delivery model that utilizes contracted managed care organizations (MCO) or a primary care case management (PCCM) system; and a fee-for-service (FFS) model, where service providers are reimbursed directly by DMAS. Managed care is the main service delivery model for children, pregnant women, and more than 55,000 elderly and disabled clients. Fee for service is the main service delivery model for a majority of the elderly and disabled that are dual eligibles or require long term care services and for some services, such as non-traditional behavioral health services and long term care services. There is also one geographic area in the state, the Southwest, that currently does not have coordinated care services. Those populations and services that are currently outside a managed or coordinated care model are the most expensive and the focus of reform efforts discussed in a later section.

As of November 2010, 532,965 Virginia Medicaid beneficiaries were enrolled in managed care (62 percent of total beneficiaries), 56,812 beneficiaries enrolled in the PCCM program (7 percent of total beneficiaries), and 270,790 beneficiaries enrolled in the FFS program (31 percent of total beneficiaries). While Figure 2 below shows that Virginia is similar to North Carolina, it is important to note that Virginia has 62% of its beneficiaries receiving care through managed care organizations while North Carolina serves its clients through primary case management models.

Virginia's MCO program started in 1996, and is available in most regions of the state (see Figure 3). The managed care delivery system represents a care delivery model where the goal is to deliver quality, cost effective healthcare through monitoring and managing the utilization of services. The program has also provided the Commonwealth with value and high quality healthcare via an integrated and

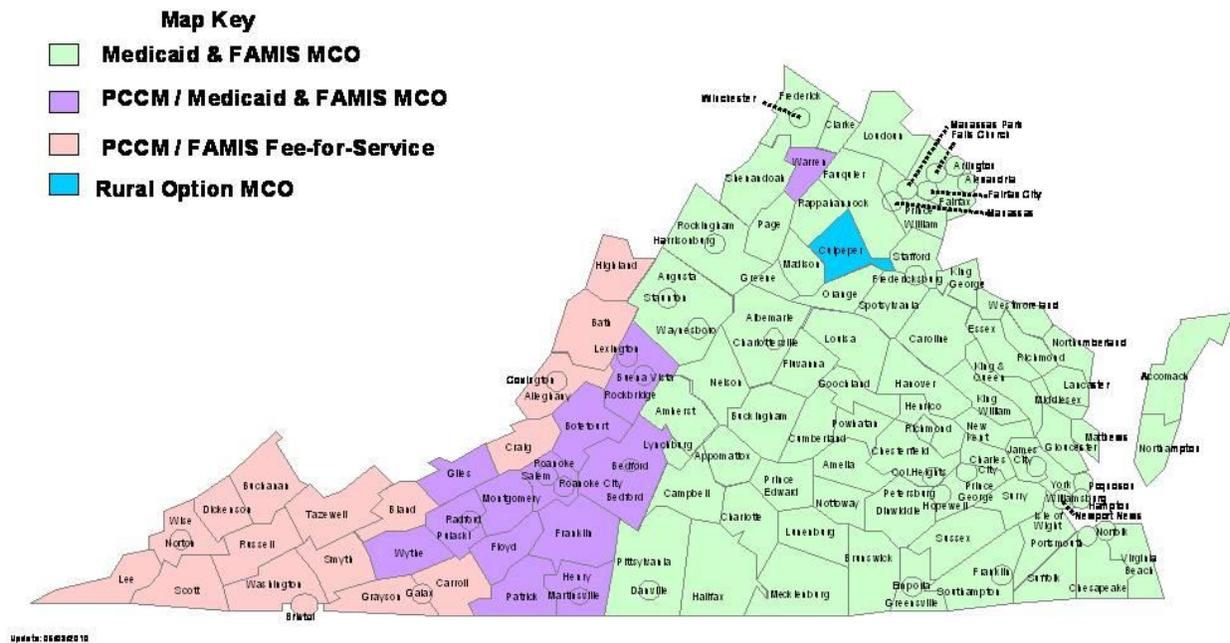
## Medicaid Managed Care Penetration



Note: Managed care includes individuals enrolled in managed care organizations (MCOs) and primary care case management (PCCM) arrangements.

SOURCE: Medicaid Managed Care Penetration Rates by State as of June 30, 2008, CMS, U.S. Department of Health and Human Services.

## Managed Care Coverage Areas in Virginia



comprehensive delivery system to Medicaid and FAMIS recipients. This includes disease and case management programs, enrollee outreach, and ongoing quality improvement. The Commonwealth also requires its MCOs to have national quality accreditation. This accreditation measures access to care, overall member satisfaction, prevention, and treatment. Four of the five MCOs currently have achieved the National Committee for Quality Assurance (NCQA) status of excellence.

Virginia's MCO program is a full-risk managed care model in which a monthly per member per month (PMPM) capitation fee is pre-set, and the MCOs accept the PMPM as payment-in-full regardless of the cost of services actually incurred by the individual recipients. There are no monetary caps where once reached, services would be denied, nor are there risk-corridors or other re-insurance options in which the state would assume the cost of services beyond a certain monetary threshold. Thus, to the managed care participant, the program remains a defined-benefit approach, but the utilization is managed through typical MCO processes of prior authorization and quality management review.

DMAS regulates the managed care program through monthly MCO meetings, network reviews, on-site visits, pattern of care studies, ongoing assessment and approval of member documents. DMAS contracts with an external quality review organization to examine each MCO's policies, procedures, and services with respect to enrollee rights and protections, quality assessment and performance improvement, and grievance systems. The Bureau of Insurance regulates the licensure and solvency of the MCOs in Virginia. This oversight has resulted in DMAS having MCOs that are fiscally strong and administratively efficient.

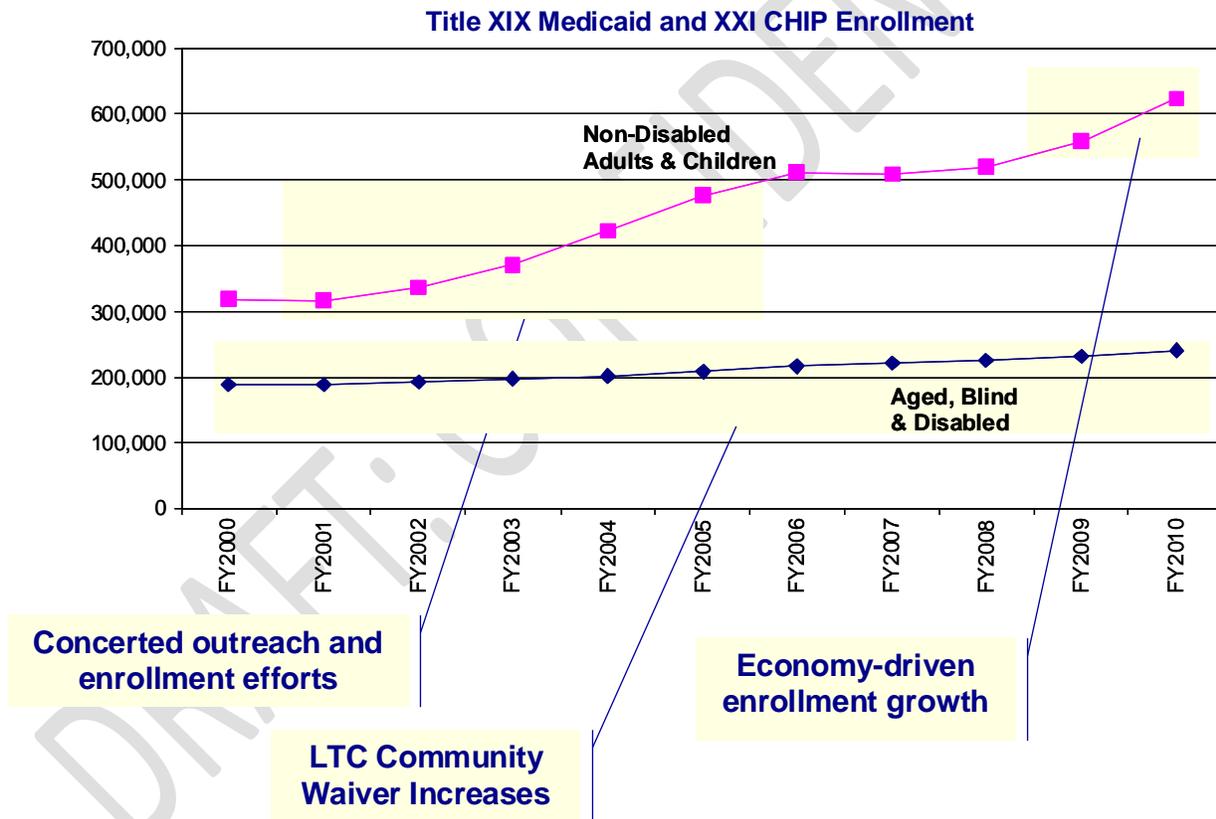
Medicaid MCOs are successful in enhancing access and availability of care by requiring physician, hospitals, ancillary, transportation, and specialty provider networks that are more extensive than what was historically available in regular Medicaid. The program promotes preventive care services, continuity and appropriateness of care, extensive member services including 24-hour nurse advice lines, enhanced services and benefits (such as adult vision services, enhanced pre-natal programs, case management services, and group and individualized enrollee health education and outreach). MCOs actively recruit providers, build networks, and credential providers to assure well-qualified providers are giving care to their enrollees.

Another managed delivery option for long-term care recipients is the Program for All-Inclusive Care for the Elderly (PACE). PACE is designed to allow Medicaid only and dual eligible individuals aged 55 or older, who meet the nursing facility level of care, to access comprehensive and coordinated acute, primary, and long term care services in their homes and communities. This interdisciplinary team approach combines both the Medicare and Medicaid funding to ensure that the right services are provided in an appropriate manner and are not driven by funding source. There are currently seven PACE programs across the Commonwealth.

*Medicaid expenditures and number of enrollees continue to grow.*

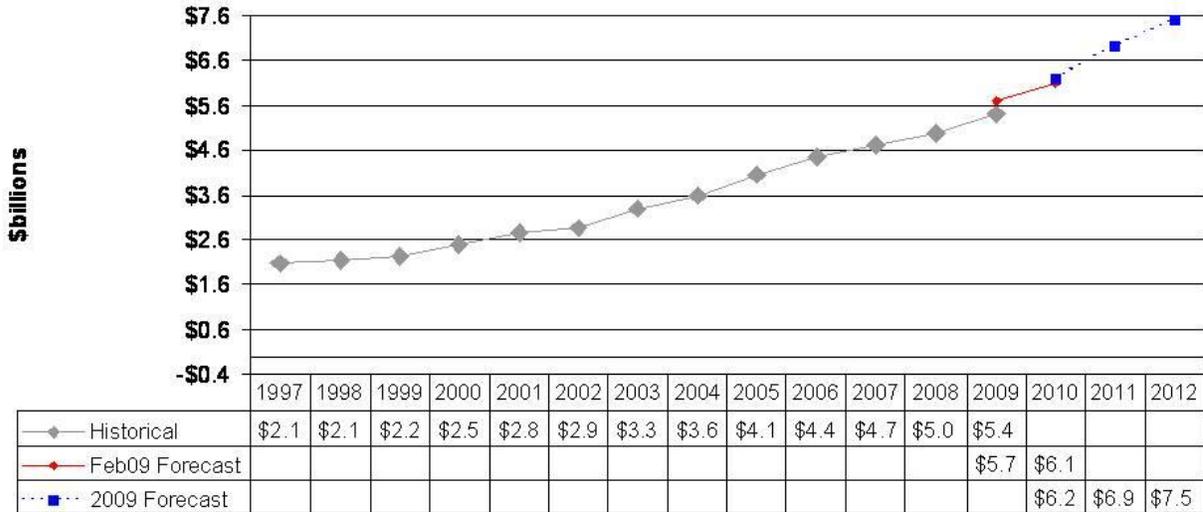
Over the past ten years, the number of people enrolled in the Virginia Medicaid program has increased more than 39 percent. The three key drivers have been a concerted outreach to enroll more children, increases in the number of aged and disabled individuals enrolled in home and community based waiver programs, and most recently, the cyclical impact of economy (as shown in Figure 4 and 5). Despite this enrollment growth, Virginia’s eligibility criteria are among the strictest in the nation. In addition to population increases, expenditures have increased as well, albeit consistent with those of other states. Expenditure levels are affected by population and economic changes, such as health care cost inflation, as well as by advances in health care delivery and program changes directed by federal and state law makers. In comparison to other states, Virginia’s rate of growth in expenditures is comparable; however, the absolute level of spending remains low.

### Title XIX Medicaid and XXI CHIP Enrollment 2000-2010



## Medicaid Spending Trend (Virginia 1997-2012(projected))

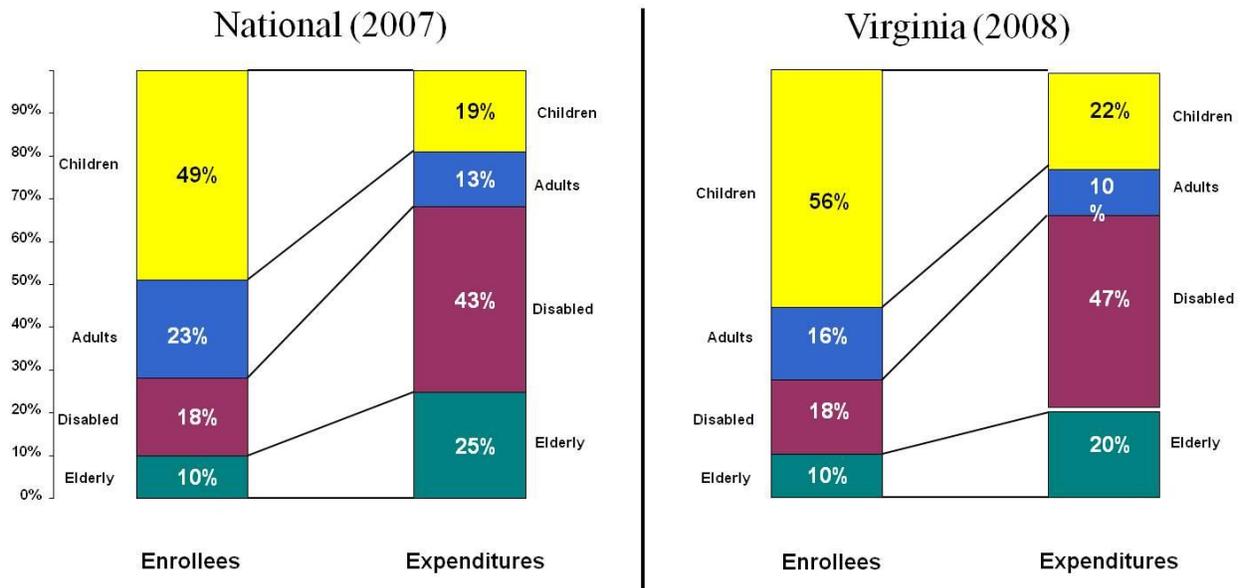
**Historical and Projected Expenditures for  
General Medicaid, Long-Term Care and Mental Health Services  
(Total Funds, \$billions)**



*Medicaid seniors and individuals with disabilities make up 30 percent of the enrollees, yet they account for 70 percent of the expenditures.*

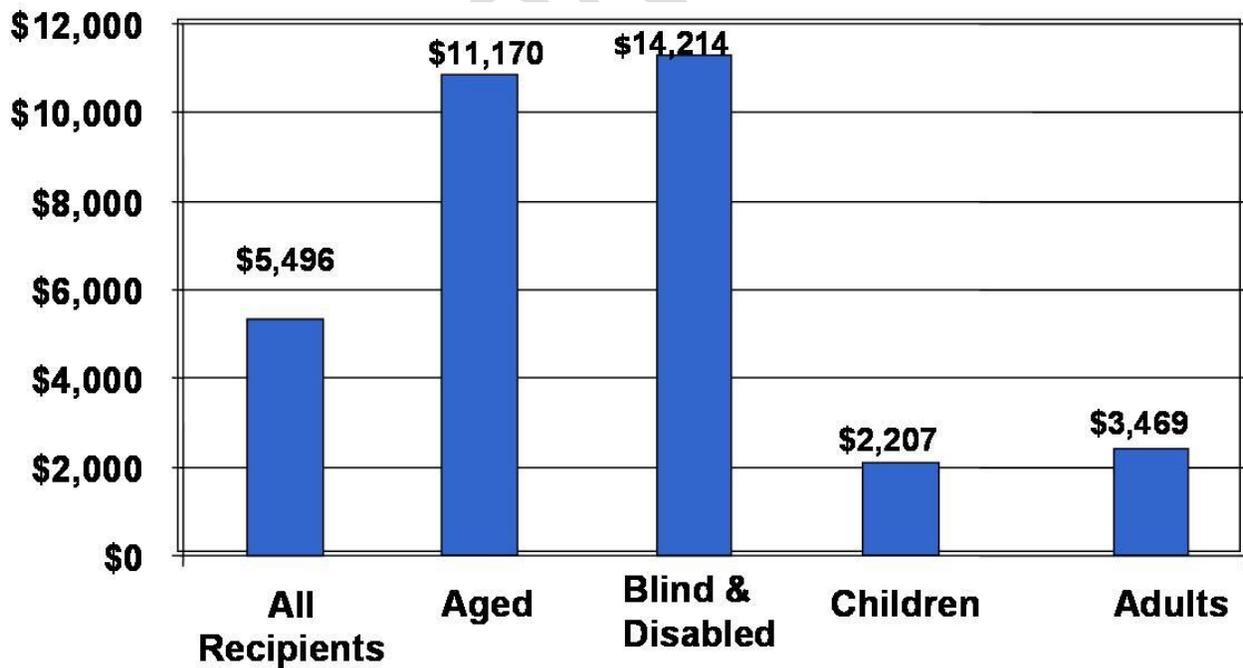
The interaction between the type of enrollees and overall Medicaid expenditures is shown in Figure 6. While children and adult caretakers make up about 70 percent of the Medicaid beneficiaries, they account for only 30 percent of Medicaid spending. On the other hand, seniors and individuals with disabilities make up about 30 percent of the enrollees, yet they account for the majority (70 percent) of Medicaid spending because of their intensive use of acute and long-term care services. Children cost an average of \$2,207 on an annual basis; the disabled cost \$14,214 annually (see figure below).

## Medicaid Enrollees and Expenditures



Source: Kaiser Commission on Medicaid and the Uninsured; DMAS

## Virginia Medicaid Cost Per Recipient Type



### *What do we still need to know?*

The two key questions that we still need to know is what is the impact of the federal health care reform on the Medicaid program; and what ways can Virginia reform its current Medicaid program?

The Virginia Medicaid program is about to expand significantly, if PPACA is implemented as currently written, both in number of beneficiaries and in size of expenditures. The numbers of new enrollees are estimated from 270,000 (lower bound enrollment increase) to 425,000 (upper bound enrollment increase) at a cost of \$1.5 billion to \$2.2 billion in state funds between 2010 and 2022. Two contributing factors are the result of the new federal health reform legislation and the growing number of seniors and individuals with disabilities who rely on Medicaid for long term care services. All this comes at a time when Virginia's budget is under great fiscal pressure.

This expansion of the Medicaid program creates several implementation challenges for Virginia Medicaid in four major areas: (1) how to improve the eligibility processes to enroll and maintain the current and expanded Medicaid populations; (2) how to define the "benchmark" benefit package that will be available to the expanded Medicaid populations; (3) how to ensure access to health care for current and new enrollees; and (4) how to sustain funding for the Medicaid program in Virginia. However, there are also opportunities in the expansion, which include the ability to provide healthcare to populations unable to afford coverage with significantly increased federal funding, and it provides significant momentum to examine and implement needed reforms of both Medicaid and the healthcare system generally.

The Advisory Council asked the Medicaid Task Force to answer several questions about the current Medicaid program, including administrative simplification, potential reforms for reducing the costs of the most expensive populations and services, and how Medicaid interacts with certain providers and other health and human services. The Council also asked a series of questions on the impact of PPACA on the Medicaid program, including enrollment, expenditures, eligibility, and benefit packages. Most of these questions are answered throughout this section.

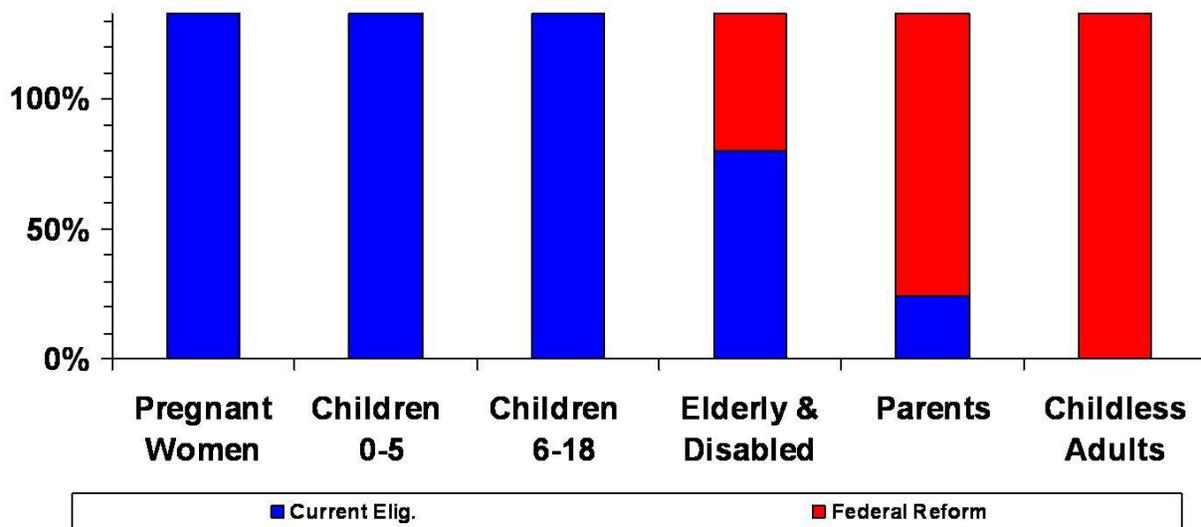
### *What is the Impact of Federal Health Reform?*

*Eligibility.* The biggest impact of the federal health reform bill is the significant expansion of Medicaid program. Given its expansion, about 50 percent of the uninsured in Virginia will now qualify for Medicaid. The impact on the number of new enrollees and expenditures hits Virginia particularly hard because of its historically low eligibility levels. Effective January 1, 2014, new coverage is available to adults **without** children who are not currently covered under Virginia's program. Additionally, it expands coverage to two adult groups: parents and the elderly and disabled. It also includes new coverage for childless adults and former foster care children up to

age 26 years. Figure 8 below shows the contrast between the existing eligibility levels and the expanded levels under PPACA beginning in 2014.

Even though eligibility will now be a standard 133 percent of the federal poverty level (in 2010, \$14,404 for individuals and \$29,327 for a family of four) across all groups, the determination of eligibility and the associated funding is still complicated with the new federal law. The current Medicaid eligible groups will still be evaluated using existing and complicated income and resource rules and receive only 50 percent federal match, while the new Medicaid eligible groups will utilize more streamlined eligibility rules and receive 100 percent federal match for the first three years (gradually decreasing to 90 percent by 2020).

**Virginia Medicaid Eligibility Before and After Federal Health Reform**



The preliminary fiscal impact estimate of federal health reform provides a range of \$1.5 billion (lower bound estimate) to \$2.2 billion (higher bound estimate) additional state costs through 2022. Virginia’s costs are higher than some states because of its lower eligibility levels prior to reform, it does not offset potential state savings from other programs outside of the Medicaid and CHIP program, and it reflects costs through the biennium which includes the year 2022.

The Medicaid Task Force understands that the impact of federal reform on the eligibility determination process and case maintenance is a significant implementation issue. Challenges will arise for several reasons: 1) eligibility rules will differ based upon categorical eligibility, 2) federal match rates will vary among the current and expanded Medicaid program and 3) eligibility determination at the local level will need to coordinate and interact with the Health Benefit Exchange. Virginia, however, under the leadership of Secretary Bill Hazel, is already

laying the ground work for a new gateway for publicly funded services. This gateway will allow an individual to apply for Medicaid and other services, such the Supplemental Nutrition Assistance Program (SNAP), in one of two ways. Applicants will be able to use the electronic self-directed service option 24 hours a day, seven days a week or use the assisted service option by going to a local office. This new gateway and standardization of forms and services will eventually lead to the phase out of silo agency computer systems and the development of a system where clients can be tracked across publically funded programs and services. Once this multi-service eligibility service system is complete, its platform can be used to develop the enrollment and tracking system needed for the Health Benefit Exchange. If the Commonwealth decides to move forward in the near future, this new mulit-service eligibility system can be developed with 90 percent federal dollars. The state must come up with the 10 percent match.

*Benchmark Benefits and Cost Sharing.* States are required to provide benchmark or “benchmark equivalent” benefit packages to most individuals in the Medicaid expansion population. The goal of these packages is to allow the states greater flexibility to provide alternative benefit packages to individuals outside of the core Medicaid populations. Benchmark packages are defined in federal regulations as coverage equaling one of the following: *federal employee health benefit package, state employee coverage, coverage offered through the largest commerial HMO plan in the state, or any other plan approved by the federal health and human services Secretary.*

Under PPACA, the benchmark benefits must include the “essential health benefits” required of the Health Benefit Exchange plans ( including; ambulatory and emergency services, maternity care, mental health and substance abuse services, prescriptions drugs, rehabilitative services, laboratory services, preventive and wellness services, and pediatric services). PPACA also ties benchmark coverage for the expansion population under Medicaid to the “minimal essential coverage” or “Bronze” level offered through the Exchange. The “Bronze” level represents a level of coverage at an actuarial equivalent of 60 percent of the full scope of the Essential Benefits plan.

The Task Force did not discuss the potential benchmark benefit package in detail because the recently published federal Final Regulations covering benchmark benefit packages did not include changes made in PPACA and the Secretary of Health and Human Services has not yet defined the scope of “essential health benefits.” Therefore, at this time, it is unclear as to the required scope of coverage for the Medicaid expansion population. Once this information is provided, Virginia will need to conduct a cost benefit analysis for the options of changing or keeping the benefit packages for the current and expanded Medicaid groups.

During the discussion of benefits, however, the Task Force was interested in learning about potential cost sharing that could be required of the expanded Medicaid population. Federal law dictates the extent to which cost sharing can be imposed on Medicaid recipients. Several groups of beneficiaries (such as children and pregnant women) have always been exempted from cost

sharing; the rest have been subject to nominal amounts. With the passage of the Deficit Reduction Act (DRA) in 2005, states were provided additional flexibility to increase cost sharing for higher income recipients as well as authority to enforce payment of cost sharing. Virginia did not implement these additional cost sharing opportunities at the time due to the low income of its Medicaid recipients and the negative impact on provider payments (cost sharing is taken prior to Medicaid payment to providers and many providers fail to collect). Cost sharing for the Medicaid expansion population will follow the DRA guidelines. The two groups in the expanded Medicaid population that are subject to cost sharing will largely be parents and childless adults. The following table outlines the cost sharing guidelines for these adult populations.

	<b>Less than 100% FPL</b>	<b>101%-133% FPL</b>
<b>Premiums</b>	<b>Not allowed</b>	
<b>Most Services</b>	<b>Nominal</b>	<b>Up to 10% of the cost of the service or a nominal charge</b>
<b>Prescription Drugs</b>	<b>Nominal</b>	
<b>Non-emergency use of the E R</b>	<b>Nominal</b>	<b>Up to twice the nominal amount</b>
<b>Preventive services</b>	<b>Nominal</b>	<b>Up to 10% of the cost of the service or a nominal charge</b>
<b>Cap on total cost sharing</b>	<b>5% of family income</b>	
<b>Service may be denied for not paying cost sharing</b>	<b>No</b>	<b>Yes</b>

*What are the Current and Potential Reforms for the Virginia Medicaid Program?*

The Virginia Medicaid program is constantly evaluating and implementing reforms to improve the quality of services, enhance service delivery, and promote best practices in administrative and cost avoidance programs. Given the upcoming expansion of the Medicaid program under the Patient Protection and Affordable Care Act (PPACA), it is imperative for the Commonwealth to move forward more aggressively on innovative programs that will ensure that the right people get the right services at the right time. What we do know is that Virginia cannot solve the growing expenditures of the Medicaid program by focusing on reforms for only the children and pregnant women; we must also focus on programs and services for the seniors and individuals with disabilities.

*Current Reforms.* The Department of Medical Assistance has implemented several reforms in recent years for quality improvement, enhanced service delivery, and to promote best practices in cost avoidance and administrative programs.

Quality improvement activities include the following examples:

- Virginia was one of the first states in the nation to require its Medicaid Managed Care Organizations (MCOs) to be accredited by the National Committee for Quality Assurance (NCQA), a mutually beneficial achievement for the MCOs, enrollees, and DMAS. Four of the five MCOs have achieved a NCQA status of excellence. The Department leads a MCO collaborative which each year focuses on two targeted quality initiative projects.
- The Department contracts with an external quality review organization (EQRO) to conduct the federal mandatory quality studies as well as optional focused studies on child health and childhood immunizations.
- The Department has obtained National Academy for State Health Policy (NASHP) Quality Focused Grants, on maximizing enrollment and data sharing for children, an ABCDII project on provider referrals and coordination for children, and a Medical home project with a Federally Qualified Health Center (FQHC) in Southwestern Virginia.

Enhanced service delivery activities include the following examples:

- The Department expanded the Medicaid/CHIP managed care program across the Commonwealth. In 1996, there was managed care service delivery in seven localities; today managed care is operational in 114 of 134 localities, providing health care services to 69% of all Medicaid recipients. In addition, in 2006, the Department developed the Blueprint for the Integration of Acute and Long Term Care Services, which provided a strategic plan for adding the more costly senior and disabled populations and long term care services into a managed care environment.
- The Department redesigned its dental program for children, known as “Smiles for Children.” This change significantly increased provider participation and recipient access to needed dental care.
- The Department conducted several activities to support the movement of individuals in need of long term care from institutional settings to community based settings, including participation in the Money Follows the Person Demonstration project, increasing home and community based waiver slots, and the establishment of the Program for All-Inclusive Care for the Elderly (PACE) in Virginia.

Cost avoidance activities include the following examples:

- The Department was aggressive in implementing national best practices in its pharmacy program reforms, including the establishment of Pharmaceutical and Therapeutic and Pharmaceutical and Drug Utilization Review Boards, a Preferred Drug List, maximum allowable cost program for generic drugs, pro- and retro-drug utilization review, mandatory generic substitution, dose optimization, and quantity limits.
- In September 1, 2007, Virginia was the third state (since the Deficit Reduction Act) to launch its Long Term Care Partnership program and the first state to launch its Partnership with a coordinated consumer outreach campaign. Long Term Care partnerships are designed to encourage individuals to plan for their future through the purchase of a private LTC insurance policy that has special asset protection limits if an individual were to exhaust their policy and need to apply for Medicaid. This policy will help fund an individual's LTC needs, up front, rather than immediately relying on Medicaid to do so. Over 4,000 LTC partnership policies have been sold in Virginia.
- The Department also enhanced its program integrity activities by refocusing its internal processes and hiring national contractors to increase its audits capabilities. These contractors identified approximately \$17.6 million in potentially inappropriate claims during the last two fiscal years; DMAS projects to collect at least \$21 million in fiscal year 2010.

The Department of Medical Assistance Services has several potential reforms under development. Many of these reforms are possible with out PPACA but some could reduce administrative burdens and/or receive additional federal funding through state plan options, grants, and demonstration projects that are funded or supported through federal health care reform. The key focus on Virginia's reforms are on the populations and services that are currently outside a managed or coordinated care environment. Over the next 10 years, seniors and individuals with disabilities are projected to have the fastest growth rate in population and the largest impact on the Commonwealth's Medicaid budget.

Curbing Medicaid growth in the long run, without compromising access to services for vulnerable populations, represents a significant challenge for the Commonwealth. While Virginia has been successful in implementing managed care for low-income children and pregnant women, it has not applied the same successful principles to programs specifically designed for long-term care populations. Currently in Virginia, most Medicaid seniors and individuals with disabilities receive acute and long-term care services through a patchwork of fragmented health and social programs that are not necessarily responsive to individual consumer needs. Acute care is provided in a fee-for-service environment with little or no chronic care management. Long-term care is provided in a nursing facility or by a variety of home and community-based care providers with little or no overall care coordination or case management. In addition, most of the Medicaid seniors and individuals with disabilities qualify for both

Medicare and Medicaid (often referred to as “Dual Eligible or Duals), which further complicates the access, quality, and funding of an integrated system.

*Potential Reforms.* Some of the key potential reforms that the Virginia Medicaid program is pursuing include the following:

- The Department is examining options for applying coordinated care concepts to certain non-traditional community mental health services, including intensive in home, therapeutic day treatment, community based residential, crisis intervention, and others. These services are considered non-traditional because commercial insurance carriers typically do not cover these services. The traditional mental health services are currently included in the managed care organization delivery model; non-traditional services are “carved” out. The key points of this initiative will be:
  - Assumption of some risk or planned assumption of risk
  - Strong case management and care coordination
  - Integration of physical and mental health care
  - Quality improvement and client-based outcome measurements
  - May include a screening for admission to acute care
- The Department is continuing to determine the best models for integrating and coordinating acute and long term care services, which includes one or more of the home and community based care waivers. The models include adding care coordination to individuals served in the the Elderly and Disabled with Consumer Direction waiver program and integrated care for the dual eligibles (individuals receiving both Medicare and Medicaid funding for health care services). The dual eligible model will be greatly facilitated by the newly created federal office of integration which will focus on making this model a reality for the states.
- The Department is examining options for expanding coordinated care coverage geographically where there is only one managed care organization in the area or there is no managed care at all. This expansion will provide the opportunity for the Department to develop pilots and test some of the service delivery and payment options discussed by the the Delivery and Payment Reform Task Force, such as health/medical homes and accountable care organizations, as well as expand the current managed care delivery system.

*Potential Reforms Under Federal Health Care Reform.* There are several PPACA state plan options, grants and demonstration grants that may support the reforms that are currently under consideration by the Department. The Department has identified 17 optional provisions in PPACA related to the Medicaid program; six are grants, six are demonstration projects, and five are optional services or eligibility groups. Several have considerable potential and several more

need further guidance from the federal government. Some of the relevant PPACA provisions include:

- Community-Based Care Incentives: Provides incentives for states (through increase federal match) to shift enrollees out of nursing homes and into home and community based services.
- Chronic care homes: Provides enhanced federal match of 90 percent for two years for all states who implement this option beginning January 1, 2011. Given the high medical expenditures for chronically ill enrollees (the national average is \$6,672 annually versus \$432 for non-chronically ill), pursuing this option may provide a good option to reduce costs and improve the quality of care for this population.
- Patient Centered Medical Homes: Provides grants to establish community-based interdisciplinary teams to support primary care practices within given hospital services areas and provide capitated payments to primary care providers.
- Promotion of Healthy Lifestyles: Provides grants to enrollees who participate in programs to promote health lifestyles (smoking cessation, weight, cholesterol, or blood pressure control, and managing chronic conditions). Target date for grants is January 1, 2011. Funding could allow DMAS to establish a disease management program for chronically ill Medicaid fee for service recipients.
- Primary Care/Behavioral Health Homes: Provides grants to establish projects that coordinate and integrate services through co-location of primary and specialty care in community-based mental and behavioral health settings. This grant could be a good opportunity to help localities partner with primary care physician and specialty behavioral health care.
- Family planning services: Adds a state plan option for Medicaid eligibility for non-pregnant individuals. Services are limited to family planning services and supplies and related medical diagnosis and treatment services. Virginia currently covers individuals under a Section 1115 demonstration waiver up to 133 percent of the federal poverty limit (with a request for up to 200 percent). Switching to a state plan option would reduce administrative costs but may increase service costs.
- Hospital Episodes of Care: This option will fund eight states beginning January 1, 2012 to evaluate the use of bundled payments for integrated care during an episode of care that includes a hospitalization.

Several of the PPACA grants or incentive options may be combined to best address the reform needs of the Virginia Medicaid program. Another option now available under PPACA is the creation of the Centers for Medicare and Medicaid Services Center for Innovation. This Center

will provide significant funding for demonstration projects to test innovative payment and services delivery models under Medicare, Medicaid, and CHIP. The Center will give preference to models (18 specific models are listed) that improve coordination, quality, and efficiency of health care services.

*Administrative Simplification.* The Task Force also asked the Department to provide information on a potential administrative reform for improving electronic access to Medicaid payment. The Department processes tens of millions of claims each year. There are two ways to improve electronic access to Medicaid provider payments: electronic funds transfer and electronic claims submission.

- Electronic Funds Transfer (EFT): This is the capability to electronically transfer funds from the DMAS/Fiscal agent claims account to an individual provider bank account for money owed for approved healthcare services. Approximately 54 percent of the actively billing providers participate in EFT, representing 87 percent of the claims dollars reimbursed. At this time, EFT is optional but strongly encouraged by DMAS.
- Electronic Claims Submission: This is the capability to submit claims transactions, electronically, to the DMAS fiscal agent. Recent statistics indicate that approximately 84 percent of claims submitted to the DMAS fiscal agent are electronic transactions; this rate drops to 69 percent when pharmacy claims are also excluded (virtually all pharmacy claims are submitted electronically). DMAS is currently implementing (in 2011) a web based enhancement which will allow providers (at no additional cost) to submit claims through the internet.

***Recommendations:***

The Medicaid Task force heard several key themes throughout the presentations provided at their meetings, including:

- The Virginia Medicaid program, which served more than one million low-income beneficiaries in 2010 at a cost of more than \$6.6 billion dollars, is a lean program in terms of eligibility levels and provider payments.
- The Program is well managed and has implemented many best practices for quality, service delivery, and cost saving strategies.
- In spite of this, the Medicaid program is the second largest budget in the Commonwealth and there are serious concerns about its sustainability.
- The expansion of the Medicaid program under PPACA will increase the Medicaid enrollment by more than 270,000 new enrollees at a cost to the state of more than \$1.5 billion dollars by 2022.

- The implementation of PPACA is complex and there are still many unknowns due to lack of federal regulations.
- The Virginia Medicaid program must continue to implement reforms in the area of care coordination for the populations and services that are the most costly in the Medicaid program.
- Public comments provided feedback on a variety of issues and topics, including current care coordination models that work, ways to implement the new PPACA requirements, ways to improve coordination between health care providers, and potential administrative improvements.

Based on the presentations and public comment, the Medicaid Task Force had the following discussions and made the following recommendations on; care coordination and chronic care management, administration simplification, and eligibility and benefits. All recommendations were made by motion and the voice vote was unanimous.

{Note: there have been 16 Recommendations by other task forces to this point }

*#17: The Department of Medical Assistance Services should continue to pursue additional care coordination models for additional geographic areas, clients, and services, including behavioral health and long term care services.*

The Task Force was asked how the Department of Medical Assistance Services can improve care coordination across the spectrum of Medicaid recipients. Information received highlighted that the traditional Virginia Medicaid managed care network is currently limited by geography, recipient type, and services, and that the most expensive populations [to care for] and services are being delivered in a fragmented and uncoordinated fee for service model. As federal health reform increases participation in Medicaid, expansion of care coordination is critical to help bend the cost curve.

The Task Force had two key comments about care coordination initiatives. First, as the state moves forward with additional care coordination, it must look across its health and human services agencies and other partner agencies to ensure that there is not duplication of case management/care coordination services and that clients do not fall between the cracks in service delivery. Examples provided were TANF, SNAP, mental health, acute care, long term care, and care delivered in correctional facilities. Second, with the current Medicaid funded program and with future care coordination efforts, we need to ensure that beneficiaries are experiencing positive outcomes, with standards for service delivery, and there incentives for both providers and recipients.

The Task Force heard public comment from several persons representing the Community Services Board who emphasized how case management services played a critical part in the coordination, service delivery, and quality of care of the clients they serve.

*#18: The Department of Medical Assistance Services should work with nursing facilities, hospitals, and physicians to determine whether there are alternate strategies for caring for the acute medical needs of nursing facilities residents to decrease avoidable emergency care visits. These strategies may include but are not limited to the use of telemedicine, electronic health records, and/or use of nurse practitioners working more closely with physicians.*

The Task Force heard public comment from the Virginia Health Care Association on recommended reform initiatives. One recommendation was the development of a pilot program to address the frequency and appropriateness of transfers between nursing facilities and hospital emergency rooms. These transfers are costly and disruptive to quality patient care.

*Recommendation 19: The Department of Medical Assistance Services should continue to evaluate and pursue where appropriate, demonstration projects, grants, and state plan options provided under federal health care reform for improvements to chronic care management opportunities, care coordination for recipients of long term care and behavioral health services, and patient centered medical homes.*

Additionally, the Task Force was asked what the Department should pursue in terms of chronic care management opportunities, care coordination for recipients of long care services, and recipients of behavioral health services under the federal health care reform. DMAS identified 17 optional provisions within the federal health reform bill that could be pursued. Some options are grants, some are demonstration projects, and some are coverage for optional services or eligibility groups. As noted previously, DMAS has determined that several options have considerable potential for Virginia.

The Task Force commented that the state must weigh the pursuit of grant opportunities based on staff resources to pursue and manage, as well as the ability for the state to sustain the project and costs when the initial federal funding is decreased or eliminated. The state must be clear on the savings and consequences for providers and recipients if grant opportunities are sought or declined. With some of the most successful models in the nation, Virginia should utilize the lessons learned from the PACE model when looking towards further integration and care coordination for long term care services. Finally, the Commonwealth should examine existing models for integration and/or coordination of behavioral health services.

*# 20: The Department of Medical Assistance Services should require that all providers, after a certain date, submit electronic claims submissions and receive electronic funds transfers. The Department's director should develop a procedure to provide a variance for a fixed period of time to allow full compliance for unique and extreme outliers of providers who may not have access to internet services. This lack of internet service would need to be supported by the survey on broadband use and access.*

In order to improve the administrative efficiency of the Medicaid program, the Task Force was asked whether DMAS should require Medicaid providers to participate in electronic claims submission and electronic funds transfer for payment. They learned that approximately 54 percent of the actively billing providers participate in electronic funds transfers, representing 87 percent of the claims dollars reimbursed. They also heard that 84 percent of claims submitted to the DMAS fiscal agent are electronic transactions; this rate drops to 69% when pharmacy claims are excluded. In 2011, DMAS will implement a web-based portal which will allow providers to submit individual claims through the internet at no additional cost to the provider.

*# 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 and provides the platform for future needs, including the Health Benefit Exchange. This project is led by the Office of the Secretary for Health and Human Resources.*

The Task Force heard a presentation on the proposed Virginia gateway to all publicly funded services, which would streamline and modernize the eligibility and case tracking for a variety of publically funded services, including Medicaid. While the federal government will provide 90 percent match, the state will need to come up with 10 percent match to begin the development of the new system.

*#22: The Department of Medicaid Assistance Services should explore the cost sharing opportunities for the expanded Medicaid population.*

The Task Force received information on the variety of benefit options that must be considered, including the potential for requiring cost sharing on the new expanded Medicaid population. While most members agreed with pursuing cost sharing for the expanded population, there was still concern expressed on the potential negative impact on the expanded population whose incomes are still very low and on providers.

## Insurance Reform

### *What Do We Know?*

*The current state of the insurance market in Virginia, especially for small employers, is unsustainable.*

Table 1 above makes the point that premiums for small firms have been rising even faster than for large firms in Virginia, and average premium inflation continues to exceed health care cost and income growth. Thus, small firm premium growth is putting even more pressure on their bottom lines and their ability to compete for the labor they need to run their businesses. Many small employers report that if current trends continue, they will not be able to keep offering health insurance to their workers and stay in business.

*Many Virginians cannot afford private health insurance and are not eligible for Medicaid, and despite the best efforts of those in Virginia's elaborate safety net, some go without needed services as a result.*

Table 2 helps make clear that private insurance coverage falls as income falls, and since Virginia Medicaid does not cover childless adults and covers parents only up to 29% of poverty, many people with lower incomes are uninsured because they cannot afford private premiums. For a family of four, 200% of poverty in 2009 was \$44,100. A typical family premium then was \$12,622, or 29% of gross family income. If the breadwinner does not work for a firm that offers insurance, families at that income level and below are much more likely to be uninsured than families making more than 400% of poverty. FAMIS picks up many children of lower income working parents, but not their parents.

**Coverage status by income for non-elderly adults and children in Virginia in 2009.**

	0-139% FPL	139-250%	250-400%	400% +
<b>Adults</b>	844,300	763,000	940,400	2,197,500
<i>Employer</i>	21%	50%	73%	86%
<i>Individual</i>	7%	7%	5%	4%
<i>Medicaid</i>	21%	*	*	*
<i>Uninsured</i>	44%	29%	14%	4%
<b>Children</b>	520,000	361,700	396,500	725,600
<i>Employer</i>	21%	57%	80%	87%
<i>Individual</i>	*	*	*	*
<i>Medicaid/FAMIS</i>	56%	26%	*	*
<i>Uninsured</i>	16%	*	*	*

Source: Kaiser Family Foundation analysis of CPS data, accessed November 29, 2010, from <http://www.statehealthfacts.org/profileglance.jsp?rgn=48#>. \* insufficient data to produce a reliable estimate.

*The Virginia Bureau of Insurance (BOI) will need new statutory authority to enforce some elements of the new federal reform law that went into effect September 23, 2010.*

The alternative to Virginia enforcement is federal enforcement, and no one in Virginia (and very few in Washington) actually wants that to happen. The provisions in question include: dependent coverage for children up to age 26, the end of lifetime and restrictions on annual limits, prohibition of rescissions except in case of fraud, zero-co pay coverage of certain preventive health care services, prohibition of pre-existing condition exclusions for children under the age of 19. At the request of Secretary Hazel, the BOI has prepared draft of legislation to obtain the necessary enforcement authority.

*The federal law gives states many choices regarding the new insurance marketplace, the “Exchange” or Health Benefits Exchange (to differentiate it from the Health Information Exchange (HIE), we will call the Health Insurance Exchange the (HBE), including whether to create a Virginia HBE or let the federal government set it up and operate it. It is clear at this point that the solvency and market conduct oversight and other regulatory functions of the BOI are separate and distinct from the potential competition rule enforcement authority of the new Health Benefits Exchange (HBE). The regulatory functions of the BOI should not be performed by the Exchange in any event.*

This observation comes from the general desire to avoid duplication of function or confusion about who is regulating what.

*The exchange that the federal law requires to be operational by 2014 is for those without employer offers of insurance and for those in small firms (less than 50 full-time workers in 2014 and less than 100 in 2016, though states could choose to allow firms up to 100 in in 2014) that choose to use the HBE rather than health plans that will be sold only outside the HBE.*

According to data supplied by the Virginia Employment Commission and the US Agency for Health Research and Quality, roughly 2.6 million people are likely to be eligible to enter the exchange in VA in 2014, or 56% of the current private insurance market.

*The HBE and Medicaid will have to coordinate eligibility and enrollment determination very closely.*

Federal law requires there to be one common eligibility determination mechanism, to simplify things for citizens and governments alike since some people will be eligible for Medicaid and for the HBE at different times. In addition, most of these individuals will also be eligible for federal tax credit subsidies when they are eligible to join the HBE. Since many will be subsidized one way or another, sorting out the appropriate financial liability of state and federal governments, the individuals, and any employers who may be contributing on their behalf from time to time will require a 21<sup>st</sup> century eligibility and tracking system. DHHR has already begun planning and applying for federal grants to partially fund the information system upgrades that will be necessary to make all this happen as planned on schedule.

The coordination imperative also suggests that it may be worth considering the creation of a special insurance product, PPACA envisioned a “basic health plan” for this purpose, that would cover certain individuals whether they are eligible for Medicaid or the HBE and tax credits, to simplify matters for families in a modest income range and to promote continuity of patient-clinician relationships as well.

*Designing a HBE requires many decisions, the most important of which are:*

*(1) Whether to have a state or federal HBE ?*

*ASSUMING STATE: Which the Task Force and the VHRI as a whole have already recommended*

*(2) Will it be a government entity or a non-profit?*

*(3) If government, will it be a new or within an existing agency?*

*(4) If non-profit or independent, how will it be governed?*

- (5) *Will individual and small group markets in the HBE be combined or kept separate?*
- (6) *How small will “small” be in 2014, and after 2016 (when firms larger than 100 could come in with state permission)*
- (7) *Will the HBE be state-wide, a set of contiguous sub-state HBEs, or one large multi-state HBE?*
- (8) *Will the HBE be an “active” or a “passive” purchaser or setter of competitive rules within the HBE?*
- (9) *What other actions might the state choose to take to minimize the risk of adverse selection into the HBE ? (whether and how to protect the HBE from becoming a dumping ground for poor health risks).*

The Office of the Secretary of Health and Human Resources has secured a non-competitive planning grant and is evaluating other opportunities to allow Virginia to shape the HBE that is best suited for Virginia.

The Task Force is also mindful of some key deadlines in the federal law. The main deadline is January 2013, for that is when the Secretary of HHS will determine if each state is making adequate progress toward making a HBE operational, and if not, then the federal government will take over. Technically, the HBE is supposed to be created in law by March 13, 2012, two years after enactment. But the “operational” judgment is made in early 2013.

*Three other states – Massachusetts, Utah, and California – have already created a HBE, and while only California’s was created after federal reform became law, all offer examples and choices which Virginia policy makers should consider when making determinations and recommendations for Virginia’s HBE.*

The Task Force benefited from many presentations and documents which described the many options before Virginia in setting up a HBE.<sup>46</sup> A presentation by a representative from the Utah governor’s office, John T. Neilson, was particularly well-received, as he outlined the thinking and debate behind the choices their legislature made in setting up a HBE to serve the small group health insurance market better than the status quo. He noted that the original motivation was because otherwise successful farmers could not afford to provide health insurance to their employees and families. Mr. Neilson emphasized that reform is a multi-year process, and that the HBE in Utah was one part of an integrated strategy that included a clinical health information exchange (HIE) and an all payer claims data base (APCD) and that continues to focus on increased transparency and consumerism to reduce overuse and excess health cost growth. He

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<sup>46</sup> These can all be accessed at VHRI’s website.

stressed the need for leadership at all levels, especially from the Governor's office, the business community, and the public, for real reform requires a paradigm shift for consumers and providers alike from health care for money to health for life. Change is never easy, but necessary when the status quo is unsustainable.

***What do we still need to know?***

*How will the BOI implement the rate review and consumer assistance functions as required by the new federal law?*

The BOI applied for federal grants to assist in both areas, and is in the process of negotiating with HHS on modifications of the grant conditions so that BOI participation can be made consistent with state law and custom about the BOI not making policy.

***Recommendations***

***(The previous task forces made 22 recommendations.)***

*# 23 Virginia should create and operate its own health benefits exchange to preserve and enhance competition. We suggest the Governor and legislature work together to create a process to work through the various issues in detail, with broad stakeholder input, in time for implementation to satisfy the timing requirements of the federal law.*

This was voted on by the Task Force after the first face to face meeting, and adopted by the Advisory Council in Chantilly in October. Ideas about all the other design features have not been finalized, though most Task Force members feel far better informed about the implications of these choices than when the VHRI began. The following goals stood out.

*# 24 Whatever form the Virginia HBE ultimately takes, there was broad agreement about what the HBE should achieve in practice, about what would be considered a successful HBE, and therefore what the Secretary and Legislature and Governor should keep in mind:*

- (1) Provide small employers with an opportunity to be financially successful while providing health insurance to their workers*
- (2) Provide a marketplace that works well for those without insurance today*
- (3) Provide a marketplace that facilitates the transformation of the delivery system to produce more value per dollar spent, by focusing on quality and transparency*
- (4) Transparency in all things should promote choice, stability and innovation*
- (5) The HBE must address the cost of health care and the competitive disadvantage that small firms and ultimately all US firms labor under now. We should not miss an opportunity to explore how the HBE can help on the cost front.*

- (6) *The HBE should help educate employees and employers through a user-friendly website*
- (7) *Individuals and employees should be engaged in their own care as well as in regular wellness and prevention activities*
- (8) *Maximizing effective competition and number of competitors with qualified health plans should be the goal, with absolute transparency about the implications of consumer choices in cost and quality dimensions. Access to a robust all payer claims database may help us all become smarter consumers together.*
- (9) *Above all: remember to keep it simple, so that small employers and average citizens can understand how to use and benefit from the HBE marketplace.*

DRAFT: CONFIDENTIAL

## Purchaser Perspectives

The Purchaser Perspectives Task Force was created to enable employers and consumers of health insurance and health care to have their own seat at the table in discussing reform options. Their purview was meant to be broader than the other five task forces, and was therefore technically unlimited. Nevertheless, group discussions led to a coherent set of fact findings and then to a focus on four major questions:

1. What is driving high health costs and cost growth?
2. What tools are available, existing or in recent legislation, for employers big and small to promote wellness and prevention?
3. What is likely to be the impact of health spending and reform on jobs and the economy?
4. What insurance options will be available inside and outside the Health Benefit Exchange (HBE) after reform takes place?

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

*Employers, combined, pay for more health care than any other single payer, including Medicare or Medicaid.*

According to CMS data presented at the initial retreat in Roanoke, private insurance pays for 33% of health care in the United States, whereas Medicare and Medicaid + SCHIP pay for 20% and 15%, respectively. Group insurance is at least 90% of total private, and employers pay for roughly 75% of group insurance, so the total employer share ( $.9 \times .75 \times .33 = .22$ ) exceeds Medicare. Therefore, employers *could* be a potent force for incentive realignment and change in system reform *if* they act in concert.<sup>47</sup>

*Health care costs so much more here than in other countries that US employers are having a more difficult time competing with global firms than they used to.*

According to data presented at the Roanoke retreat the US spends over twice as much per labor hour on health care as our major trading partners and we rely relatively more on employer

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<sup>47</sup> Eileen Ciccotelli and Len M. Nichols, "Purchaser Perspectives on Health Reform," Presented to the VHRI Advisory Council, August 21, 2010, Available from

<http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/purchaser.pdf> .

financing than other countries.<sup>48</sup> As a consequence, maintaining competitiveness requires us to lower cost growth trajectories.

*Individuals and families, through out-of-pocket payments, reduced wages, and taxes, ultimately pay for all of health care, and therefore individuals are purchasers, too.*

This observation makes clear that all of us are purchasers, and that ultimately, the burden of paying for health care falls to families in one form or another. Therefore affordability has two dimensions, for individual families, and for the Commonwealth as a whole. A sustainable health system will be affordable for both.

*An unhealthy workforce is less productive and more costly to employers than a healthy workforce, whether they provide health insurance or not.*

According to peer-reviewed research presented at the Roanoke retreat, presenteeism (being at work but not being productive) and absenteeism are actually more costly to employers than medical care for many common conditions including hypertension, diabetes, arthritis, depression, and headaches.<sup>49</sup>

The following statements or facts were stated or agreed upon by Advisory Council members and are part of the important context of the underlying knowledge base and values of the Task Force on Purchaser Perspectives:

- *Employers want choice, honest dealings in negotiating premiums, and transparency in price and quality when buying health insurance and health care.*
- *Employers often lack actionable data from insurers (e.g., on chronic disease prevalence).*

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<sup>48</sup> <sup>48</sup> Eileen Ciccotelli and Len M. Nichols, "Purchaser Perspectives on Health Reform," Presented to the VHRI Advisory Council, August 21, 2010, Available from <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/purchaser.pdf> .

<sup>49</sup> <sup>49</sup> Eileen Ciccotelli and Len M. Nichols, "Purchaser Perspectives on Health Reform," Presented to the VHRI Advisory Council, August 21, 2010, Available from <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/purchaser.pdf> .

Much of this research was done by Ron Goetzel, Ph.D. of Thompson Reuters and Emory University, who graciously allowed us to use some of his slides. Also, Joseph Thompson, MD, Surgeon General of the State of Arkansas, graciously allowed us to show some of his analytic work on obesity with the Arkansas state employees.

- *Individuals want choice, fair value and transparency in insurance and care. Some also need subsidies to afford insurance and appropriate care.*
- *Personal responsibility for health and health care choices must be part of any reformed system.*
- *The insurance reforms, new taxes, and employer requirements in PPACA will likely increase premium costs, somewhat, for most sponsoring firms in the next few years.<sup>50</sup> Tax credits would lower costs for certain small, lower wage firms.<sup>51</sup> The big unknowns are whether delivery reforms and health benefit exchanges will help lower costs vs. baseline in the long run.*

*The vast majority of Virginia employers have fewer than 100 workers, and roughly half the workforce is employed by firms in that size range. These firms, especially the smallest, are far less likely to offer health insurance to their workers than are firms with more than 100 workers, in Virginia and around the country.*

A memo and a presentation summarized the professional and consulting firm literature and addressed the underlying causes of high costs and cost growth for the Task Force.<sup>52</sup> The following are the salient findings of the memo.

*Costs are higher – 28-50% higher depending on the measure -- in the US mostly because we pay higher prices than other countries, because we perform more invasive procedures and advanced*

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<sup>50</sup> Eileen Ciccotelli and Len M. Nichols, “Purchaser Perspectives on Health Reform,” Presented to the VHRI Advisory Council, August 21, 2010, Available from <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/purchaser.pdf> .

<sup>51</sup> The Purchaser Task Force heard a presentation that suggested that the number of small firms who will qualify for the small business low wage tax credits could be far smaller than expectations which have been created.

Llewellyn, Elizabeth, “Patient Protection and Affordable Care Act” Presentation to the VHRI Purchasers Perspectives Task Force, November 9, 2010, Richmond, Virginia, Available from: <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

<sup>52</sup> Len M. Nichols, “Looking Under the ‘Blanket’ Of Health Care Costs: A FAQ Style Essay, With Footnotes.” , and “Looking Under the Blanket of Health Care Costs,” November 9, 2010, both available at <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>.

*imaging, and because clinicians here are more worried about medical mal-practice lawsuits for not “doing enough” for a patient.*

Virginia spending per capita is lower than the US average, but premiums are higher. However, deductibles are lower in Virginia, and Virginia has more benefit mandates than most states, so it is not clear that Virginians are getting lower value from insurance than other Americans. What is clear is that the average Virginian and American is getting lower health value per dollar spent than citizens of other advanced countries.

*Specific and complex procedures, like transplants, are very expensive, but we still spend most of our health dollar on chronic conditions like heart disease and hypertension, cancer, mental health, and lung diseases.*

Transplant surgeries routinely cost hundreds of thousands of dollars, but they are relatively rare. What has become routine care for chronic conditions, by contrast, happens so often that over half of all spending is for the ten most expensive conditions, like heart disease, cancer, lung diseases, diabetes, and depression.

*Far more of the health dollar is spent on hospitals and clinicians than on insurance administration, but the McKinsey consulting firm estimates as much as 15% of our higher than expected spending is on administrative activities within both insurers and providers.*

And the average “load” or difference between premium and medical claims paid is considerably higher in the small group and individual markets than in the large group market. These facts help explain why administrative simplification and re-organizing the small group and individual markets are often central elements of any serious reform plan.

*Costs and premiums are growing faster in Virginia than in the US, and both have outstripped state GDP and personal income per capita growth.*

This is the main reason people and employers with coverage are feeling so stressful about health care cost growth and why reform became such a high political agenda item in the first place. Health care and insurance become relatively more expensive every year, and no one can point to any guaranteed way to arrest or reverse the trend.

*Cost growth is widely believed to be driven by four main factors, listed in order of estimated importance: technological change, reduced cost sharing, the rise in prevalence of chronic conditions, the aging of the population.*

It is impossible to assign precise and specific percentage contributions to the causes of cost growth, but a comprehensive approach to system reform should clearly address all three and be prepared for slow but steady pressure on costs from the fourth.

*The return on investment from wellness and prevention activities is beginning to be understood more precisely and promising examples are starting to spread, including in Virginia.*

Peer-reviewed research has documented successes that Johnson and Johnson and PepsiCo have achieved with their wellness and prevention programs for their employees.<sup>53</sup> Sentara has developed a similar program through its Optima insurance, first for its own employees, but now it sells the product in the commercial market in Tidewater.<sup>54</sup>

*The new federal health reform law has a number of provisions that aim to support employer-based wellness and prevention programs.*

For the first time, insurers will be allowed to charge smokers 50% more than non-smokers, and to grant up to 30% discounts for participating in a wellness program offered by the employer. Community transformation grants could be used to promote or incentivize worksite wellness programs. The CDC is directed to provide technical assistance, consultation, tools, and training to employers in how to evaluate wellness programs, and starting in 2012 and beyond, the CDC must conduct an annual survey and report to Congress and the country on best practices being used by employers. Finally, there are grants to small employers (fewer than 100 employees) to implement wellness programs at work, and in a pilot program, 10 community health centers could be grants to construct and implement wellness plans for high risk individuals, who are likely to be employees, with blood pressure, tobacco use, or weight problems.<sup>55</sup>

*Health reform's net spending and tax effects would increase GDP and jobs in Virginia, and the net positive impact would be almost tripled if health care cost growth slows by as little as 0.75% per annum.*

The Virginia Hospital and HealthCare Association commissioned a study of the impact of health reform – as envisioned in the federal legislation and assumed to be implemented in the Commonwealth – on the Virginia economy. The study was conducted by the Weldon Cooper Public Policy Institute of the University of Virginia. The net spending on health care from a

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<sup>53</sup> Ciccotelli and Nichols, Op cit, and references cited in footnote 20.

<sup>54</sup> Dr. George Hauser and Doug Gray, “Optima Health: Integrated Care Model” presentation to insurance task force, November 9, 2010, Richmond, Virginia available at <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm>

<sup>55</sup> Len M. Nichols, “Wellness Provisions of PPACA Relating to Employers,” presentation to Purchaser Task , November 9, 2010, Richmond, Virginia Force, available at <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/MtgRes.cfm> .

fully financed coverage expansion is on net stimulating to overall economic activity. Excess health care cost growth acts like a tax on the private sector, so lowering excess cost growth is like a tax cut. That is what creates the amplified job gains in the lower cost growth scenario.<sup>56</sup>

### ***What do we still need to know?***

*Options for purchasing health insurance inside and outside the Health Benefits Exchange are not totally clear.*

Details of these options cannot be known, until the rules of competition within the HBE and outside the HBE are clarified in the next two years, and really not until insurers decide what to offer in each market and at what prices, given those as yet undefined rules.

We do know some things about the kinds of products the federal law would require insurers to offer inside the exchange. While covering an “essential” set of benefits, to be defined by the Federal Secretary of HHS, insurers would be required to structure cost-sharing and/or extra benefits in such a way that the products met one of four actuarial value<sup>57</sup> targets: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%). Insurers who participate in the HBE would be required to offer at least a Silver and a Gold plan, and would be allowed to Bronze and Platinum if they choose too. Unless state or federal law changes, however, they could offer any product they want to outside the exchange, but if they do offer the same product inside and outside, they have to charge the same premium.

Without detailed premium quotes for 2014, which do not exist for any insurance product, it is impossible to know what policies will actually cost under reform at this point. Once again current federal law has set some parameters on what people who would be subsidized inside the HBE – those with incomes between 133% of poverty and 400% (\$15,000-\$88,000 per year for a family of four) – would pay as a percentage of their income *inside the HBE*. Since premium tax credits or subsidies would not be available outside the exchange, it is impossible to compare precisely, but Table 4 reports the basic personal premium cost of policies inside the exchange as a percentage of income, by income class.

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<sup>56</sup> This study is available on the VHHA and the VHRI websites.

<sup>57</sup> Actuarial value is the percent of expected costs incurred by a population of average health risk that the specific insurance policy would pay. Higher actuarial values reflect more generous or comprehensive policies. The Fortune 100 average is around 80%, the Federal Employee’s Blue Cross Blue Shield Standard product, the one with the largest enrollment, is about 78%. Actuarial value norms are lower in the small group and individual markets, but representative data are not publicly available.

**Premium obligations of the subsidized population in the Health Benefits Exchange under the Patient Protection and Affordability Act, 2014.**

Household income as percent of the poverty line	Actual income using 2010 poverty guidelines for a family of 4 (100% of poverty for family of 4 = \$22,050)	Percent of income required of families for premiums	Annual premium share for individual (based on 2010 income levels)
Under 133%	< \$29,326.50	Eligible for Medicaid	\$0
133% up to 150%	\$29,326.50-\$33,075	3%-4%	\$880 - \$1,323
150% up to 200%	\$33,075-\$44,100	4% to 6.3%	\$1,323-\$2,778
200% up to 250%	\$44,100-\$55,125	6.3% to 8.05%	\$2,778-\$4,438
250% up to 300%	\$55,125-\$66,150	8.05% to 9.5%	\$4,438-\$6,284
300% up to 400%	\$66,150-\$88,200	9.5% to 9.5%	\$6,284-\$8,379

Note the HBE subsidies are generous compared to the cost of a premium (a family policy is over \$13,000 nationwide today), so that would tend to attract people to the HBE. But also note the amount a person would have to pay, even at the lowest income in the exchange, is more than the penalty for not being covered. The penalty is the greater of \$95 and 1% of income for 2014, \$325 and 2% of income for 2015, and \$695 or 2.5% of income for 2016 and beyond. After 2016, the flat dollar amount goes up by CPI to the nearest \$50. Given the sliding scale nature of the subsidy plan, the higher one's income, the greater the incentive to remain uninsured. Today we do observe that higher income people are the most likely to be insured (remember Table 2). It is an empirical question, and a risk, to see if "enough" people would buy insurance to avoid an adverse selection meltdown with the penalties this low. CBO thought enough would, but a wide range of people are worried about this issue going into 2014. We don't risk a meltdown now, because insurers are allowed to underwrite. But the insurance reforms scheduled to go into effect in 2014 – especially guaranteed issue (insurers must sell to all comers) and modified community rating (no differential rating by health status) – would make adverse selection a much greater risk if there is no mandate or if the mandate is ineffectual. Given the lawsuits challenging the constitutionality of the individual mandate, as well as the controversy over the weak mandate penalty if it does remain in place, the likelihood of national reform legislation changing between now and 2014 is relatively high.

### ***Recommendations***

Since so much of the point of reform is to make insurance and care more affordable for small employers and their workers and their families, policy makers need to listen to the business voice in what they really want HBEs, and reform generally, to accomplish. We note however, it is not easy to obtain a representative sample of business views, especially small business views, for most are often too busy running their business to participate in public policy discussions and processes. Therefore we recommend:

*#25 The Secretary work with small business leaders, researchers and private foundations to commission and conduct a representative survey of Virginia employer opinions about what features they want in a Health Benefits Exchange and what they want from health reform generally.*

DRAFT: CONFIDENTIAL

## Summary and Conclusions

Health reform is a process, and successful health reform is a participation sport. The Advisory Council and Task Forces were created to ensure that the VHRI reflects the values, wisdom, and experience that only a broad array of private citizens, acting in deliberative concert around a common purpose, possess. When coupled with the leadership exhibited by Secretary Hazel, in 4 months the effort has identified 25 specific and evidence-based steps that would move Virginia toward the vision of healthier people, healthier communities, a better health care system, and a stronger economy. The vast majority of these suggested actions are independent of the new federal law. This accentuates the fundamental point that health system reform can be in the Commonwealth's interest regardless of federal actions or inactions.

This report and these observations suggest two broad conclusions.

One, the Advisory Council should continue its role as fact-finder and sounding board for the VHRI and the Secretary as he works with the Governor and the legislature to implement the recommended steps and develop subsequent proposals. Quarterly meetings throughout 2011, wherein the Secretary and others report on progress and findings as they develop, might be the right interval.

Two, given that "health reform Virginia's way" is worth doing regardless of federal law, there should be no unnecessary delay in beginning implementation. Since so many recommendations hold promise to improve quality, lower cost, or make insurance and care more affordable and accessible, opportunities for "early adoption" should be prudently explored and acted upon. For example, the Health Benefits Exchange could be created before 2014 and thereby designed and shaped to fit Virginia's goals and values more than the contours of PPACA as passed in 2010. There would still need to be study and much stakeholder input, but the need to make a more effective marketplace for small employers, their workers and their workers' families has rarely been more self-evident.

## Appendix A



### *Commonwealth of Virginia* *Office of Governor Bob McDonnell*

**FOR IMMEDIATE RELEASE**

August 16, 2010

Contact: Stacey Johnson

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E-mail: [Stacey.Johnson@Governor.Virginia.Gov](mailto:Stacey.Johnson@Governor.Virginia.Gov)

#### **Governor Bob McDonnell Announces Members of the Virginia Health Reform Initiative Advisory Council**

**RICHMOND**-Governor Bob McDonnell today announced the members of his Virginia Health Reform Initiative Advisory Council. This Council will provide recommendations to the Governor towards a comprehensive strategy for implementing health reform in Virginia. The Advisory Council will go beyond federal health reform and recommend other innovative healthcare solutions that meet the needs of Virginia's citizens and government. The Advisory Council's recommendations for addressing health care access, cost and delivery in Virginia may serve as a model for other states. The recommendations of the Council will help create an improved health system that is an economic driver for Virginia while allowing for more effective and efficient delivery of high quality health care at lower cost.

Speaking about the Council's composition, Governor McDonnell remarked, "Every Virginian needs access to affordable health care. The challenge is how to provide that access in an economically responsible manner. This group of leaders will help us plan for the future of healthcare in Virginia, and the growing costs that will have a significant impact on our budget and our taxpayers unless we act proactively and wisely today. The tremendous rate of growth in Medicaid spending in Virginia, which is only going to increase due to federal health care reform, is unsustainable. I look forward to their recommendations and work in the months ahead."

Secretary of Health and Human Resources Dr. Bill Hazel remarked, "We have assembled a dynamic group of leaders from the legislature, health care delivery, health care policy, health insurance, and the business community that will help shape the future of healthcare in Virginia. I am grateful for their time, expertise, and commitment to the task of ensuring a safe, effective, and quality healthcare delivery system while reducing costs."

The Advisory Council will establish task forces in six key areas: Medicaid Reform, Insurance Market Reform, Delivery and Payment Reform, Capacity, Technology, and Purchasers Perspective. In June, Governor McDonnell appointed Cindi Jones as the Director of the Virginia Health Reform Initiative; Jones is one of the nation's first state officials dedicated to health care reform. Additional healthcare stakeholders and business representatives will be asked to serve on these critical task forces. The Advisory Council will hold its initial meeting on August 20 and August 21, 2010 in Roanoke, Virginia.

## Members of the Virginia Health Reform Initiative Council

### Chair

- **Dr. Bill Hazel**, Secretary of Health and Human Resources

### Council Members:

- **Cindi B. Jones**, Director, Virginia Health Reform Initiative (ex-officio)
- **W. Scott Burnette**, President, and Chief Executive Officer, Community Memorial Health Center
- **Geoff Brown**, Senior Vice President and Chief Information Officer, INOVA Health System
- **Jim Carlson**, Chairman and Chief Executive Officer, Amerigroup
- **Honorable Ben L. Cline**, Member, Virginia House of Delegates
- **Monty Dise**, President, Asset Protection Group, Inc.
- **William H. Fralin, Jr.**, Chief Executive Officer and President, Medical Facilities of America
- **Shirley Gibson**, RN, Interim Vice President of Nursing Operations, VCU Health System
- **Chuck Hall**, Executive Director, Hampton/Newport News Community Services Board
- **Richard M. Hamrick, III**, MD, Physician and Partner, Pulmonary Associates of Richmond
- **Honorable Patrick A. Hope**, Member, Virginia House of Delegates
- **Steve Horan**, President, Community Health Solutions
- **Honorable R. Edward Houck**, Member, Virginia State Senate
- **Clarion E. Johnson**, M.D., Global Medical Director, Medicine and Occupational Health Department, Exxon Mobil Corporation
- **W. Scott Johnson**, Hancock, Daniel, Johnson & Nagle, P.C
- **Honorable S. Chris Jones**, Member, Virginia House of Delegates
- **C. Burke King**, President, Virginia Market, Anthem Blue Cross and Blue Shield
- **Jane Kusiak**, Executive Director, Council on Virginia's Future
- **John A. Luke, Jr.**, Chairman and Chief Executive Officer, MWV MeadWestVaco
- **Elizabeth Teisberg**, Ph.D., Darden Graduate School of Business, University of Virginia
- **Dixie Tooke-Rawlins**, D.O., Dean and Executive Vice President, Edward Via College of Osteopathic Medicine (VCOM)
- **Honorable William C. Wampler, Jr.**, Member, Virginia State Senate
- **Joe R. Wilson**, Chief Operating Officer, PermaTreat Pest Control

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## Appendix B



### *Commonwealth of Virginia* *Office of Governor Bob McDonnell*

**FOR IMMEDIATE RELEASE**

August 16, 2010

Contact: Stacey Johnson

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#### **Governor Bob McDonnell Announces Taskforce Membership of Virginia Health Reform Initiative**

**RICHMOND-** Governor Bob McDonnell today announced the members of the six taskforces working in coordination with the Virginia Health Reform Initiative Advisory Council. The taskforces are: Medicaid Reform, Insurance Reform, Service Delivery, Capacity, Technology, and Purchasers. These taskforces will work to bring recommendations and information to the Advisory Council who will then provide recommendations to the Governor towards a comprehensive strategy for implementing health reform in Virginia. Like the Advisory Council, the work of the taskforces will go beyond federal health reform and recommend other innovative healthcare solutions that meet the needs of Virginia's citizens and government.

Speaking about the composition of the six taskforces, Governor McDonnell remarked, "Every Virginian needs access to affordable health care. The challenge is how to provide that access in an economically responsible manner. The make-up of these taskforces includes a wide array of expertise and opinions from across the Commonwealth. The taskforces are comprised of individuals who recognize the need for Virginia to lead the nation by establishing a responsible model for health reform and will work to the success of this initiative, both professionally and personally."

Secretary of Health and Human Resources Dr. Bill Hazel stated, "We have pulled together a topnotch group of stakeholders that will help set the platform for the future of healthcare in Virginia. The task ahead is not easy, but I am appreciative of the commitment being made by each taskforce member. Through their guidance, our Commonwealth will begin to tackle the issues within the existing health care system and work towards affordable, quality care for all Virginians."

As the director of the Virginia Health Reform Initiative, Cindi Jones will oversee the work of the taskforces. To ensure continuity of information, the Advisory Council members will be divided among the six taskforces. The initial taskforce meetings will be held September 21<sup>st</sup> and 22<sup>nd</sup>. More information regarding these meetings will be posted on the Commonwealth Calendar and the Legislative Information Systems meeting website.

## Members of the Virginia Health Reform Initiative Six Task Forces

### Medicaid Reform Task Force

- **Scott Johnson**, Hancock, Daniel, Johnson & Nagle, P.C.; Advisory Council Member, Co-Chair
- **William Fralin**, Chief Executive Officer and President, Medical Facilities of America; Advisory Council Member, Co-Chair
- **Chuck Hall**, Executive Director, Hampton-Newport News Community Services Board; Advisory Council Member
- **Jim Carlson**, Chairman and Chief Executive Officer, Amerigroup; Advisory Council Member
- **Ed Howell**, Vice President and Chief Executive Officer, University of Virginia Health System
- **Nancy Dimaano**, RN, Owner, Best and Dependable Home Health Care
- **Dr. Colleen Kraft**, Associate Professor of Pediatrics, Virginia Tech Carilion School of Medicine
- **Bill Kallio**, AARP Virginia State Director (consumer representative)
- **John Fitzgerald**, Chief Executive Officer, INOVA Fair Oaks Hospital
- **Karen J. Stanley**, Executive Director, The Healing Place and CARITAS

### Insurance Reform

- **Dr. Richard Hamrick**, Physician and Partner, Pulmonary Associates of Richmond; Advisory Council Member, Co-Chair
- **Dr. Clarion Johnson**, Global Medical Director, Exxon Mobil Corporation; Advisory Council Member, Co-Chair
- **Burke King**, President, Anthem Blue Cross and Blue Shield; Advisory Council Member
- **Monty Dise**, President, Asset Protection Group; Advisory Council Member
- **Joe Wilson**, Chief Operation Officer, PermaTreat Pest Control; Advisory Council Member
- **Kendall D. Hunter**, Chief Operating Officer, Kaiser Permanente Mid-Atlantic States
- **Ann Honeycutt**, Virginia Cardiovascular Specialists
- **Nancy Agee**, Chief Operating Officer, Carilion
- **Ginger Brooking**, Co-Owner, Brookmeade Sod Farm
- **Kristin Parde**, Director of State Policy, PhRMA
- **Marcia Drinkard**, Owner, Interiors with Marcia (consumer representative)

### Service Delivery and Payment Reform

- **Scott Burnette**, President and Chief Executive Officer, Community Memorial Health Center; Advisory Council Member, Co-Chair
- **Steve Horan**, President, Community Health Solutions; Advisory Council Member, Co-Chair
- **Jane Kusiak**, Vice Chair, Board of Trustees, Virginia Health Care Foundation; Advisory Council Member
- **Julie C. Locke**, Richmond
- **John Duval**, Chief Executive Officer, MCV Hospitals, VCU Health System
- **Victor Giovanetti**, MBA, President, HCA Southwest Virginia
- **Nancy Stern**, Chief Executive Officer, Eastern Shore Rural Health System (consumer representative)
- **Dr. James Dudley**, Emergency Physician, Service Line Chief, Riverside Tappahannock Hospital
- **Howard P. Kern**, President, Sentara Healthcare
- **Sally Graham**, Executive Director, Free Clinic and Family Services of Goochland (consumer representative)
- **Dr. Stephen Norfleet**, Tidewater Physicians Multispecialty Group
- **Dorrie Fontaine**, RN, PhD, Dean and Professor, UVA School of Nursing
- **Tom G. Smith**, J.D., Partner, Shevlin Smith

### Capacity

- **Shirley Gibson**, RN, Interim Vice President of Nursing Operations, VCU Health System; Advisory Council Member, Co-Chair
- **Dixie Tooke-Rawlins**, D.O., Dean and Executive Vice President, Edward Via College of Osteopathic Medicine; Advisory Council Member, Co-Chair
- **Roderick Manifold**, Executive Director, Central Virginia Health Services, Inc. (consumer representative)
- **Frank Farrington**, DDS, Professor Emeritus, VCU School of Dentistry
- **Kurt Bell**, RPh, Pharmacy Operations Manager, Virginia Baptist Hospital, Centra Health
- **Dr. Michael Solhaug**, Dean of Admissions, Eastern Virginia Medical School
- **Anthony Miller**, Professor and Director, Physician Assistant Studies, Shenandoah University
- **Brian Foley**, Provost, Northern Virginia Community College
- **Peter Bernard**, Chief Executive Officer, Bon Secours Virginia
- **Ted LeNeave**, President and CEO, American HealthCare, LLC
- **PJ Maddox**, RN, Ph.D., Chair, Health Administration and Policy, George Mason University
- **Mary Duggan**, MS, RN, CCRN, ACNP-BC, Chair, Government Relations Committee, Virginia Council of Nurse Practitioners

### Technology

- **Geoff Brown**, Senior Vice President and Chief Information Officer, INOVA; Advisory Council Member, Chair
- **Howard Chapman**, Executive Director, Southwest Virginia Community Health Systems, Inc.
- **Dr. Karen Rheuban**, Medical Director, Office of Telemedicine, UVA School of Medicine
- **Terri Ripley**, Director of Systems and Programming, Centra
- **Dave Lawrence**, Chief Executive Officer, Farm Credit of the Virginias
- **Anna Slomovic**, Chief Privacy Officer, Anakan, Inc.
- **Jodi Fuller**, Director of Global Benefits, MWV
- **James L. Perkins**, Chief Executive Officer, West End Orthopedic Clinic
- **Ann Fleming**, Senior Vice President, Mountain States Alliance
- **Dr. Sterling N. Ransome, Jr.**, Fishing Bay Family Practice

### Purchasers

- **Monty Dise**, President, Asset Protection Group; Advisory Council Member, Co-Chair
- **John Luke**, Chairman and Chief Executive Officer, MWV; Advisory Council Member, Co-Chair
- **Elizabeth Teisberg**, Ph.D., Darden Graduate School of Business, UVA
- **Tom Snead**, Retired President, Southeast Region, Wellpoint, Inc.
- **Michel Zajur**, President and Chief Executive Officer, Virginia Hispanic Chamber of Commerce
- **Doug Coleman**, President, Total Development Solutions
- **Julia Hammond**, Virginia State Director, National Federation of Independent Business
- **Barry DuVal**, President, Virginia Chamber of Commerce
- **Susan Dess**, Senior Vice President, Health and Wellness and Product Development, VALUEOPTIONS, Inc.

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## **Appendix C**

### **Meeting Times and Dates**

#### **Virginia Health Reform Initiative Full Advisory Council**

August 20-21, 2010

Hotel Roanoke, Roanoke, Virginia

October 26-27, 2010

Chantilly, Virginia

December 13-14, 2010

Darden Business School at the University of Virginia, Charlottesville, Virginia

#### **Virginia Health Reform Initiative Taskforces**

##### **Service Delivery and Payment Reform**

September 21, 2010- Conference Call

October 22, 2010 – DMAS: 600 East Broad Street, Richmond, VA

November 18, 2010- DMAS: 600 East Broad Street, Richmond, VA

##### **Technology**

September 22, 2010- Conference Call

October 22, 2010 – DMAS: 600 East Broad Street, Richmond, VA

November 16, 2010- DMAS: 600 East Broad Street, Richmond, VA

##### **Capacity**

September 21, 2010- Conference Call

October 19, 2010 – DMAS: 600 East Broad Street, Richmond, VA

November 16, 2010- DMAS: 600 East Broad Street, Richmond, VA

##### **Medicaid**

September 22, 2010 – Conference Call

October 20, 2010 – DMAS: 600 East Broad Street, Richmond, VA

November 9, 2010- DMAS: 600 East Broad Street, Richmond, VA

##### **Insurance**

September 22, 2010 – Conference Call

October 20, 2010 – DMAS: 600 East Broad Street, Richmond, VA

November 18, 2010- DMAS: 600 East Broad Street, Richmond, VA

##### **Purchaser**

September 21, 2010 – Conference Call

October 19, 2010 – DMAS: 600 East Broad Street, Richmond, VA

November 9, 2010- DMAS: 600 East Broad Street, Richmond, VA