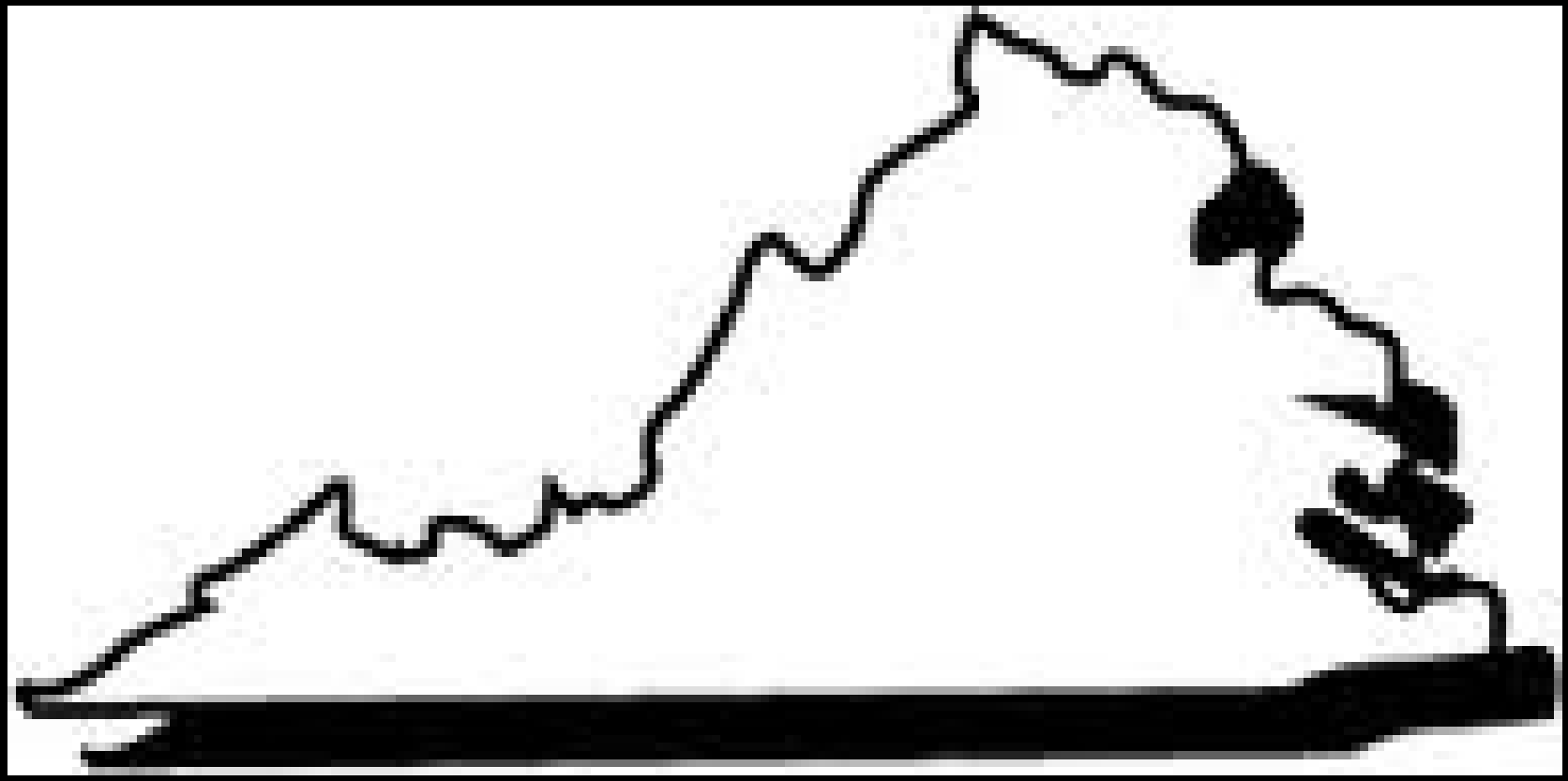
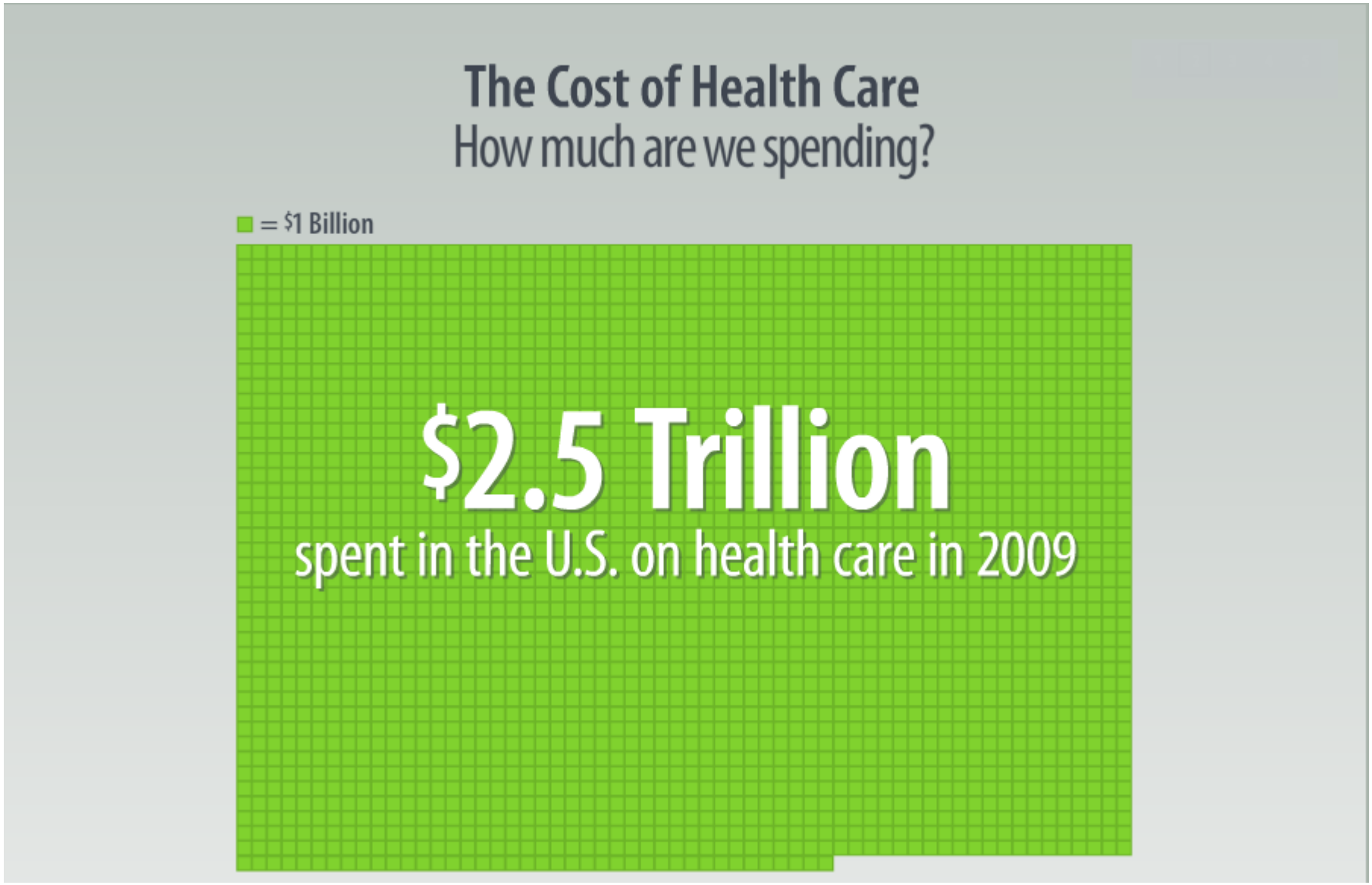
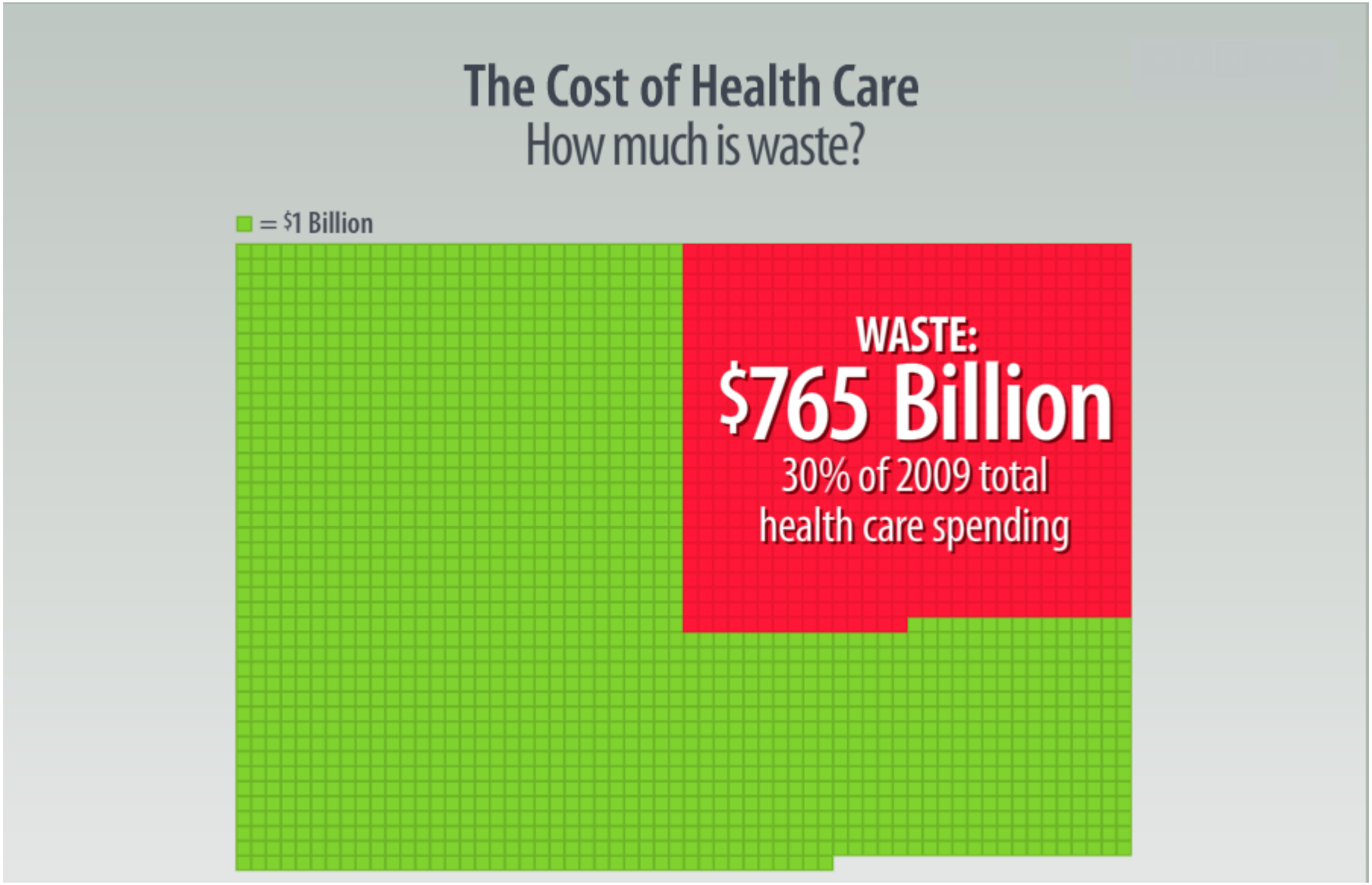
Health Reform in Virginia
Status Update - Summer 2013
Presentation to the Loudoun County Chamber



Dr. Bill Hazel
Secretary of Health and Human Resources



Source: Institute of Medicine: *The Healthcare Imperative: lowering costs and improving outcomes*



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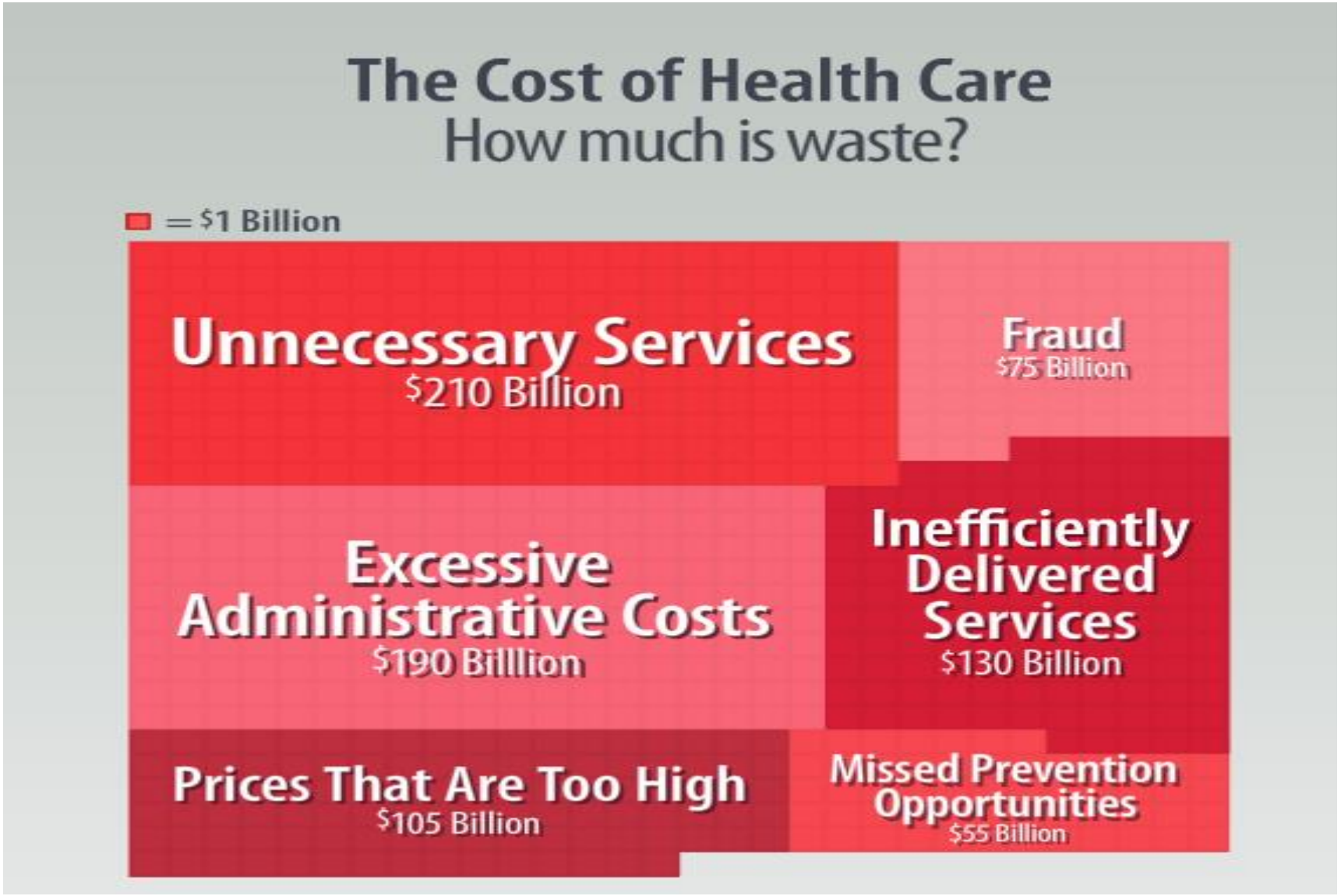

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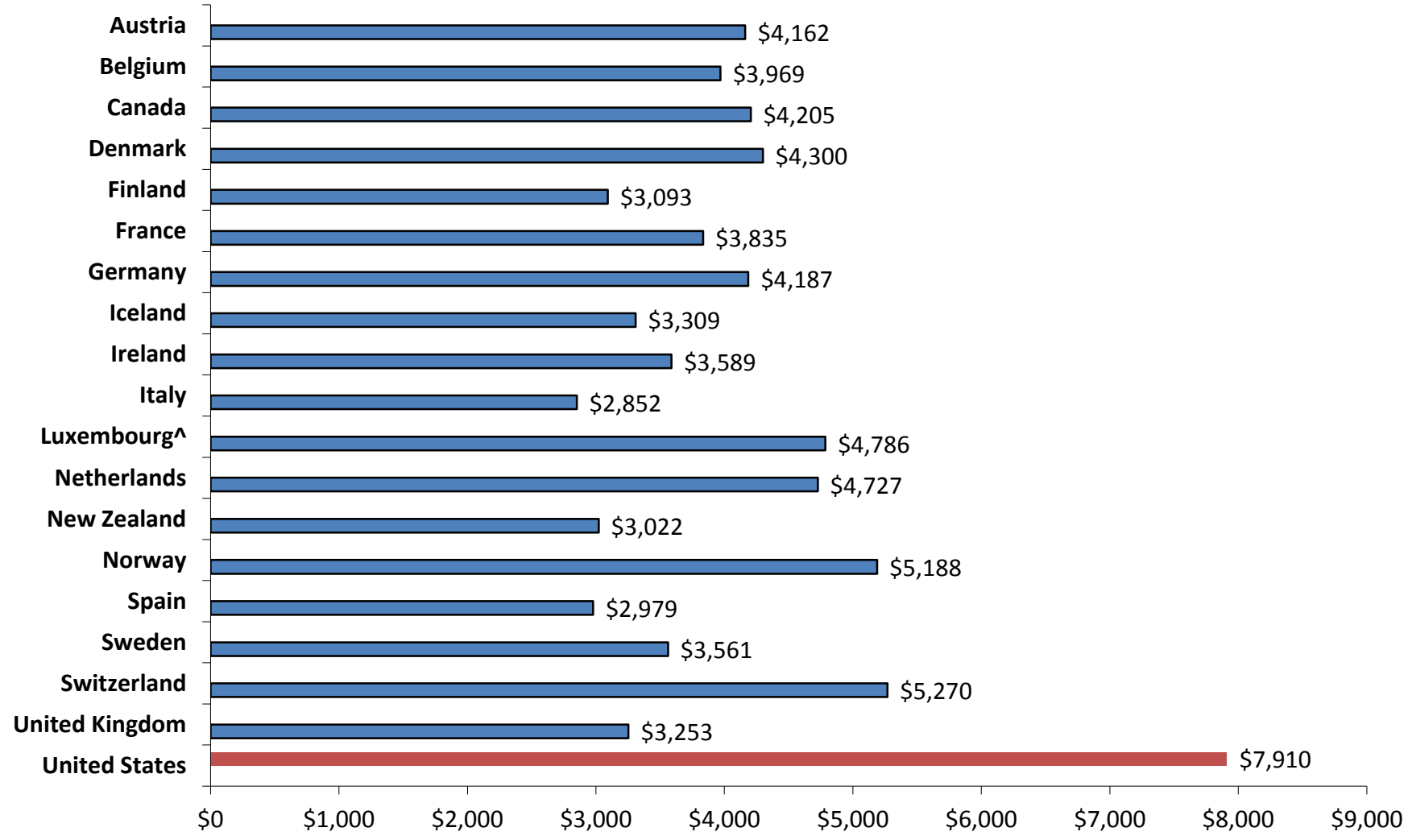
Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2010

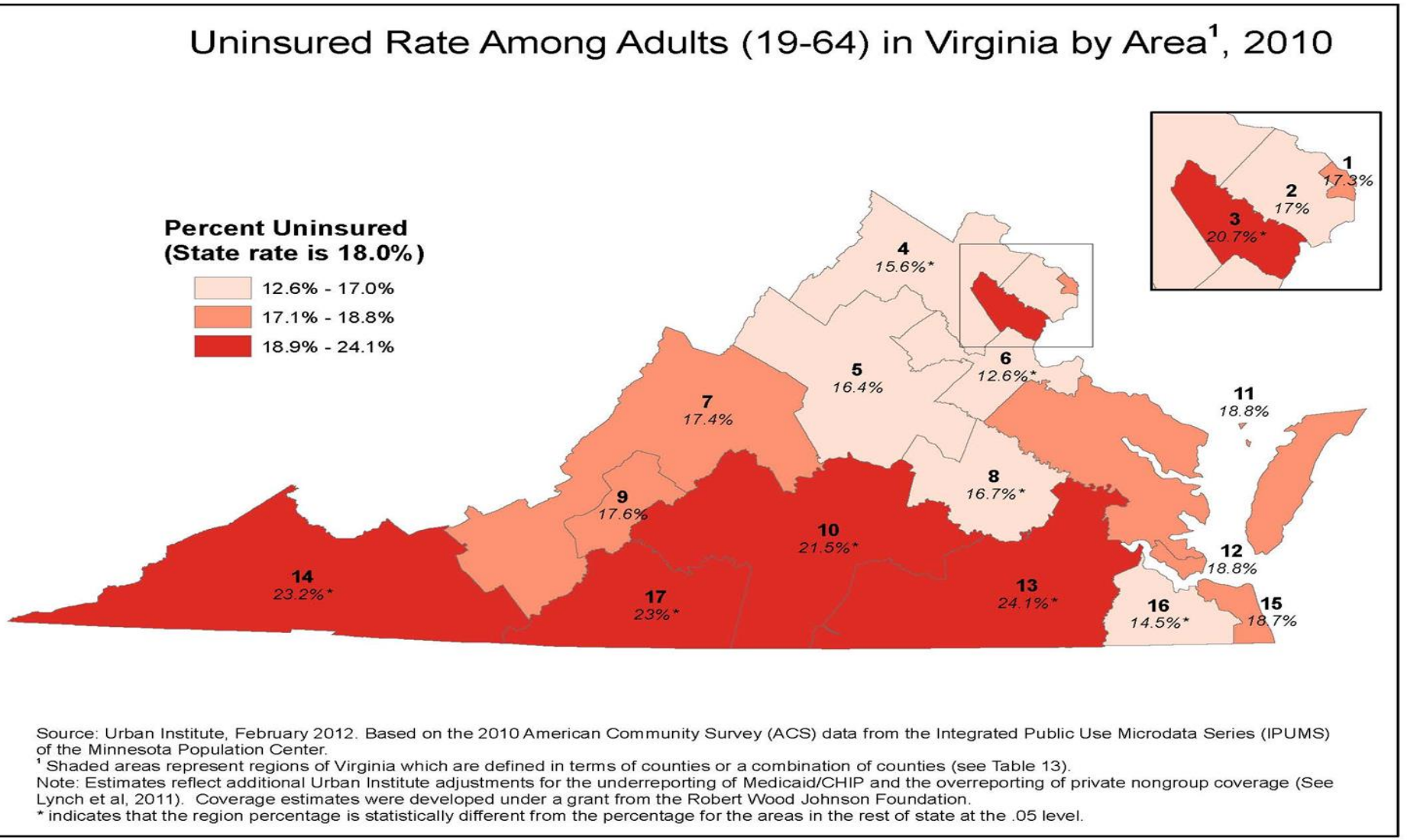


^ 2009 data

Notes: Amounts in U.S.$ Purchasing Power Parity, see www.oecd.org/std/ppp; includes only countries over $2,500. OECD defines Total Current Expenditures on Health as the sum of expenditures on personal health care, preventive and public health services, and health administration and health insurance; it excludes investment.

Source: Organisation for Economic Co-operation and Development. "OECD Health Data: Health Expenditures and Financing", OECD Health Statistics Data from internet subscription database. http://www.oecd-library.org, data accessed on 03/04/13.

Where do Uninsured Virginians Live?



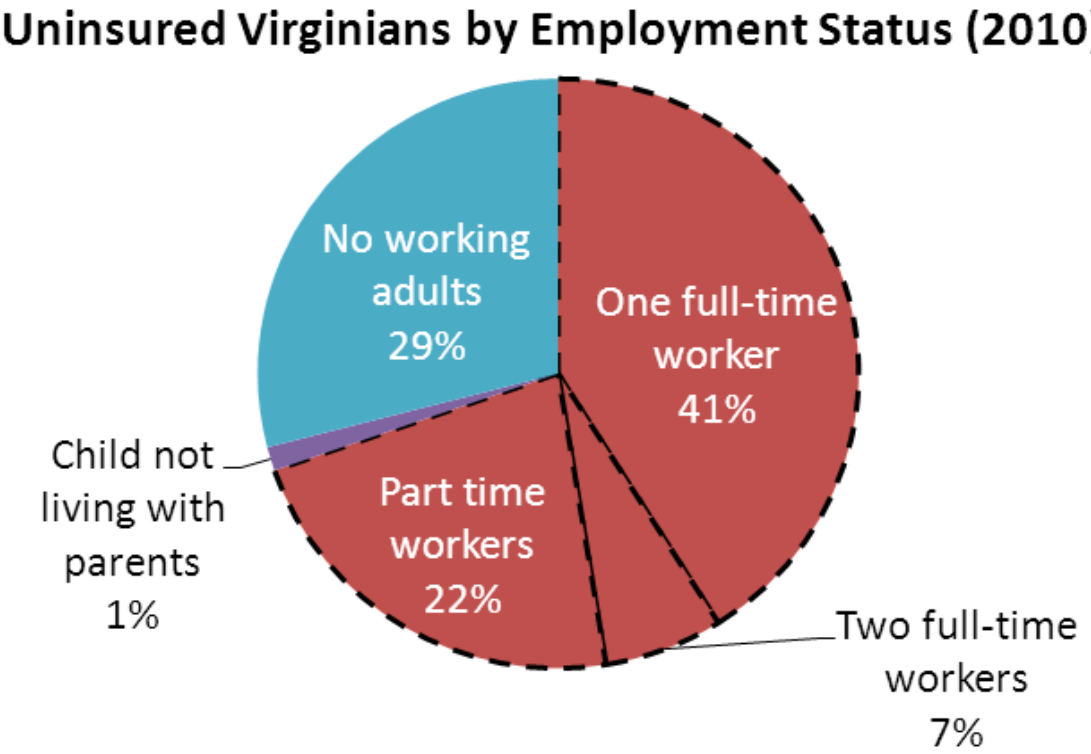
Source: Urban Institute, February 2012. Based on the 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) of the Minnesota Population Center.

[1] Shaded areas represent regions of Virginia which are defined in terms of counties or a combination of counties (see Table 13).

Note: Estimates reflect additional Urban Institute adjustments for the underreporting of Medicaid/CHIP and the overreporting of private nongroup coverage (See Lynch et al, 2011). Coverage estimates were developed under a grant from the Robert Wood Johnson Foundation.

* indicates that the region percentage is statistically different from the percentage for the areas in the rest of state at the .05 level.

Are Uninsured Virginians Working?



- 70 percent of the uninsured in Virginia live in families with at least one full-time or part-time worker.
- Only 37 percent of small businesses (under 50 employees) offer health insurance in Virginia.

The Patient Protection and Affordable Care Act
3 Major Components

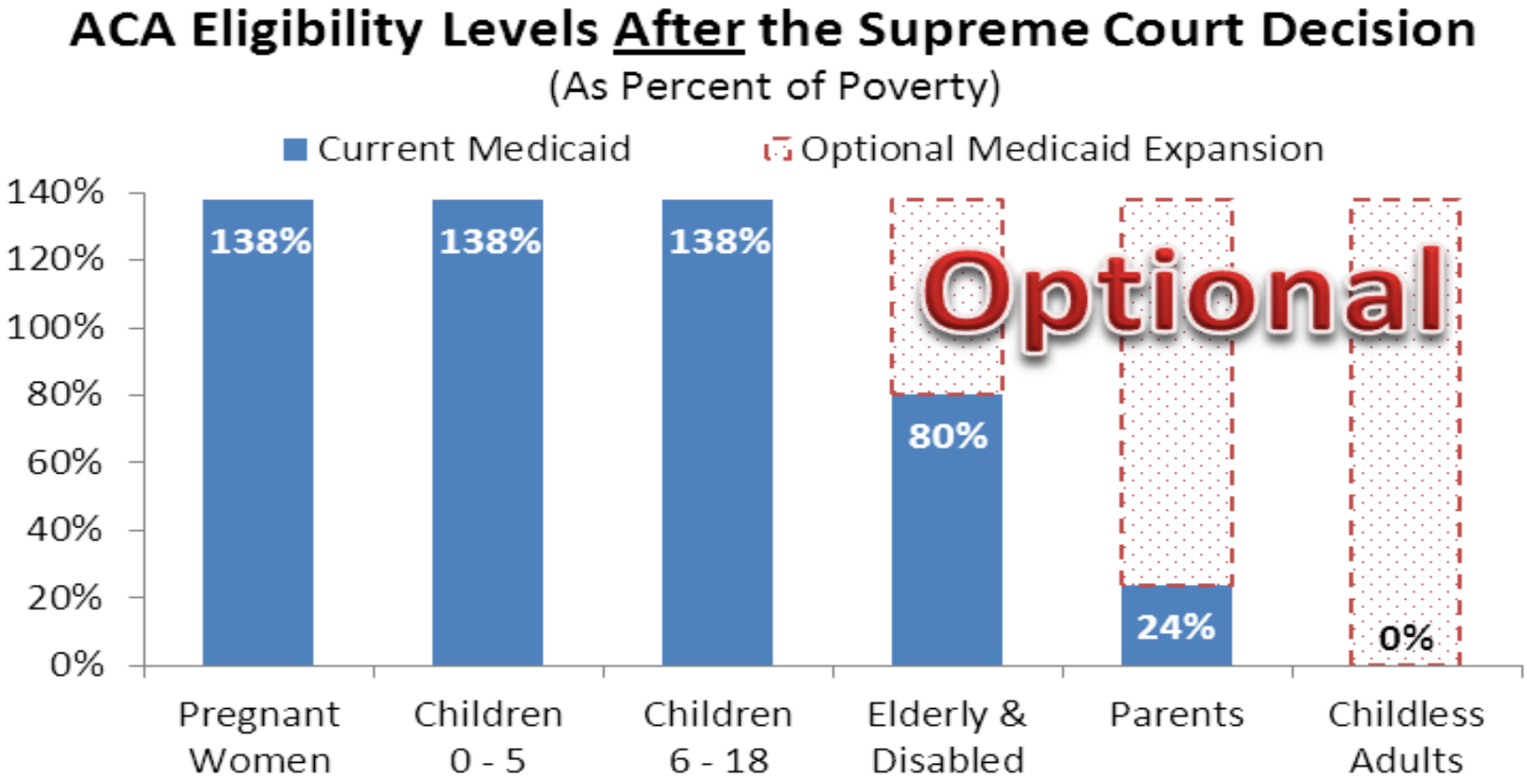
1. Requires Most U.S. Citizens and Legal Residents to Have Health Insurance;
   - Offers enhanced federal dollars for states that choose to Expand Medicaid (at state option) for all individuals with income under 133 percent of poverty. (plus a 5% income disregard).
   - Reconfigures insurance industry requiring a larger pool of insured individuals to cover the cost of eliminating insurance underwriting (i.e., pre-existing conditions) while standardizing insurance benefits and pricing.

2. Creates Health Benefits Exchanges for Individuals and Small Businesses to compare and purchase health insurance;
   - Offers subsidies to low-income individuals with income between 100 and 400 percent of poverty to purchase insurance

3. Encourages Innovation

What does Medicaid Expansion Include?

The Supreme Court's decision leaves it to state policymakers to decide whether or not to expand Medicaid's income eligibility levels to cover all individuals up to 138% of the poverty level



Estimated Cost of Expansion in Virginia

Federal Match for Expansion Population

The big question…will it remain?

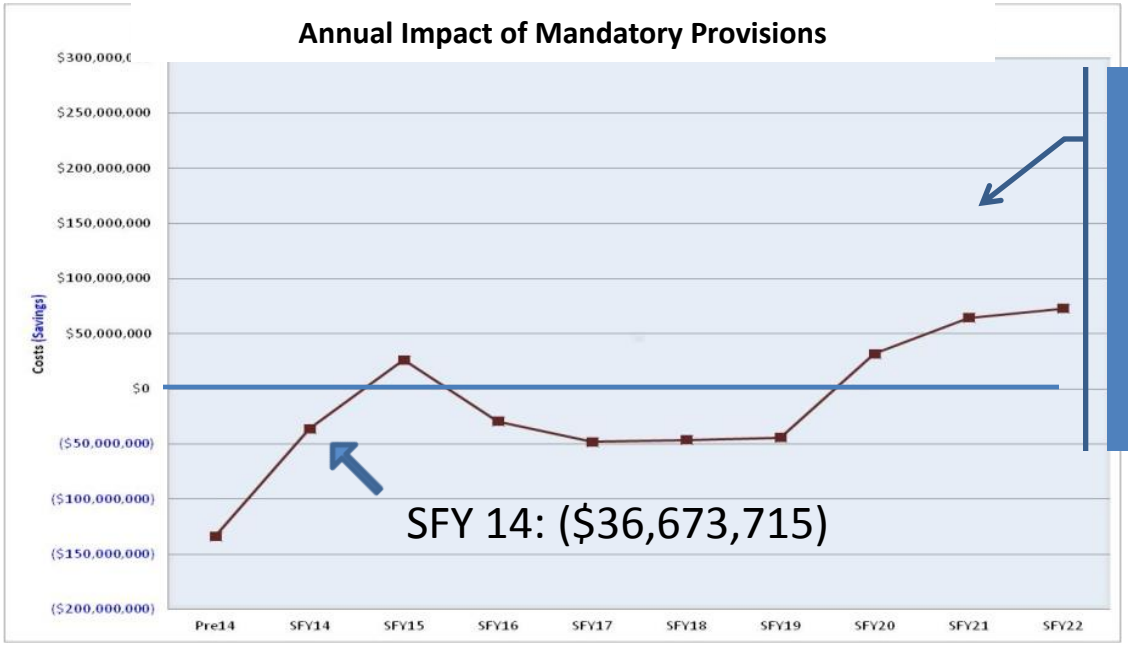
2014	2015	2016	2017	2018	2019	2020	2021	2022*
100%	100%	100%	95%	94%	93%	90%	90%	90%

* Per the PPACA, federal financial participation will continue at a 90% rate beyond 2022.

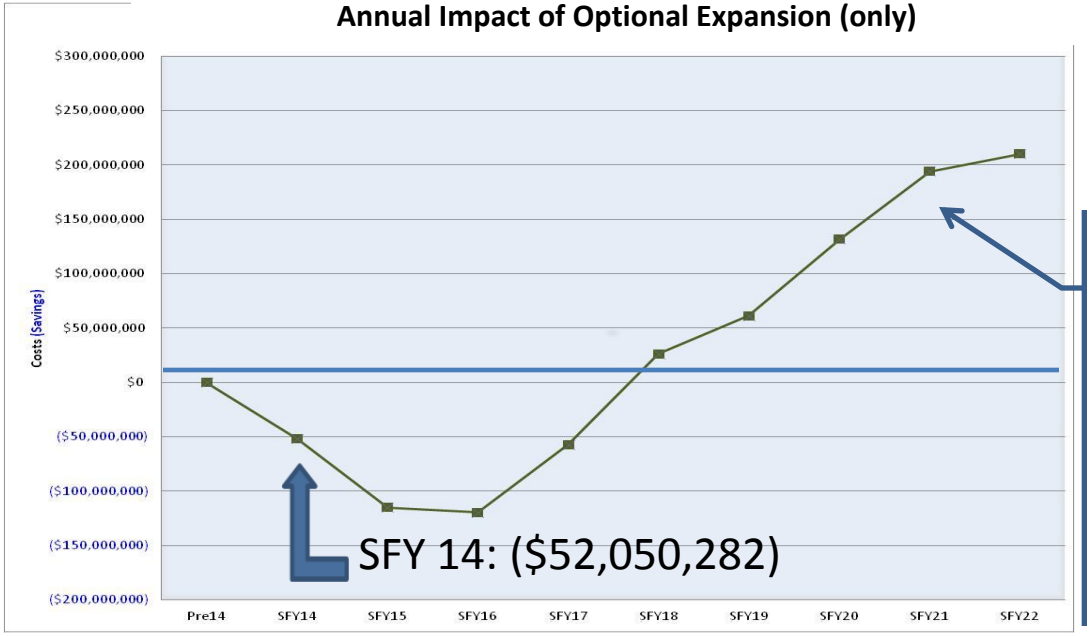
- Expansion must include individuals up to 133% (plus a 5% income disregard) of the Federal Poverty Level (FPL).
- Savings highlights:
  - Community Behavioral Health Services (shift from local and state funds to enhanced federal funds)
  - Inmate Inpatient Hospital Savings (shift from local and state funds to enhanced federal funds)
  - Indigent Care Savings (shift from state funds to enhanced federal funds)

Estimated Costs of the Affordable Care Act for Virginia: 2014-2022

Mandatory Provisions	($142m)
Optional Expansion	$280m



These costs and savings are already reflected in the Governor's Introduced Budget



These costs and savings are identified in the Fiscal Impact Statement for the ACA Expansion

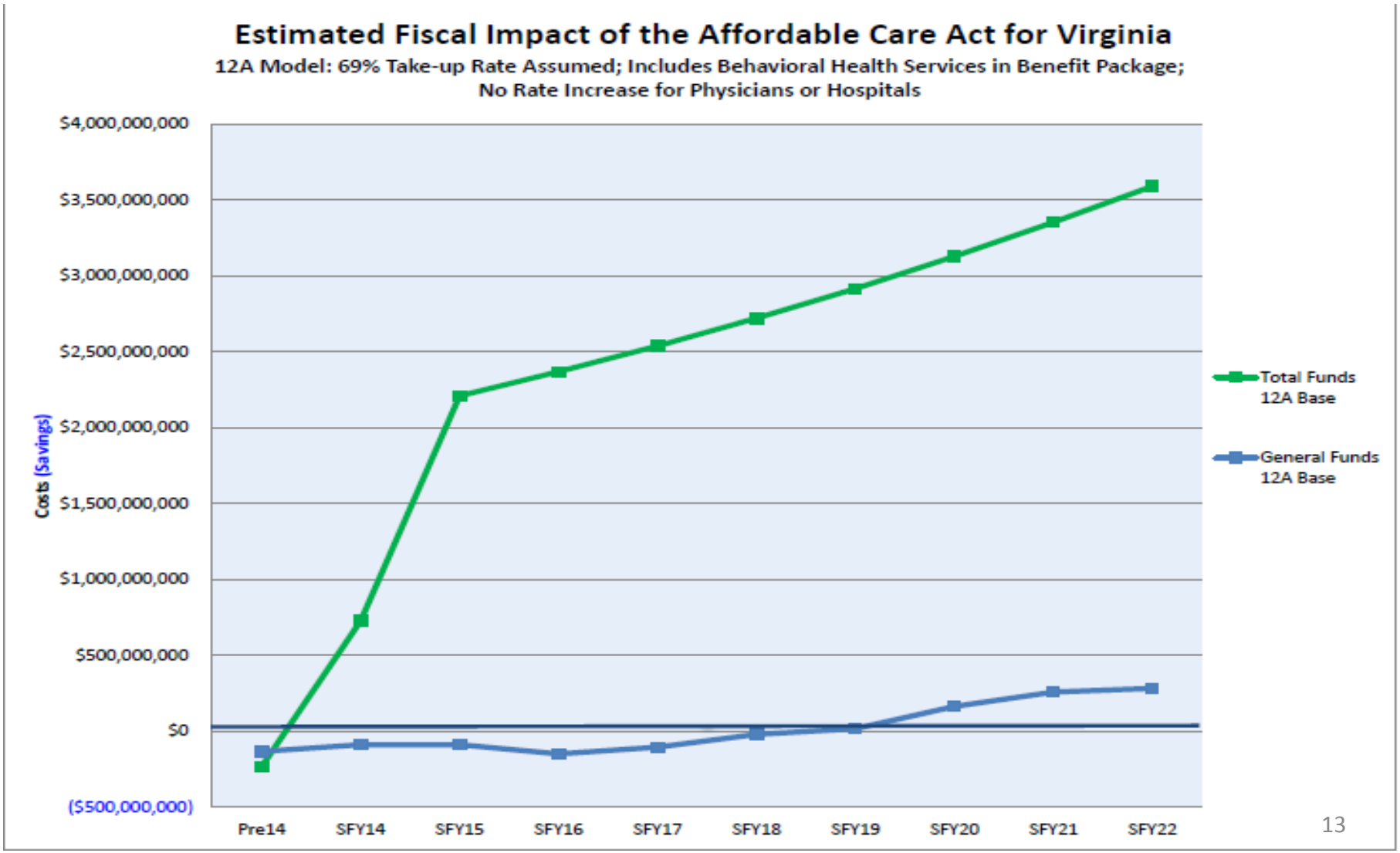
Estimated Costs of the Affordable Care Act for Virginia: 2014-2022

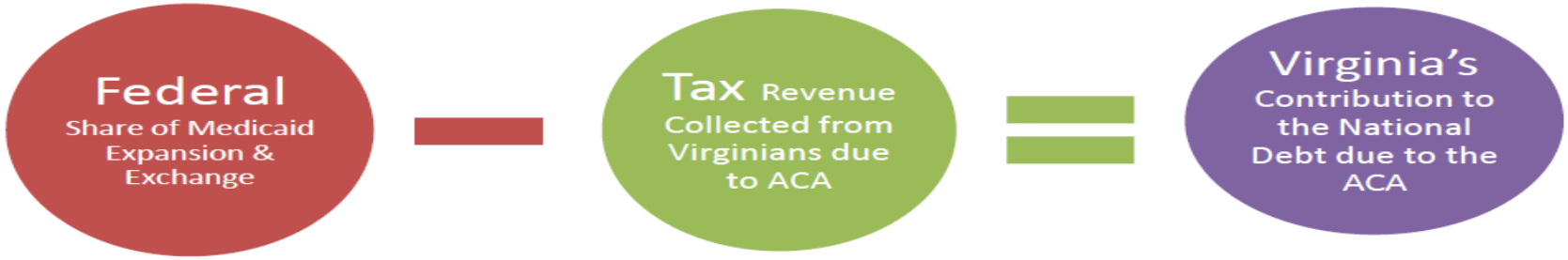
		2012 Estimate	
Mandatory Provisions	Woodwork Costs	✓	($142m)
	Foster Care Alumni	✓	
	ACA Insurance Tax	✓	
	Changes in Medicaid Drug Rebate Program	✓	
	Increase in Title XXI FMAP	✓	
	Elimination of Public Coverage Programs (FAMIS MOMS, Family Planning 133%+)	✓	
Optional Expansion	Medicaid Expansion Costs	✓	$280m
	# people estimated to ever enroll as of Jan 2014	247,923	
	Behavioral Health Savings	✓	
	Inmate Inpatient Hospital Savings	✓	
	Indigent Care Savings	✓	
	Other Savings	✓	
	Administrative Costs	✓	
	Total Estimated Cost of Mandatory Provisions AND Optional Expansion	$137,485,859	$137m

These costs and savings are already reflected in the Governor's Introduced Budget

These costs and savings are identified in the Fiscal Impact Statement for the ACA Expansion

Estimated Impact
Total vs General Funds





Federal Share of Medicaid Expansion and Exchange

Estimated Federal Share of Expansion (FY2014-2022)[6]:	$23,193,136,595
+ Estimated Federal Share of the Exchange (FY2014-2022):	$6,633,687,249[7]
Total Estimated Federal Share of Expansion and Exchange:	$29,826,823,844

Tax Revenue Collected from Virginians due to ACA

Total Estimated Tax Increases (FY2014-2022)[8]:	$26,274,700,000

Virginia's Contribution to the National Debt due to the ACA

Estimated Federal Share of Expansion and Exchange:	$29,826,823,844
- Estimated Tax Increases	$26,274,700,000
Total Estimated Contribution to National Debt:	$ 3,552,123,844

[6] Federal Share of Medicaid Expansion by Year (FY2014-2022)- Assuming a 69% take up rate

[7] Federal Cost Sharing and Premium Contributions for Individual Coverage on the Health Benefits Exchange: The Urban Institute estimates that the federal share of premium and cost sharing subsidies in Virginia each year will average $737,076,361[7] for a FY2014-2022 estimate of $6,633,687,249.

[8] Analysis from VHHA based on National data from the Congressional Budget Office on July 24, 2012

Virginia's Legislative Approach to Medicaid Expansion

- No consideration of expansion until significant reforms are underway within the Medicaid program.

- 2013 Legislative Session
  - concluded with budget language authorizing three phases of Medicaid Reform
  - created the Medicaid Innovation and Reform Commission

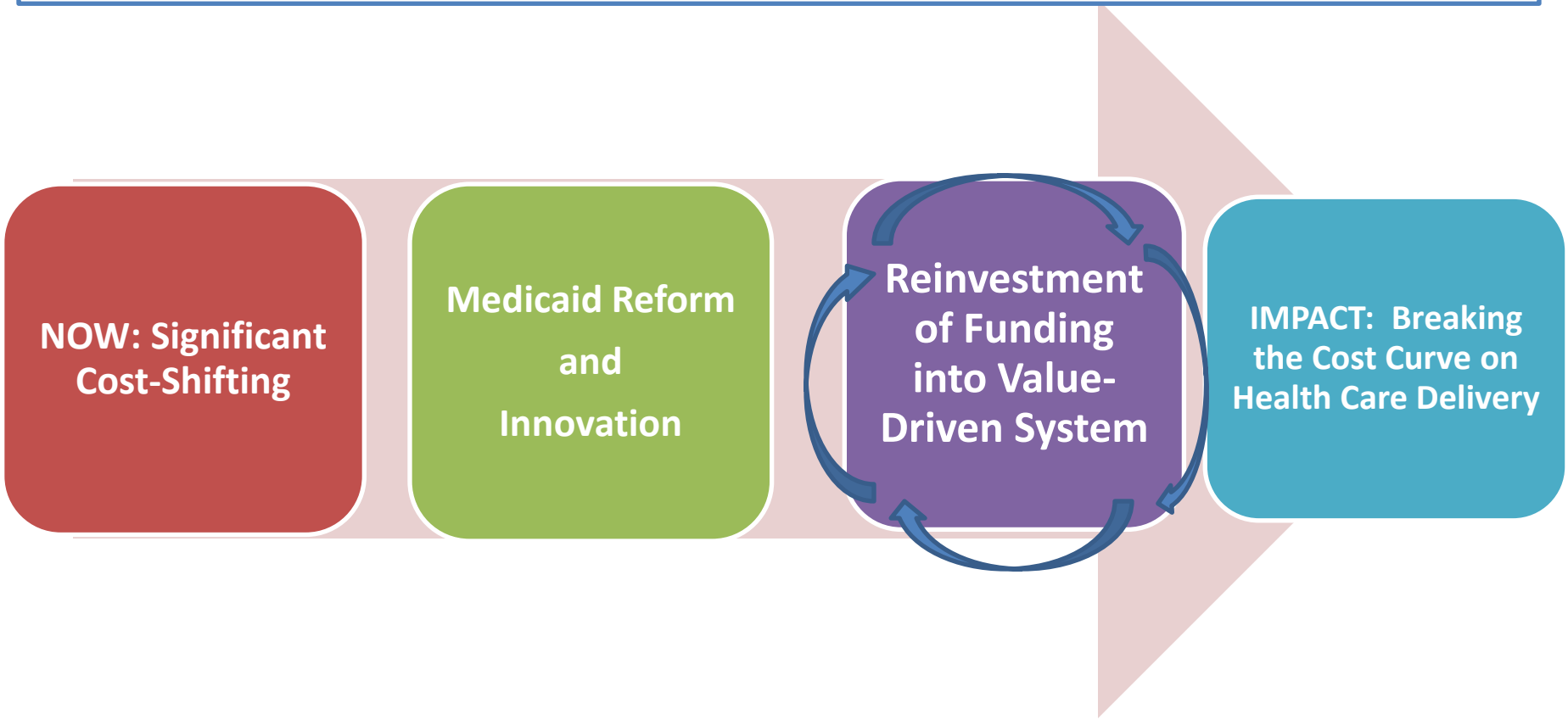
Objectives of Medicaid Reform

Improve Service Delivery:
Improve Quality, Predict Costs, and Innovate when Needed

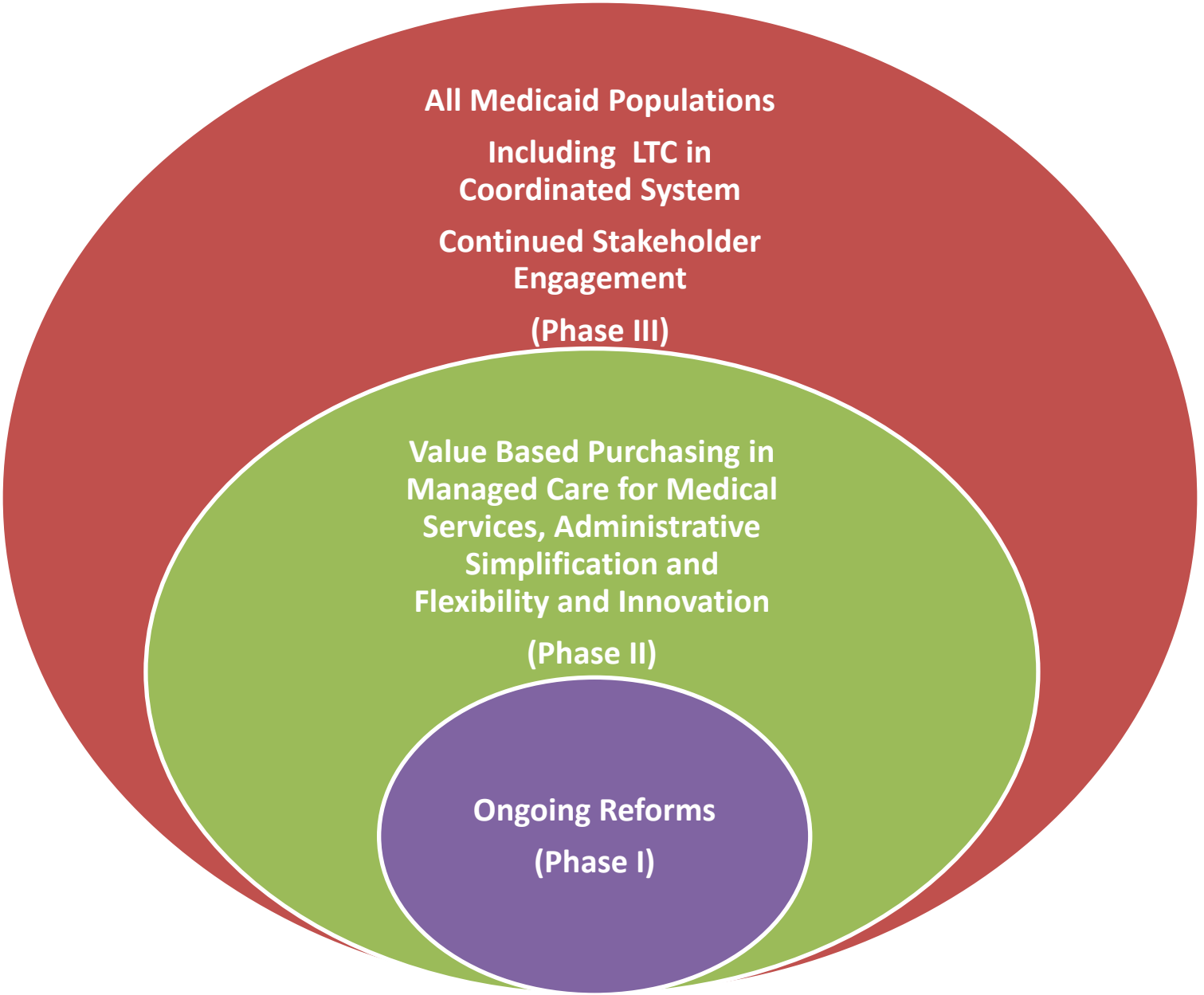
Improve Administration:
Streamline Administration and Minimize Waste, Fraud, and Abuse.

Increase Beneficiary Engagement:
Showcase Wellness and Cost Sharing

Medicaid Reform
Should Drive Public and Commercial Innovation



Three Phases of Medicaid Reform



Three Phases of Medicaid Reform

Phase I: Continue Current Reforms

- Dual Eligible Demonstration
  - MOU signed – next steps include Plan Selection, Rate Setting, and 3 way contracts signed between DMAS, Selected Plans, CMS
- Enhanced Program Integrity
- Foster Care
- New Eligibility and Enrollment System
- Veterans Benefit Program Enhancement
- Behavioral Health
  - Awarded BHSA – contract to soon be signed

Three Phases of Medicaid Reform

Phase II: Improvements in Current Managed Care and Fee For Service programs

- Commercial like benefit packages and service limits
- Cost sharing and wellness
- Coordinate Behavioral Health Services
- Limited Provider Networks and Medical Homes
- Quality Payment Incentives
- Data Improvements
- Standardization of Administrative Processes
- Health Information Exchange
- Agency Administration Simplification
- Parameters to Test Pilots

Three Phases of Medicaid Reform

Phase II (Process)

New Medallion II (Managed Care) Contracts

- Total reformat based on review of 13 state contracts – focus on life cycle
- Technical manual – reporting, automation, encounter data, scoring
- Quality incentive
- Medallion Care System Partnership – focus on models
- All Payer Claims Database (APCD)
- Program Integrity collaborative incentives
- Improved chronic care section
- Maternity care
- Foster care language
- Wellness

Three Phases of Medicaid Reform

Phase II (Process)

Medicaid Managed Care "Breakfast Club"

- Six Targeted Conversations
  - What You Get For The [Medicaid Managed Care] Dollar
  - Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
  - Emergency Room Utilization
  - Personal Responsibility and Co-pays
  - Administrative Simplification
  - Innovation Models

Three Phases of Medicaid Reform

Phase III: Coordinated Long Term Care

- Move remaining populations and waiver recipients into cost effective and coordinated delivery models

- Report due to 2014 General Assembly on design and implementation plans

Reinvestment of Medicaid Funding

Savings accrued during the first five years of the expansion should be protected and reinvested to improve the health delivery system.

- Reinvestment and Savings Strategies Include:
  - The flexibility to invest in high quality, cost saving health care innovation models
  - Improved analytical and oversight capability at DMAS
    - Requirement of timely and accurate encounter data from contracted Medicaid managed care plans
    - Creation of Data and Analytics Unit at DMAS
  - Need to identify structure to protect savings and ensure reinvestment

The Medicaid Innovation and Reform Commission

MIRC

Purpose: To review, recommend and approve innovation and reform proposals affecting the Virginia Medicaid and Family Access to Medical Insurance Security (FAMIS) programs, including eligibility and financing for proposals set out in Item 307 (Virginia Budget) in the Department of Medical Assistance Services.

Specifically, the Commission shall review:

(i) the development of reform proposals;

(ii) progress in obtaining federal approval for reforms such as benefit design, service delivery, payment reform, and quality and cost containment outcomes; and

(iii) implementation of reform measures.

MIRC Membership

Chair of Senate Finance, or his designee & 4 members of Senate Finance

—**Walter A. Stosch**

—**Janet D. Howell**

—**Emmett W. Hanger, Jr.**

—**John C. Watkins**

—**L. Louise Lucas**

Chair of House Committee on Appropriations, or his designee, & 4 members of House Appropriations

—**R. Steven Landes**

—**James P. Massie, III**

—**John M. O'Bannon, II**

—**Beverly J. Sherwood**

—**Johnny S. Joannou**

Ex Officio Members:

Secretary of Health and Human Resources

Secretary of Finance

The Affordable Care Act Requires…

- New policy criteria for Medicaid based on IRS
  (MAGI = Modified Adjustable Gross Income)
- Move towards greater automation
- VA Medicaid integrated with the Federal Data Hub for eligibility determination
  - Internal Revenue Service (IRS)
  - Social Security Administration (SSA)
  - Homeland Security
- Coordination with the Health Benefits Exchange (Federally Facilitated Marketplace)
- By law – applications must be accepted 10/1/13 and coverage begins 1/1/14

eHHR Core Elements

—CommonHelp Portal

—Case Management System

—Enterprise Data Management (EDM)

—Business Rules Engine

—Document Management System

—Enterprise Service Bus (ESB)

System Wide Innovation

Cost and Value Problems in the Healthcare Arena can't be Solved without Significant Innovation

— Innovation opportunities within PPACA are lost in the uncertainties associated with the law.

— Virginia is already making progress in key innovation areas

— Virginia has created the Virginia Center for Health Innovation (501 (c)3) housed out of the Chamber of Commerce

Virginia Center for Health Innovation Priorities

Each priority has a dedicated workgroup assigned to explore pilot programs and to reach consensus on a recommended three-year implementation plan.

Workgroups include members of the VHRI Advisory Council, the VCHI Board of Directors, as well as key thought leaders in each particular priority area.

Virginia Center for Health Innovation Inventory

- As a lead in to the creation of a Virginia Health Innovation Plan, VCHI created a statewide inventory of innovation projects already under development by Virginia stakeholders in healthcare in each of the six priority areas.
- 371 innovations were submitted in just one month.
- Beginning in June, more innovations can be submitted via the Virginia Health Innovation Network.

Health Reform Work Supported Through:

- $1 million federal planning
- Robert Wood Johnson Foundation, State Health Reform Assistance Network

Exchange in Virginia
Federally Facilitated Marketplace (FFM)

— Federal Government is responsible for architecture and marketing aspects of the FFM

— Navigator Grants to be awarded by August followed by training and certification before open enrollment begins in October, 2013.

— Virginia's Bureau of Insurance in partnership with Department of Health are conducting plan management reviews and will make recommendations to the federal government for plans applying to participate in the Virginia FFM

Five Core Exchange Functions

Eligibility **DMAS will conduct eligibility for Medicaid and CHIP clients that enter through Federal Exchange**	Accept applications from individuals and small businesses; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; determine employer and employee eligibility for SHOP enrollment; connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and conduct redeterminations and appeals.
Enrollment **Federal Responsibility (DMAS will continue enrollment into health plans for Medicaid and CHIP clients)**	Enrollment of consumers into qualified health plans; transactions with Qualified Health Plans and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions.
Consumer Assistance **Federal Responsibility**	Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.
Plan Management **Bureau of Insurance and VDH perform plan functions**	Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer and QHP certification, monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.
Financial Management **Federal Responsibility**	Premium aggregation for SHOP (option to administer individual consumer premiums); user fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs.

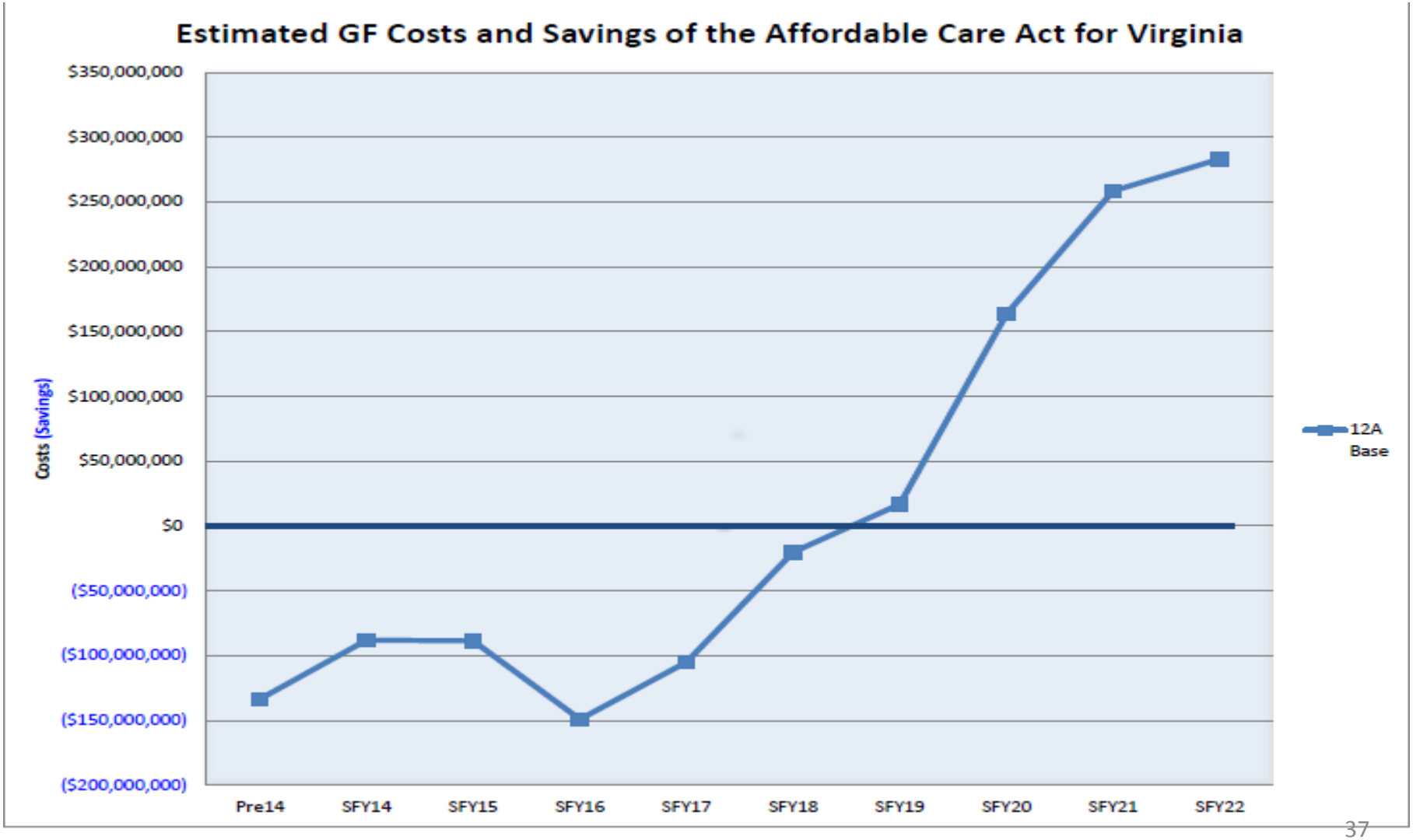
Exchange Subsidies

- Subsidies will only be available to those purchasing coverage through the exchanges, which includes people who do not have access to alternative insurance (such as Medicaid and affordable employer coverage).
- Government subsidies to be paid towards the health insurance premium will be provided to people who are purchasing coverage on their own and have family income between 100% and 400% of the federal poverty level.
- The amount that these families buying subsidized coverage in an exchange will pay towards a health insurance premium will range from 2.0% of income at 100% of poverty to 9.5% of income at 400% of poverty, with amounts at specific income levels specified in a table in the law.
- Subsidies are tied to a benchmark level of coverage based on actuarial value. And, when an exchange determines that a person is eligible for a tax credit based on expected income, and that person enrolls in coverage, subsidies will be paid directly to insurers to lower the cost of premiums.

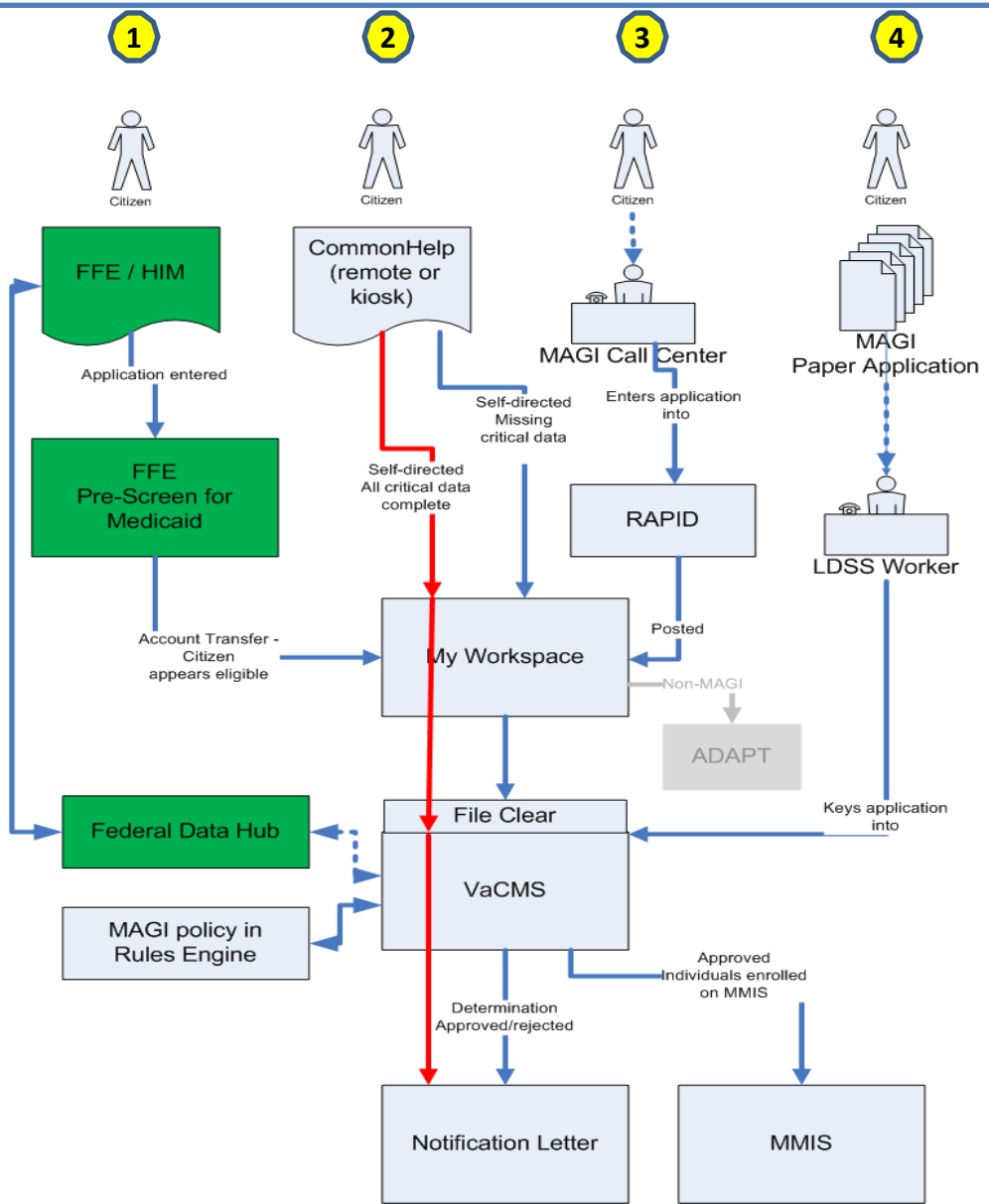
Estimated Costs of the Affordable Care Act for Virginia: 2014-2022

		2010 Estimate	2012 Estimate
Mandatory Provisions	Woodwork Costs	✓	✓
	Foster Care Alumni		✓
	ACA Insurance Tax		✓
	Changes in Medicaid Drug Rebate Program	✓	✓
	Increase in Title XXI FMAP	✓	✓
	Elimination of Public Coverage Programs (FAMIS MOMS, Family Planning 133%+)		✓
Optional Expansion	Medicaid Expansion Costs	✓	✓
	# people estimated to ever enroll as of Jan 2014	378,018	247,923
	Behavioral Health Savings		✓
	Inmate Inpatient Hospital Savings		✓
	Indigent Care Savings		✓
	Other Savings		✓
	Administrative Costs	✓	✓
	Estimated Costs at an assumed 69% take up rate	$2,158,646,389	$137,485,859

Annual Impact of Mandatory Provisions
AND
Optional Expansion



Medicaid Technology Enhancements
Application Options



1. **Starting with the Federal Exchange**
2. **On-line application in CommonHelp**
3. **Phone based application**
4. **Paper application**