VACO
Annual Fall Conference

Dr. Bill Hazel, M.D.
Secretary of Health and Human Resources

November 11, 2013

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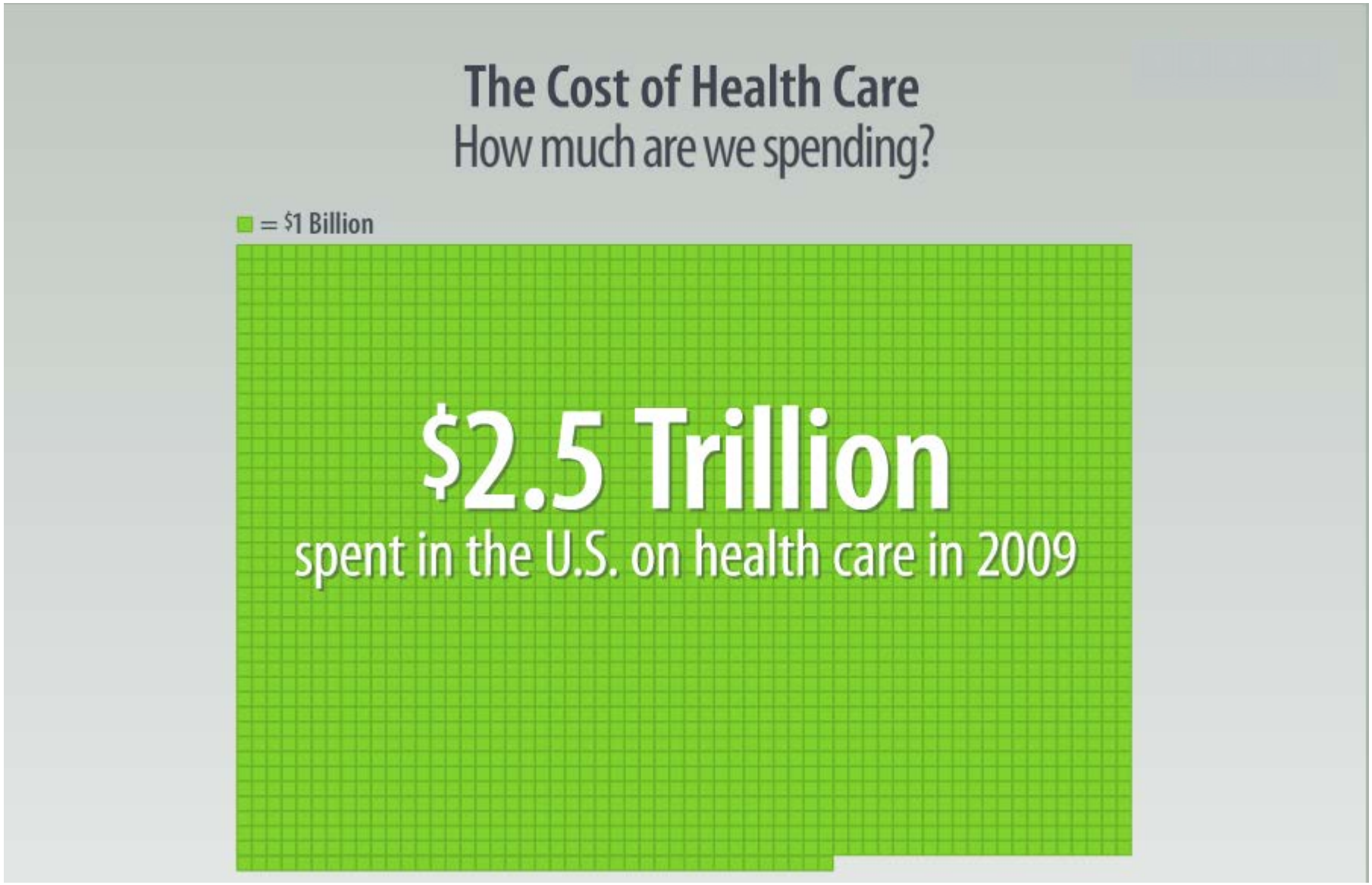
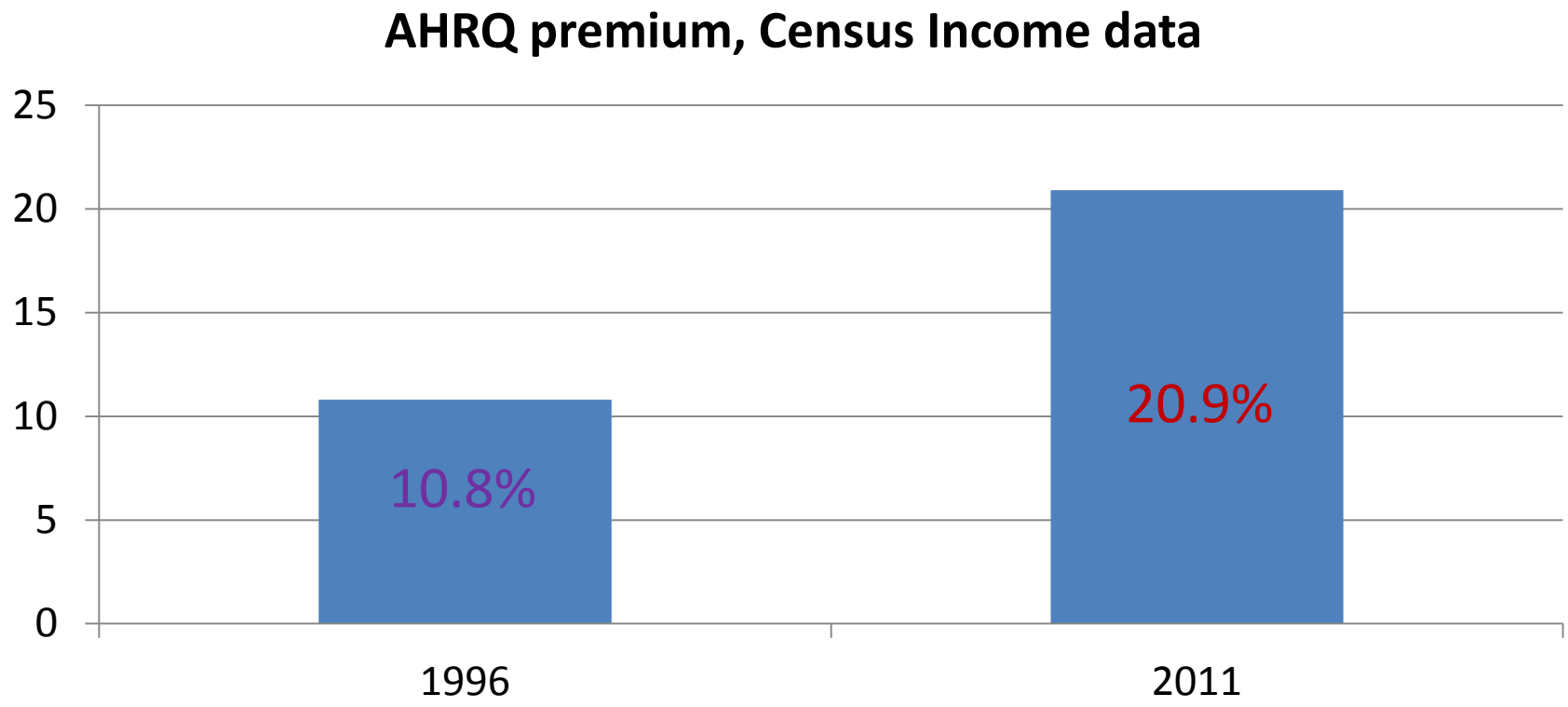


Source: Institute of Medicine: *The Healthcare Imperative: lowering costs and improving outcomes*

Family Premium / Median Income



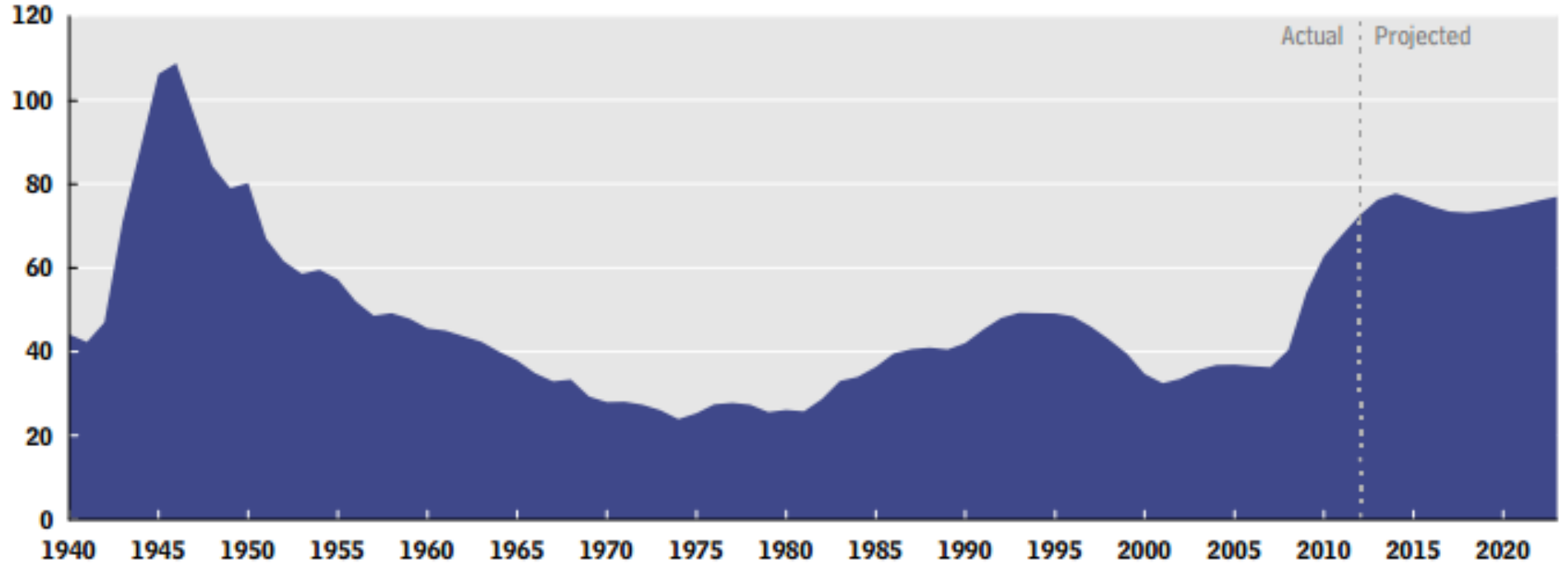
Author's calculations, treating average employer contribution as income

The Bottom Line of Where We Are

Summary Figure 1.

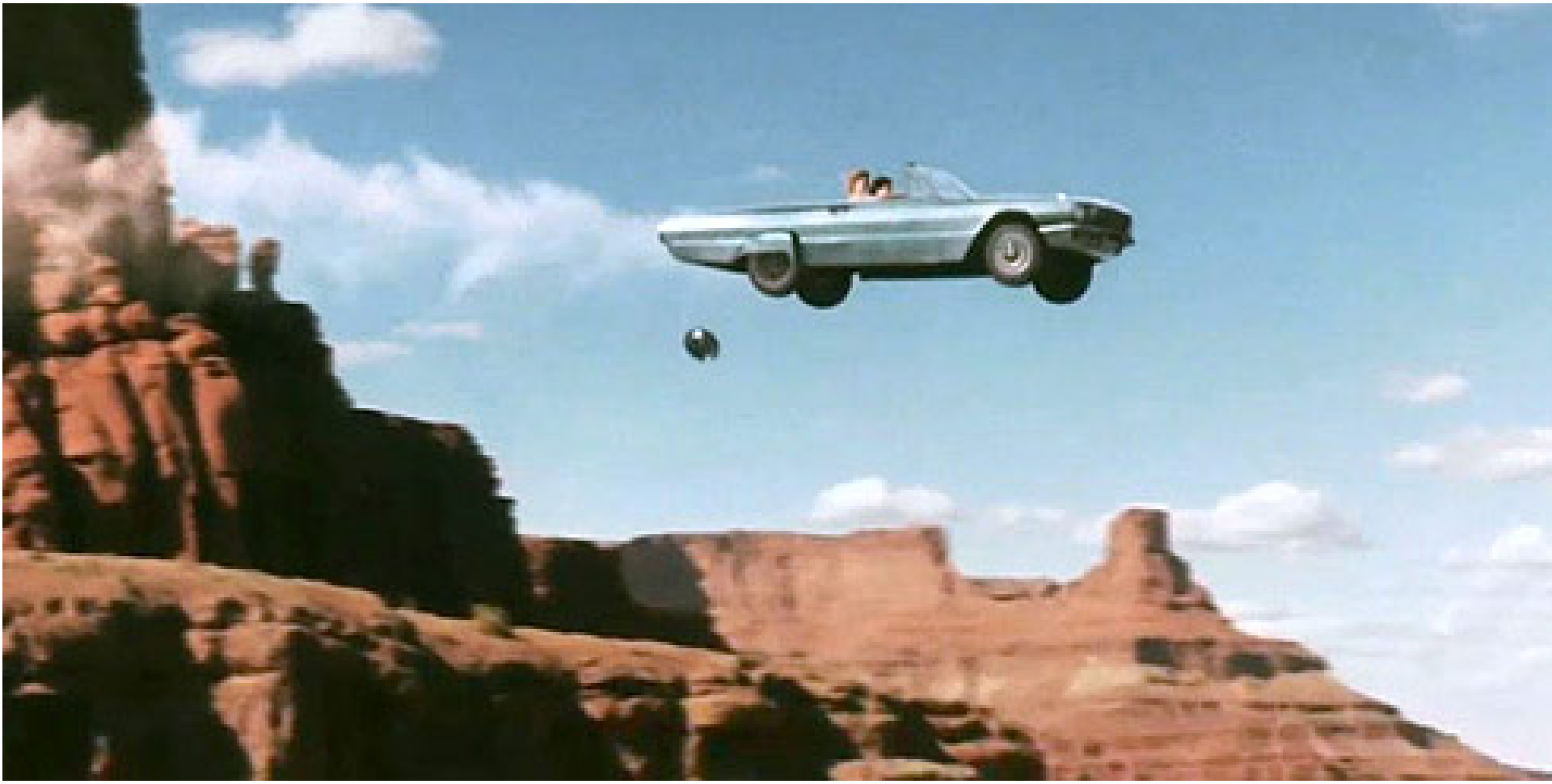
Federal Debt Held by the Public

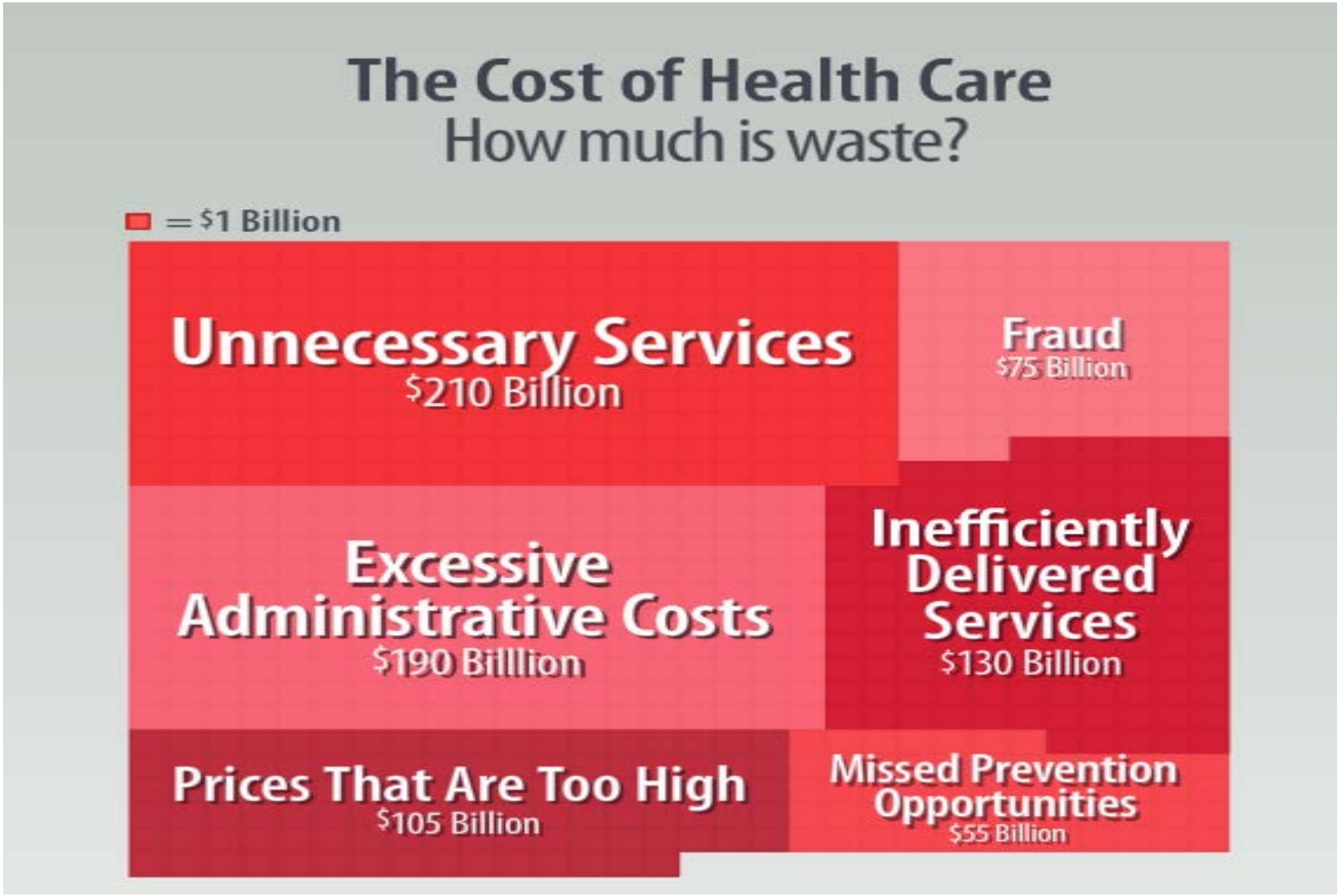
(Percentage of gross domestic product)



Source: Congressional Budget Office.

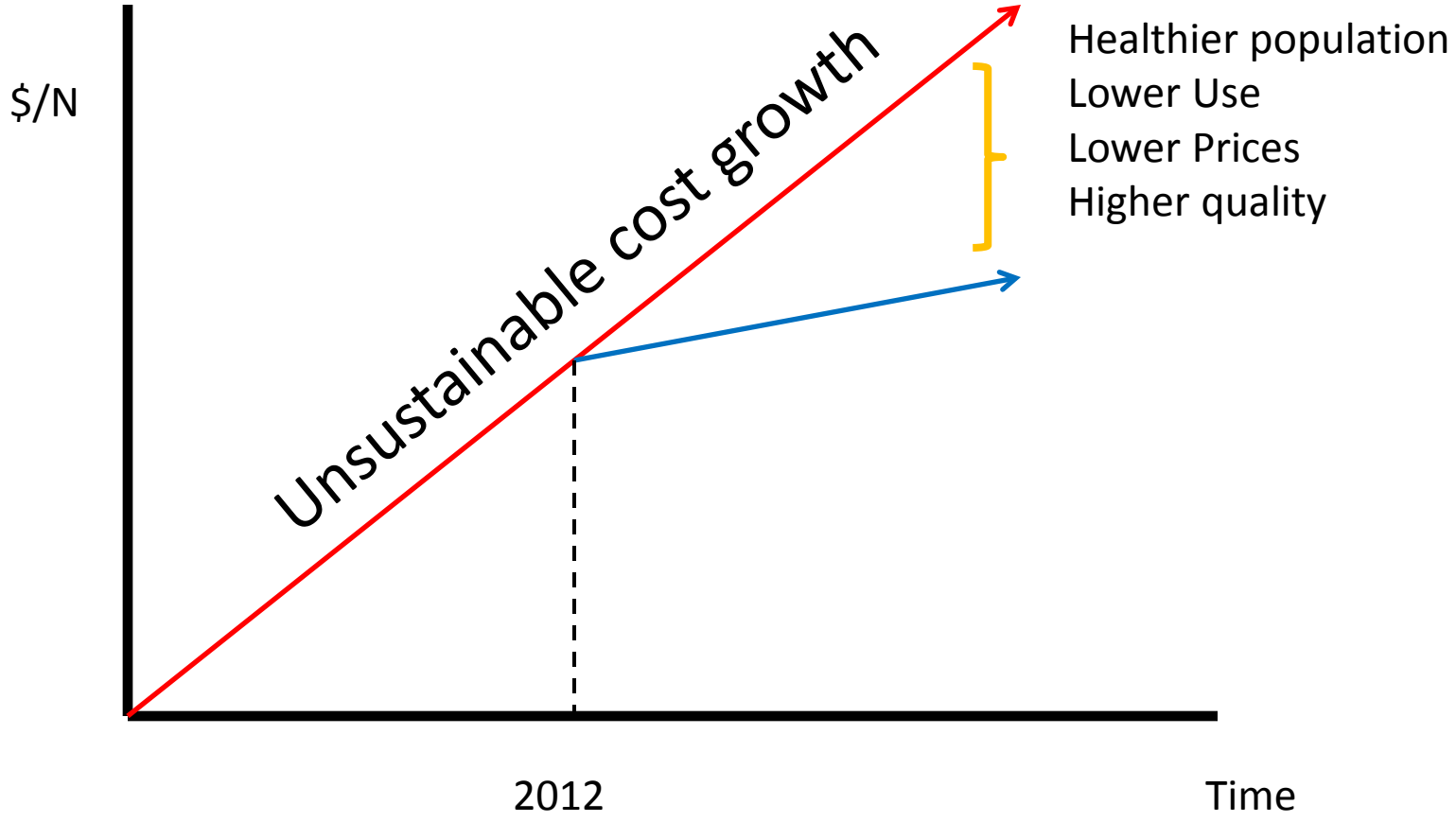
Allow US to Default ?





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

So What are we really talking about?



Targets of Spending Reductions

• Poor care delivery		
– Unnecessary services	$210B	8% of NHE
– Inefficient delivery	$130B	5%
– Missed prevention	$ 55B	2%
• Excessive Admin Costs	$190B	8%
• Prices	$105B	4%
• Fraud	$ 73B	3%
• TOTAL	$765B	31%

OECD Says 25% higher

Expls. 1/2

D. Cutler, Senate Budget Testimony, citing IOM

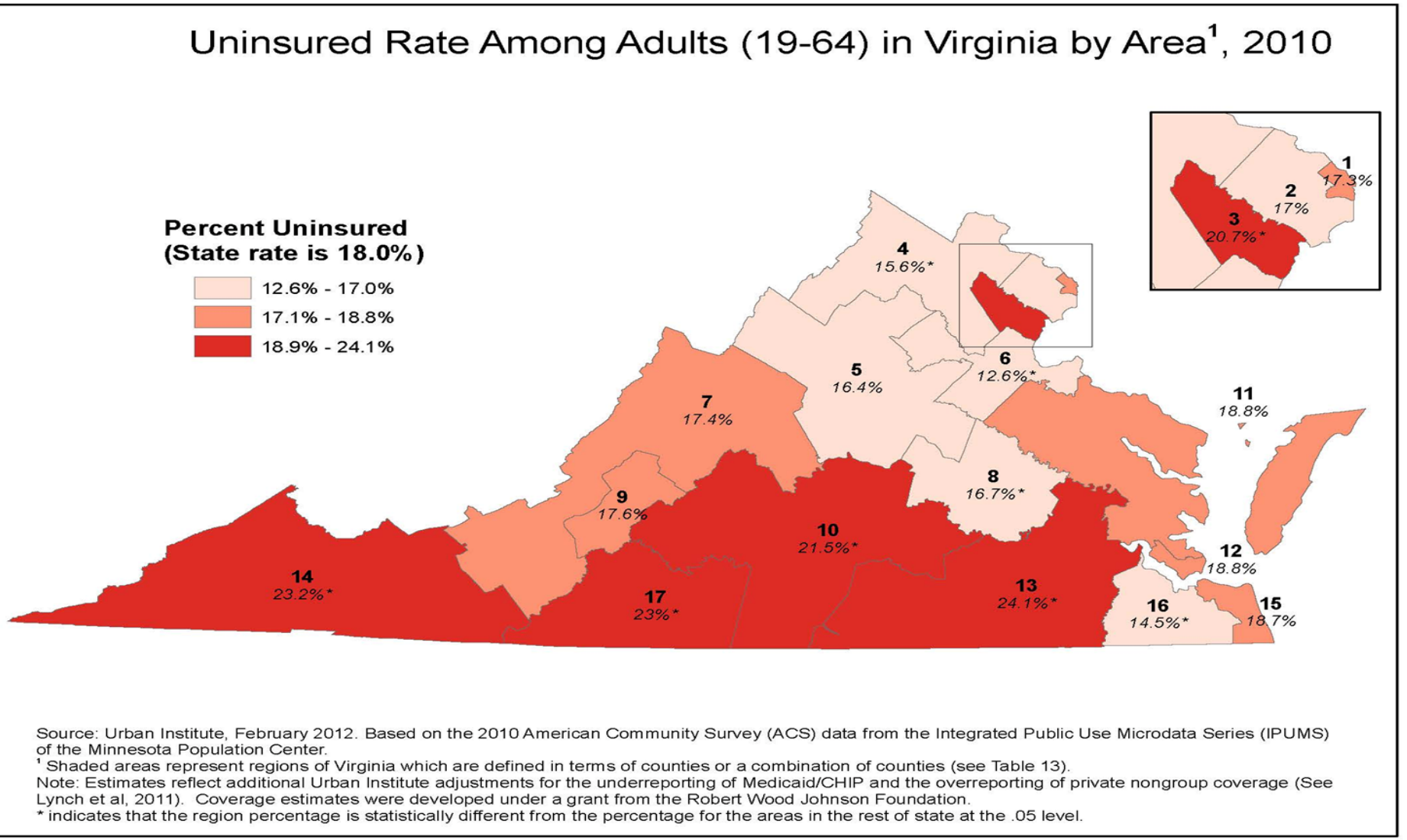
The Patient Protection and Affordable Care Act
3 Major Components

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

Where do Uninsured Virginians Live?



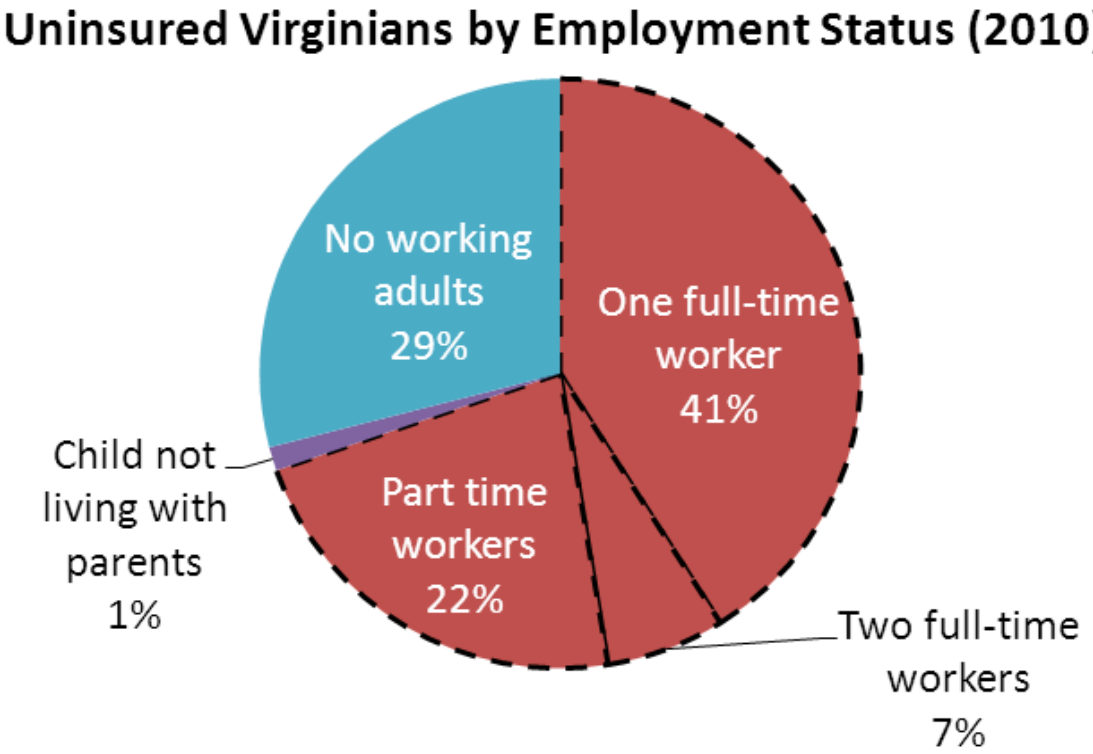
Source: Urban Institute, February 2012. Based on the 2010 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) of the Minnesota Population Center.

[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.

Explanation of “Primary Payer Status Studies” by UVA Health System
October 21, 2013

Presented By:

Irving L. Kron, M.D.
Chair, Department of Surgery
S. Hurt Watts Professor of Surgery
University of Virginia Health System

Take Aways

- Purpose of the studies was to show that payer status is a predictor of risks of surgery faced by patients
- Purpose of the studies was not to show, and does not show, that the Medicaid program negatively affects patient's health
- Despite higher risk profiles, Medicaid patients may do better than uninsured in many surgical populations.

The Oregon Medicaid Experiment

Carolyn Long Engelhard, MPA
Director, Health Policy Program
Department of Public Health Sciences
University of Virginia School of Medicine

October 21, 2013

Oregon Medicaid Experiment: Overall Findings

- **Medicaid associated with improved access to care compared to uninsured**
  - 50% improvement in having a usual source of care; similar increase in office visits
  - 30% increase in number of women who had pap smears, and a doubling in use of mammograms for women 50 years and older
  - 20% improvement in the probability of receiving all needed care
  - 3.5x more patients diagnosed and treated for diabetes
- **Led to a substantial reduction in the risk of a positive screening for depression**
  - Depression, often associated with lower rates of employment and problems with parenting, dropped by 30%

Baicker, K. et al (2013). The Oregon Experiment – Effects of Medicaid on Clinical Outcomes, NEJM 368;18; http://www.nejm.org/doi/pdf/10.1056/NEJMsa1212321

Oregon Medicaid Experiment: Overall Findings

- **Led to substantial reduction in catastrophic expenditures**
  - Out of pocket medical expenses exceeding 30% of income were 80% less than for those without insurance and the likelihood of medical debt was reduced 20%
- **No significant effect on the prevalence or diagnosis of hypertension and high cholesterol or on the use of medications for these conditions**
  - It increased probability of diagnosis and treatment for diabetes but had no significant effect on average diabetic blood sugar control

Baicker, K. et al (2013). The Oregon Experiment – Effects of Medicaid on Clinical Outcomes, NEJM 368;18; http://www.nejm.org/doi/pdf/10.1056/NEJMsa1212321

Oregon Medicaid Experiment: Lessons Learned

- **Medicaid works as health insurance**
  - Increases utilization of preventive and primary care services
  - Increases diagnoses and treatment of medical conditions
  - Increases the probability of having a usual source of care
  - Increases self reported positive health status
  - Decreases catastrophic health costs and medical bankruptcy

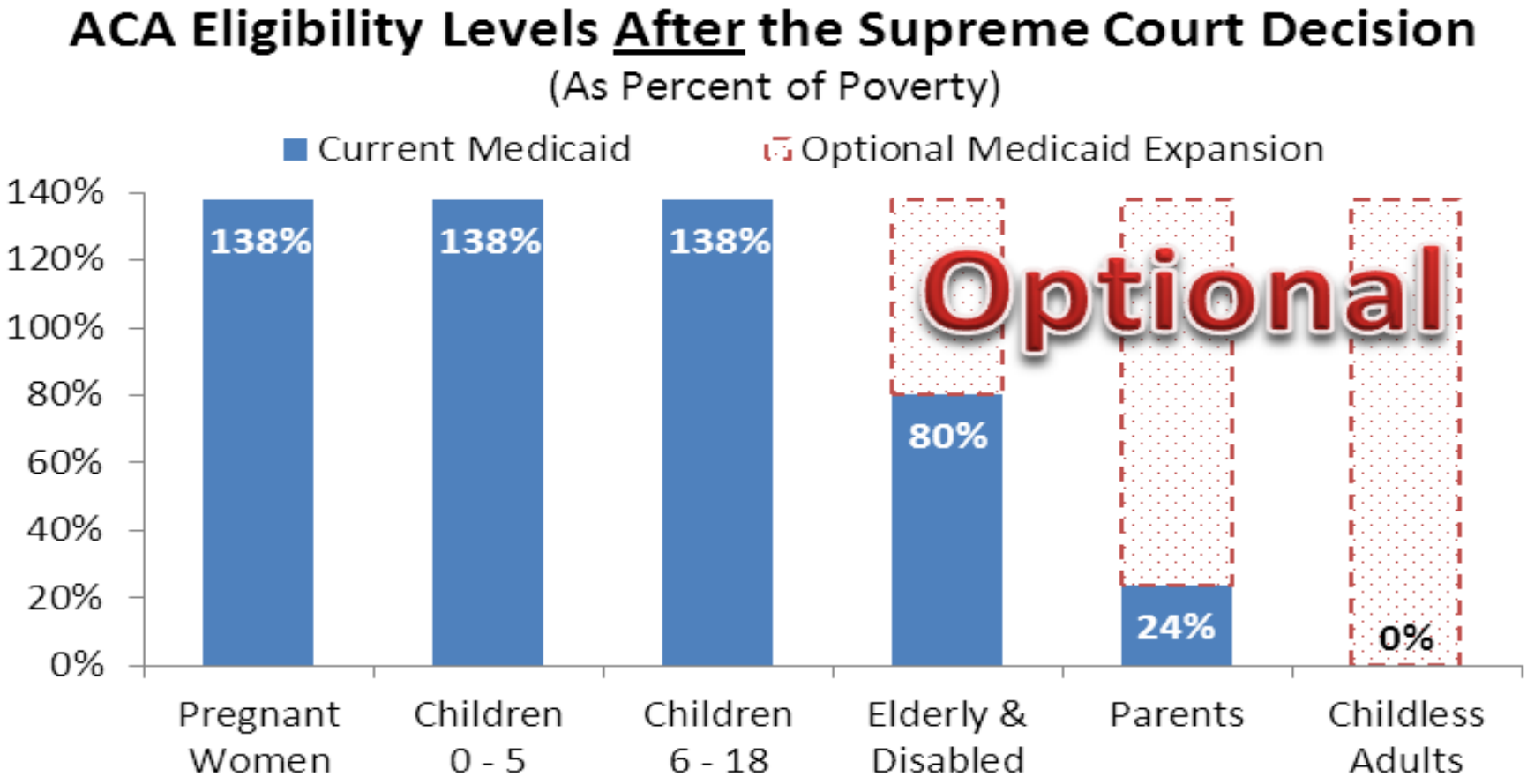
Sommers, B.D. et al (2012). Mortality and Access to Care Among Adults after State Medicaid Experiments, NEJM 367;11, http://www.nejm.org/doi/pdf/10.1056/NEJMsa1202099

Current Medicaid Factoids

- 20 % of Virginia Budget
- $9.5B in 2014
- Over 1 Million Enrollees
  - 267,000 Aged, Blind, and Disabled
  - 622,000 Adults, Pregnant Women, and Children
  - 115,000 CHIP
- Consider 3 to 4% increase in costs each year without expansion

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.

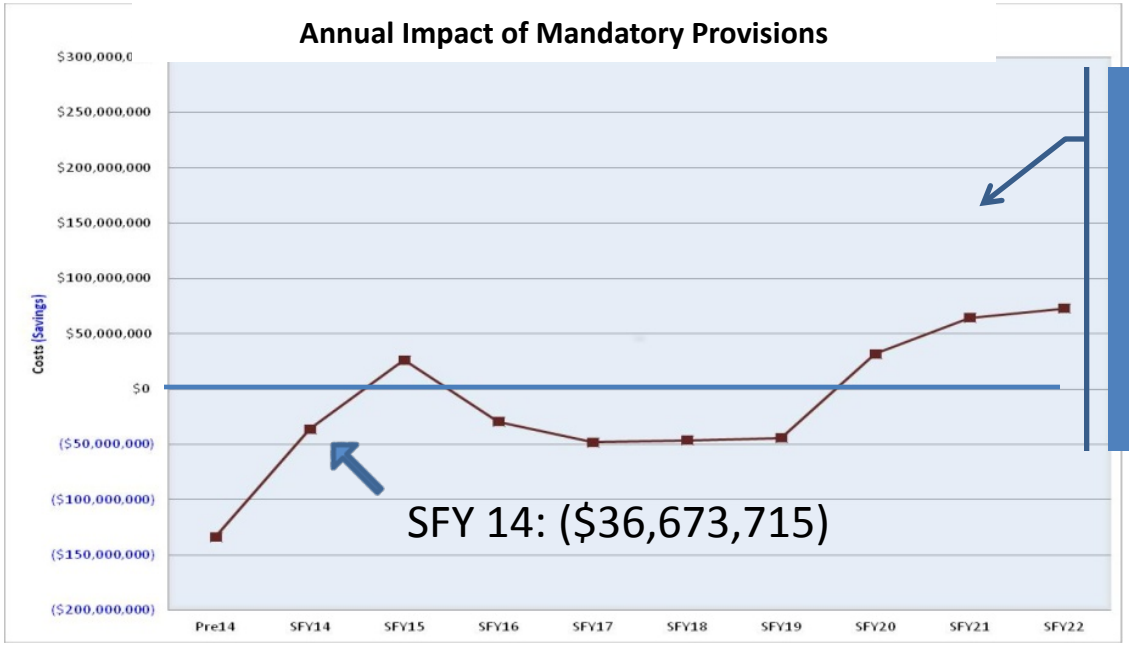
- Expansion must include individuals up to 133% (plus a 5% income disregard) of the Federal Poverty Level (FPL).
- Savings highlights:
  - Community Behavioral Health Services (shift from local and state funds to enhanced federal funds)
  - Inmate Inpatient Hospital Savings (shift from local and state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

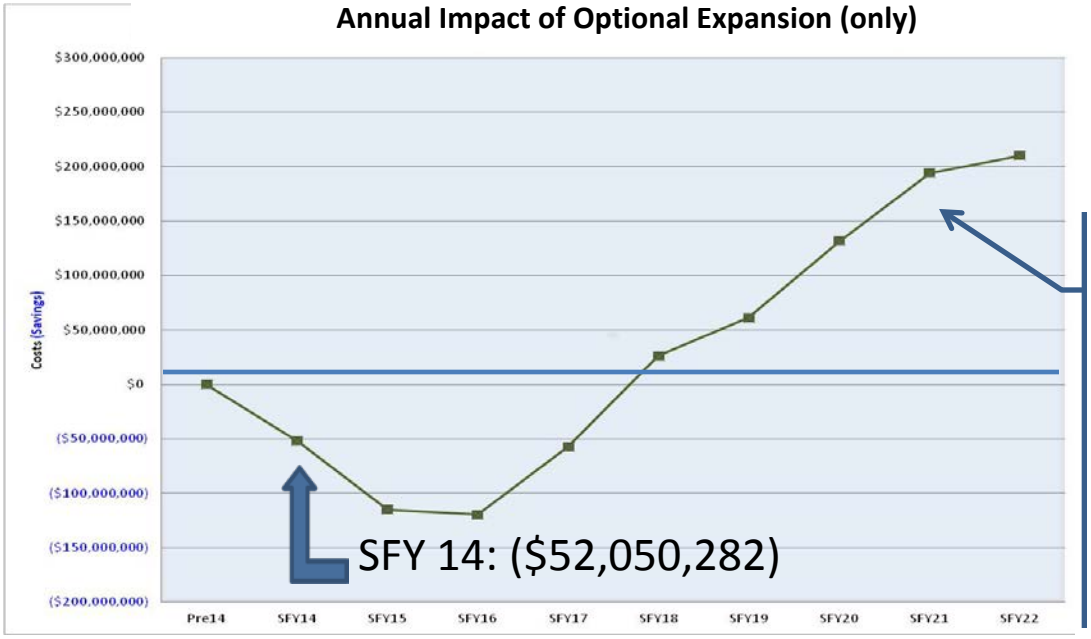
		2010 Estimate	2012 Estimate
Mandatory Provisions	Woodwork Costs	✓	✓
	Foster Care Alumni		✓
	ACA Insurance Tax		✓
	Changes in Medicaid Drug Rebate Program	✓	✓
	Increase in Title XXI FMAP	✓	✓
	Elimination of Public Coverage Programs (FAMIS MOMS, Family Planning 133%+)		✓
Optional Expansion	Medicaid Expansion 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

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)
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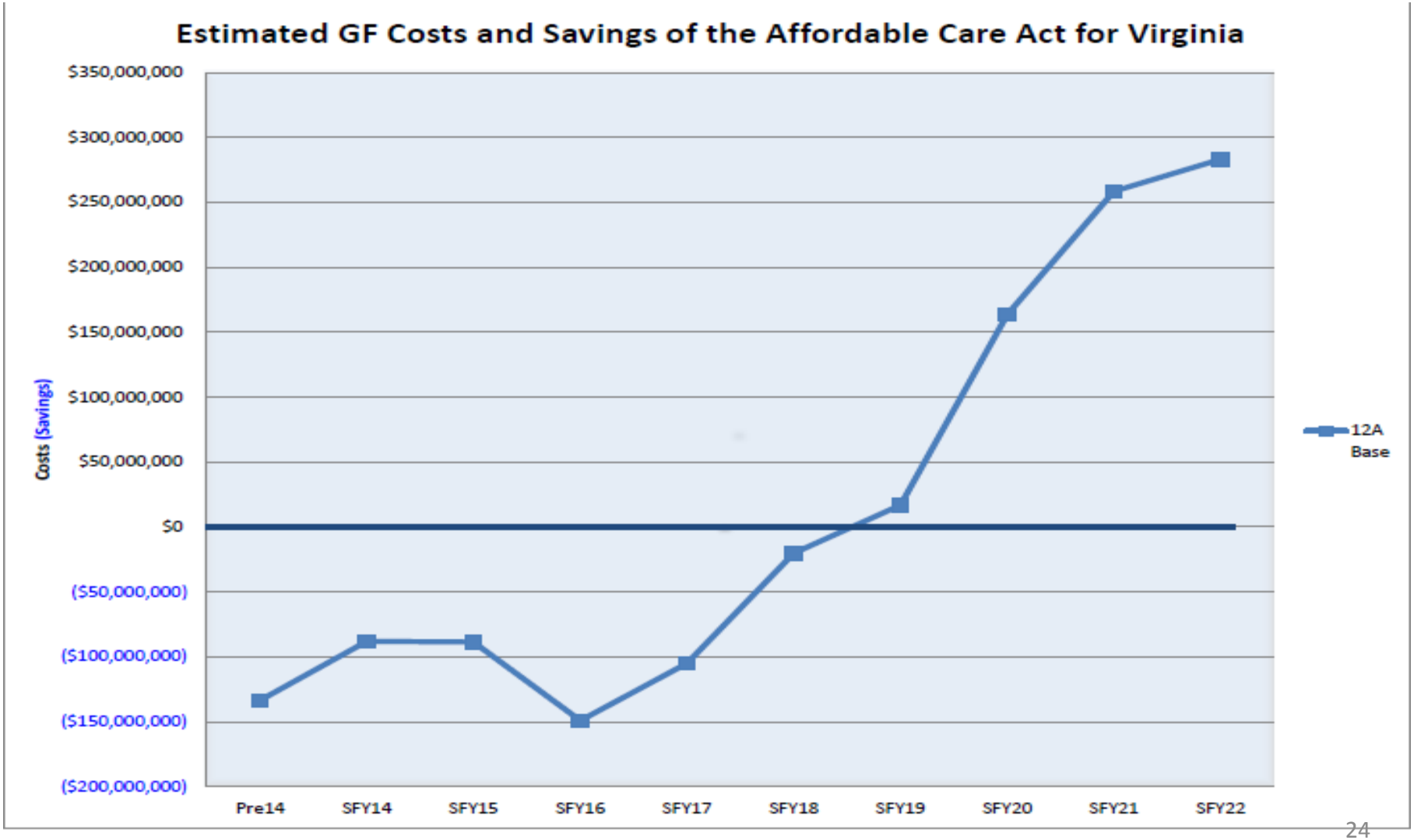
	Elimination of Public Coverage Programs (FAMIS MOMS, Family Planning 133%+)	✓	
Optional Expansion	Medicaid Expansion Costs	✓	$280m
	# people estimated to ever enroll as of Jan 2014	247,923	
	Behavioral Health Savings	✓	
	Inmate Inpatient Hospital Savings	✓	
	Indigent Care Savings	✓	
	Other Savings	✓	
	Administrative Costs	✓	
	Total Estimated Cost of Mandatory Provisions AND Optional Expansion	$137,485,859	$137m

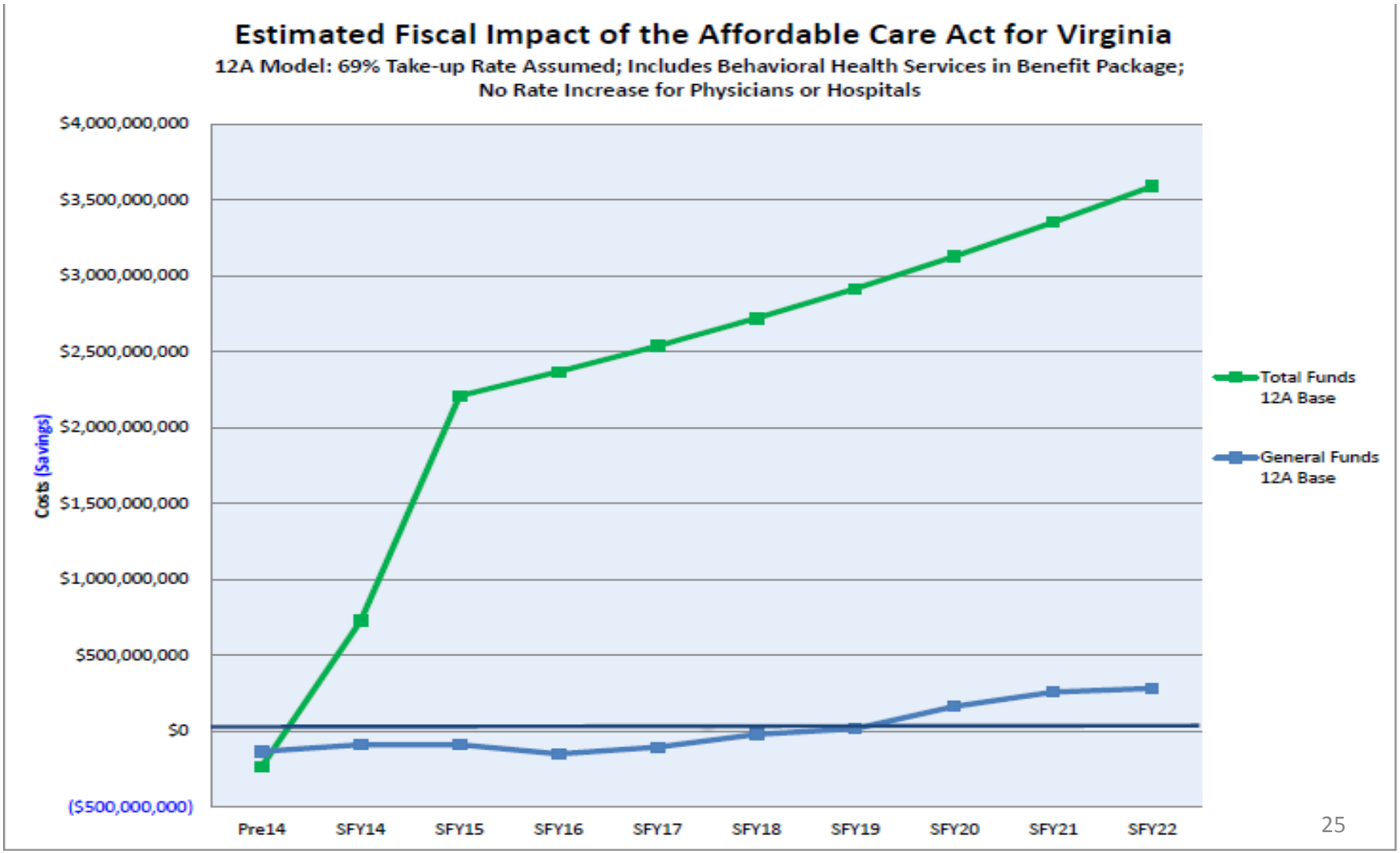
These costs and savings are already reflected in the Governor's Introduced Budget

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

Annual Impact of Mandatory Provisions
AND
Optional Expansion



Estimated Impact
Total vs General Funds

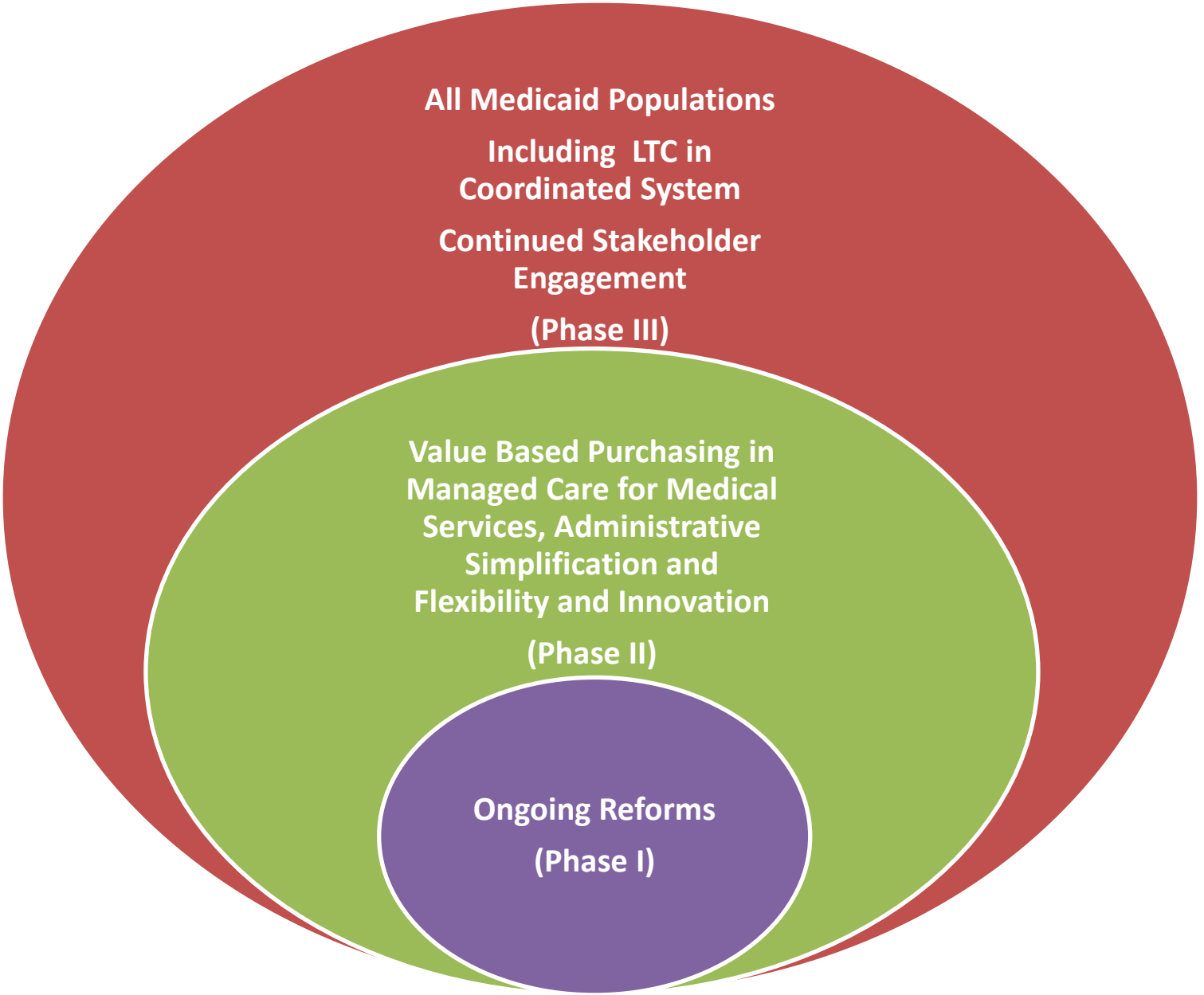


Virginia's Legislative Approach to Medicaid Expansion

- 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

Three Phases of Medicaid Reform



Virginia Medicaid Reform Goals

Coordinated Service Delivery

- DMAS provides a health system where services are coordinated, innovation is rewarded, costs are predictable, and provider compensation is based on the quality of the care.

Efficient Administration

- DMAS is efficient, streamlined, and user-friendly. Tax payer dollars are used effectively and for their intended purposes.

Significant Beneficiary Engagement

- Beneficiaries take an active role in the quality of their health care and share responsibility for using Medicaid dollars wisely.

Status of Phase 1 Reforms

Title	Progress	Timeline/Target Date
Dual Eligible Demonstration Pilot **SFY14-16 Total Savings** **50% enrollment ($27,597,465)** **80% enrollment ($44,028,619)**		• **July 2013:** Negotiations started with identified health plans • **August 2013:** Began Readiness Reviews with plans • **September 2013:** Contracting, Rates • **October 2013:** Completed desk and on-site Readiness Reviews with plans • **January 2014:** Regional phased-in enrollment begins
Enhanced Program Integrity **SFY14-16 Total Additional Savings ($17,066,946)**		**•Continued Enhancement Highlights:** 1. 145 referrals to MFCU at the OAG 2. Prevented over $363M in improper payments (over past two fiscal years) 3. $461,654 in restitution and imprisonment in some cases for fraudulent eligibility 4. Eight separate contracts to monitor and audit provider payments

Status of Phase 1 Reforms

Title	Progress	Timeline/Target Date
Foster Care Enrollment into MCOs **SFY14-16 Total Savings ($13,940,351)**		• **Tidewater**: September 1, 2013 (**LIVE**); • **Central VA**: November 1, 2013; • **NOVA**: December 1, 2013; • **Charlottesville**: March 1, 2014; • **Lynchburg**: April 1, 2014; • **Roanoke**: May 1, 2014; and, • **Far Southwest**: June 1, 2014.
Eligibility and Enrollment System **SFY14-16 Total Savings (General Funds only)** **($22,400,000 due to 75% enhanced FFP for eligibility functions)**		• **October 2013** – New VaCMS eligibility system went live for new Medicaid/FAMIS applications; Now taking Medicaid/FAMIS applications using new financial requirements MAGI • **January 1, 2014** – Additional eligibility rules required to begin (e.g., coverage up to age 26 for foster care youth)

Status of Phase 1 Reforms

Title	Progress	Timeline/Updates
Access to Veterans Benefits for Medicaid Recipients **SFY14-16 Total Savings** **Minimal at this time**		• Assisting veterans to obtain benefits and avoid Medicaid expenditures when services are more appropriately funded by the Federal Government. • To establish the program -DMAS, VDVS and VDSS have together developed an MOU, interagency data transfer and internal procedures to get the program up and running. • Now transferring quarterly data match files with federal government to link applicants with federal services when available
Behavioral Health Services **SFY14-16 Total Savings ($133,960,168)**		• **December 2013:** Implement strengthened regulations to improve integrity and quality • **December 2013:** Implement new Behavioral Health Services Administrator (Magellan)

Status of Phase 2 Reforms

Title	Progress	Timeline/Target Date
Commercial Like Benefit Package		• Weekly discussions with CMS for transition to a Commercial ("alternative") benefit package in 2014 • **July 2014:** Managed Care Benefit Package Contract Revision to implement commercial benefit package
Cost Sharing and Wellness		• **July 2013** Managed Care Changes •Chronic Care and Assessments (2013) •Wellness Programs (2013) •Maternity Program Changes (2013)
Limited Provider Networks and Medical Homes		• **July 2013** Managed Care Changes • Medallion Care Partnership System (MCSP) • **October 2013**: Addition of Kaiser Health Plan (medical home model)

Status of Phase 2 Reforms

Title	Progress	Timeline/Target Date
Quality Payment and Incentives		• **July 2013 (for MCOs):**Program implemented to establish the baseline target • **July 2014:** quality withholds begin
Parameters to Test Innovative Pilots		• **Summer 2013:** Provided claims data to GMU to assist with VCHI pilots • **August 15, 2013:** Sent proposal to CMS • **September 2013:** Ongoing conversations with CMS & conversations with VCHI regarding potential pilots • **October 2013:** Workgroups established with CMS to establish authority

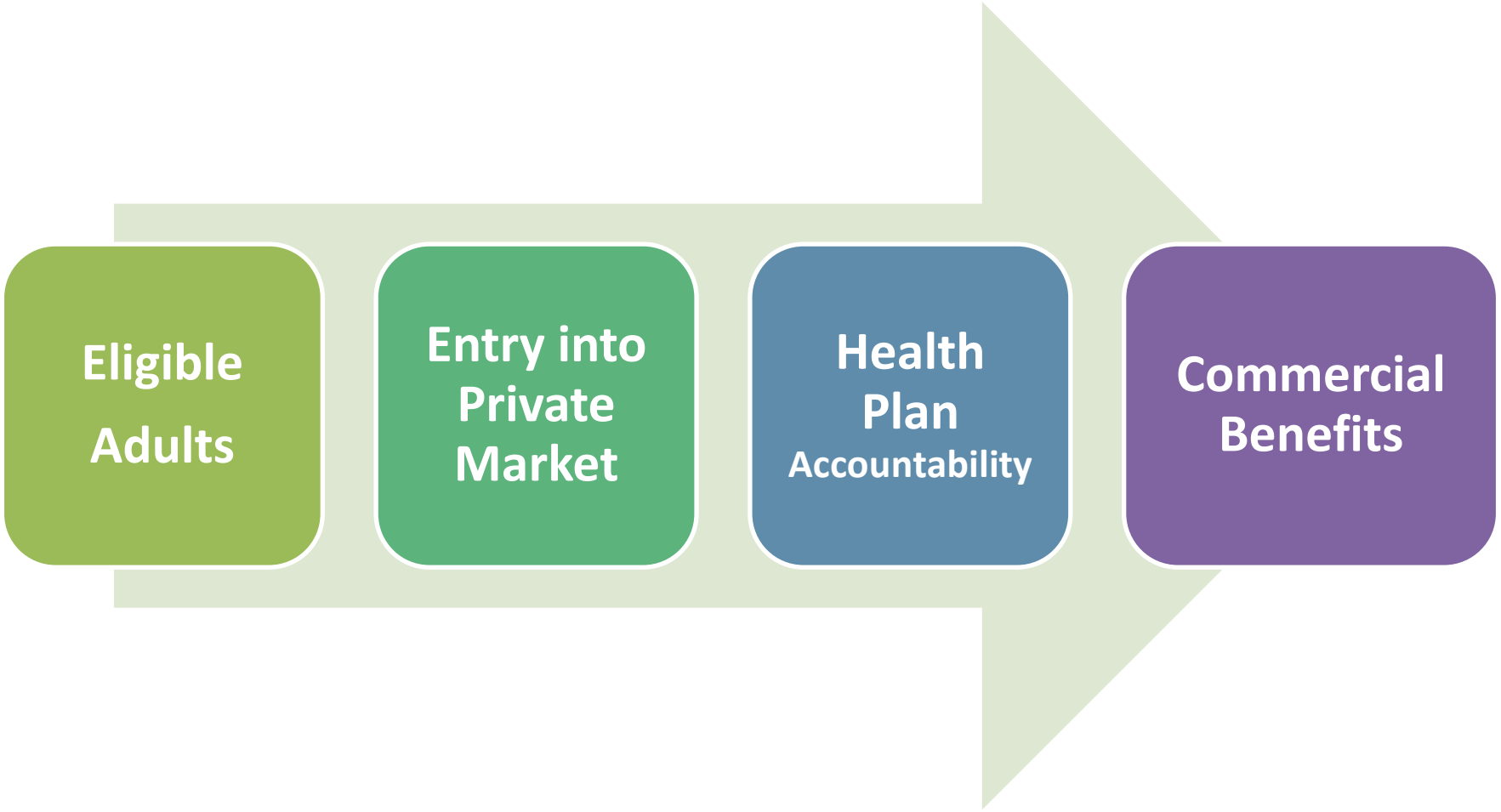
Status of Phase 3 Reforms

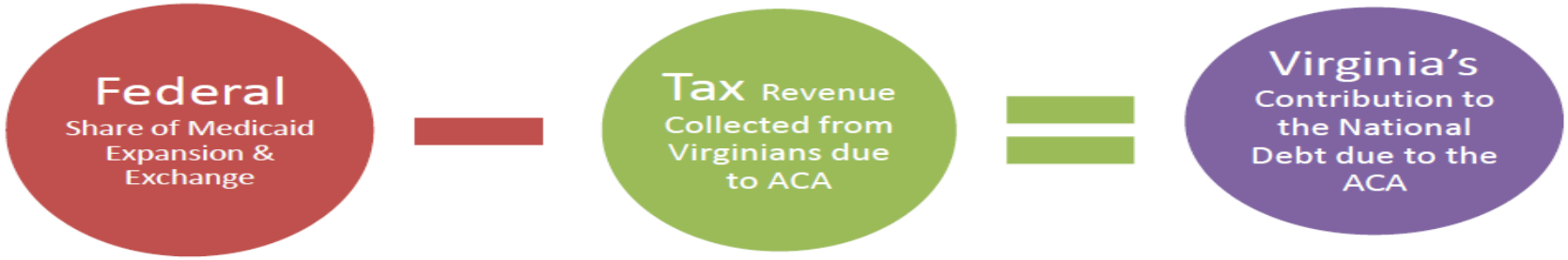
Title	Progress	Timeline/Target Date
ID/DD Waiver Redesign		• **October 2013** - First Phase of DBHDs Study completed • **July 2014** –ID/DD Waiver Renewal Due/ Redesign; second phase of DBHDS study to be complete • **July 2015-** Additional revisions to the ID/DD Waiver systems implemented as needed
All HCBC Waiver Enrollees in Managed Care for Medical Needs		• **October 2014** • Home and community-based waiver services remain out of managed care and provided through fee-for-service

Status of Phase 3 Reforms

Title	Progress	Timeline/Target Date
All Inclusive Coordinated Care for LTC Beneficiaries (coordinated delivery for all LTC services)		**July 2016**
Statewide Medicare-Medicaid (Duals) Coordinated Care, including children		**July 2018**

Potential Virginia Model: Private Option for Low-Income Adults





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

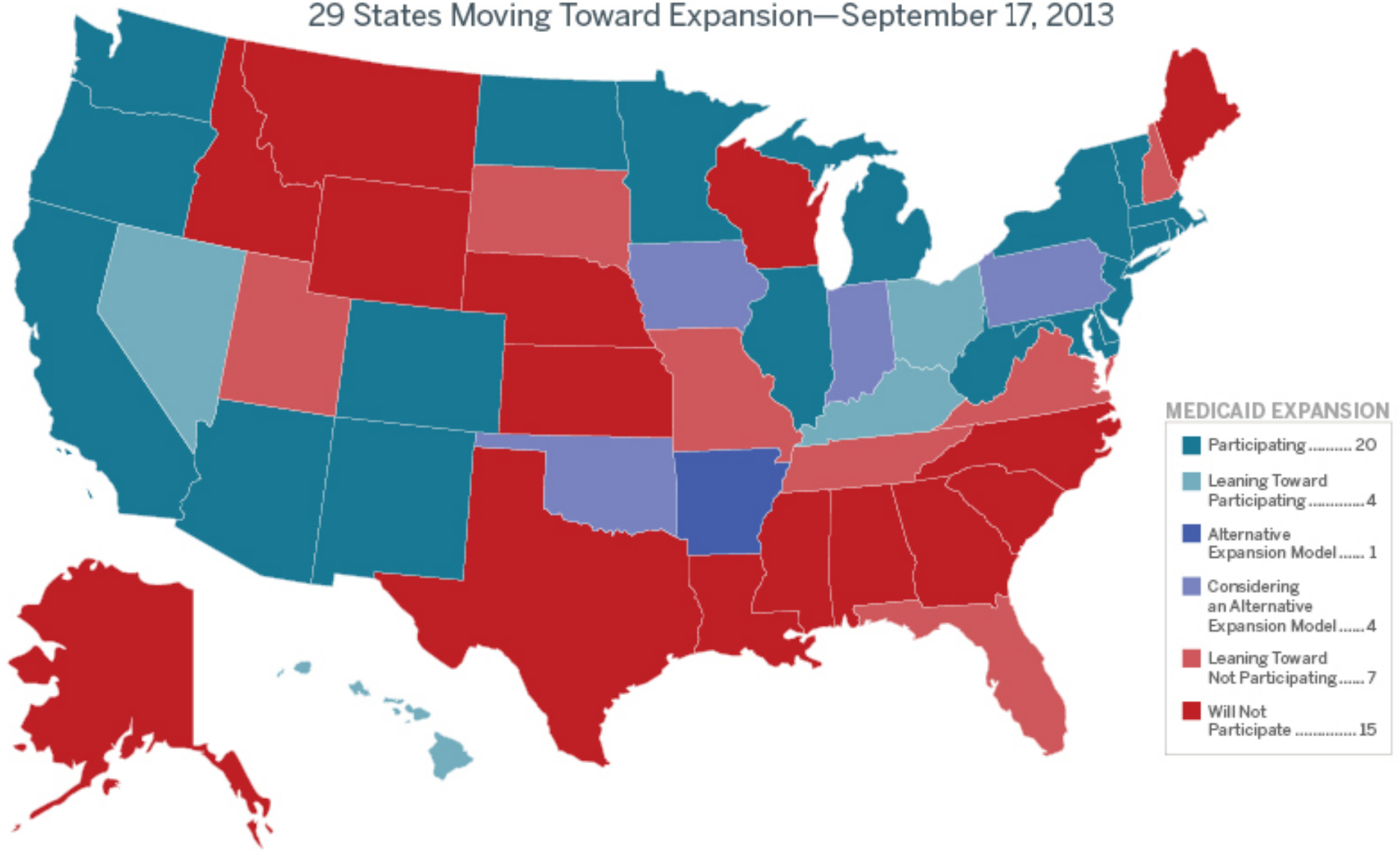
[6] Federal Share of Medicaid Expansion by Year (FY2014-2022)- Assuming a 69% take up rate

[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

Beyond the Pledges: Where the States Stand on Medicaid

29 States Moving Toward Expansion—September 17, 2013



Notes: Based on literature review as of 9/17/13. All policies subject to change without notice.

HHS has announced that states can obtain a waiver to use federal funds to shift Medicaid-eligible residents into private health plans.

The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.

Source: American Health Line, http://ahlalerts.com/2012/07/03/medicaid-where-each-state-stands-on-the-medicaid-expansion/, accessed 9/17/13.

The Advisory Board Company

Learn more about the impact of the Supreme Court ruling at **advisory.com/MedicaidMap**

Virginia Health Innovation Plan

Concept for a Virginia Health Innovation Plan

VHIP concept presented June 6, 2013 at Virginia Chamber Health Care Conference

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.

Health Reform Work Supported Through:

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