

# **Health Reform in Virginia**

## **Strategic Implications for Health Systems and the Commonwealth**

**Senate Finance HHR Subcommittee  
October 25, 2010**

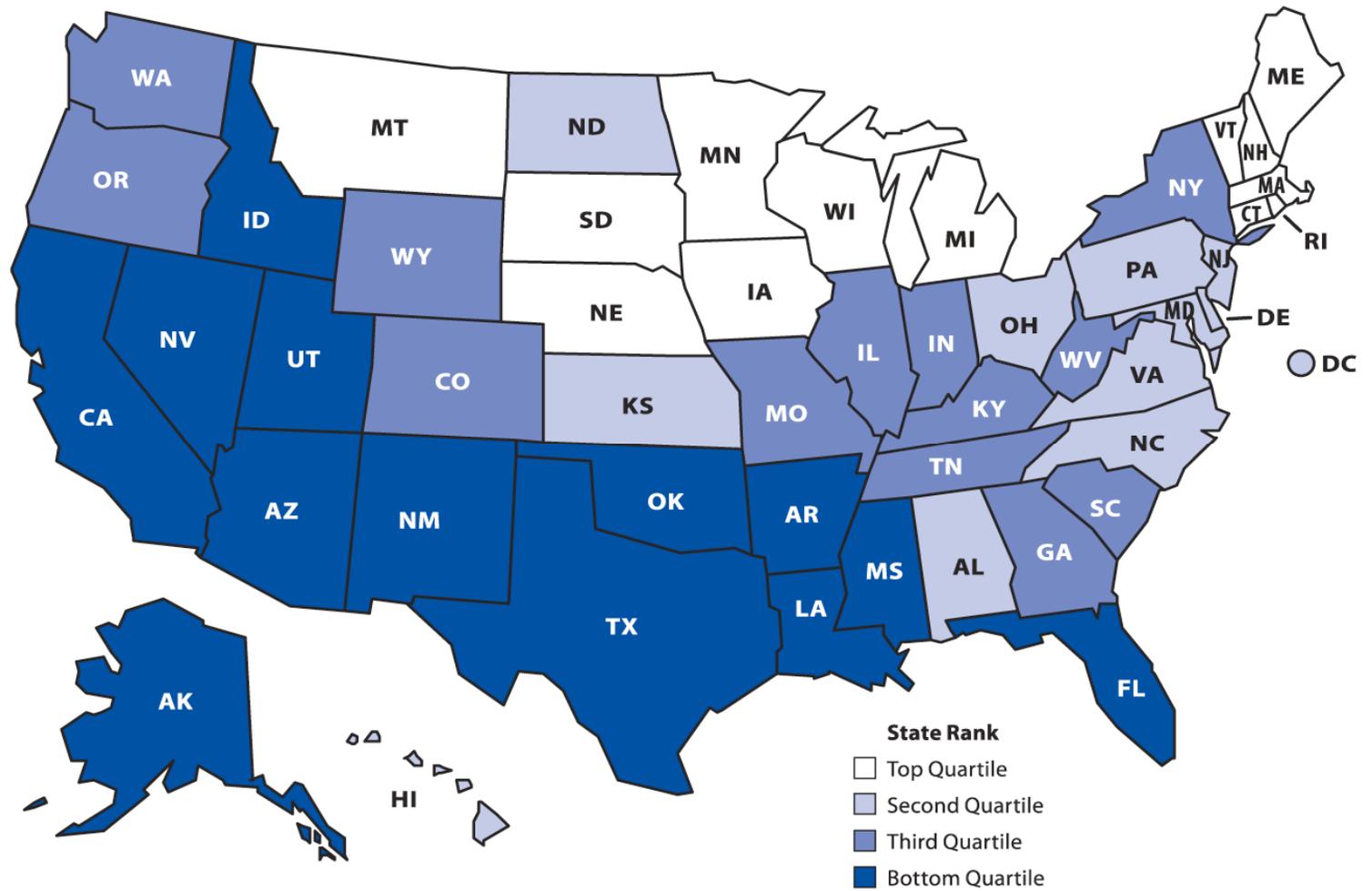
# Key Points

- **Virginia health delivery is already evolving and improving**
- **Effects of federal legislation are tremendous, but the “rules” are unknown**
- **Our Commonwealth can deal constructively with change**



# Quality Differences Among States

## State Ranking on Quality Dimension



# Improving America's Hospitals

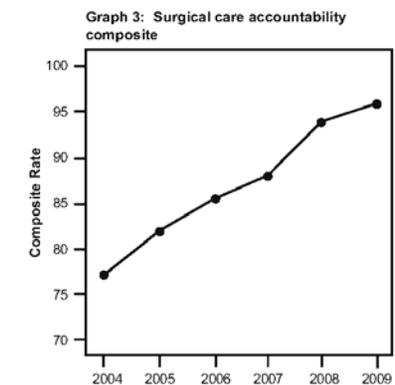
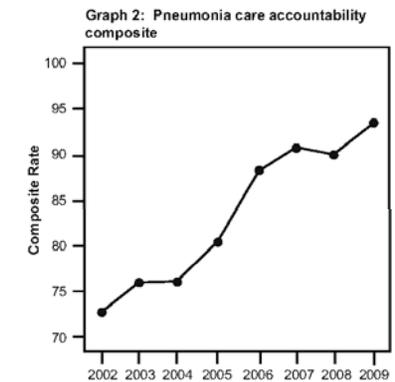
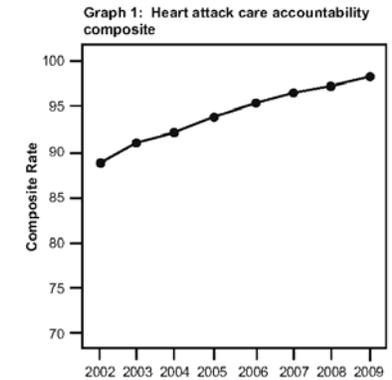
## Joint Commission 2010 Annual Report

Table 1: Accountability composite measure results

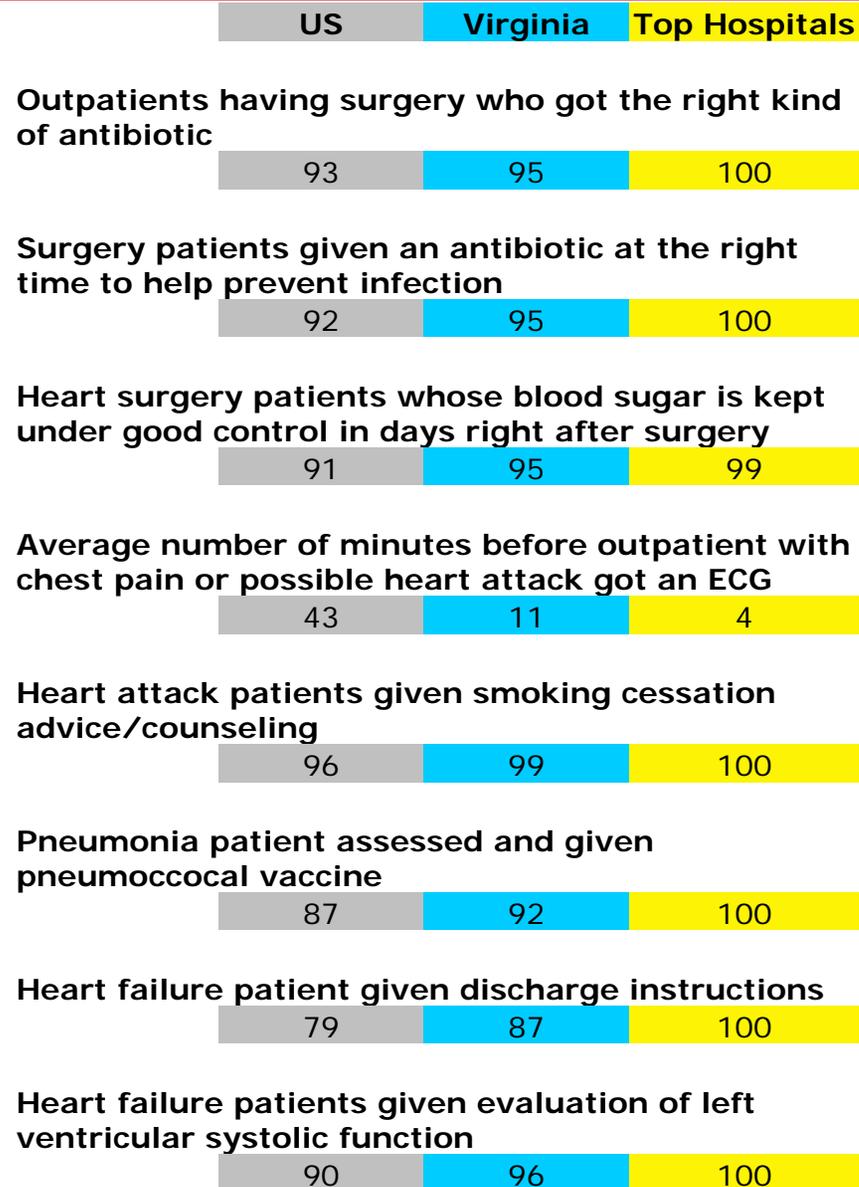
Accountability composite measures	2002	2003	2004	2005	2006	2007	2008	2009
Heart attack care composite	88.6%	91.0%	91.9%	93.2%	94.4%	95.7%	96.8%	97.7%
Pneumonia care composite	72.4%	76.5%	76.5%	80.5%	87.1%	90.3%	89.8%	92.9%
Surgical care composite	N/A	N/A	77.4%	82.1%	86.2%	88.9%	93.5%	95.8%
Children's asthma care composite	N/A	N/A	N/A	N/A	N/A	70.7%	79.8%	88.1%
Overall	81.8%	83.9%	83.3%	84.9%	88.2%	90.0%	93.1%	95.4%

Table 2: Percentage of hospitals achieving accountability composite rates greater than 90 percent

Accountability composite measures	2002	2003	2004	2005	2006	2007	2008	2009
Heart attack care composite	49.8%	56.6%	59.6%	68.3%	76.7%	85.0%	91.1%	94.5%
Pneumonia care composite	5.4%	9.5%	6.5%	11.3%	33.9%	57.0%	55.8%	75.5%
Surgical care composite	N/A	N/A	10.2%	15.2%	30.2%	42.1%	74.4%	89.5%
Children's asthma care composite	N/A	N/A	N/A	N/A	N/A	2.6%	21.3%	50.8%
Overall	20.4%	24.6%	16.5%	21.9%	41.5%	60.0%	70.8%	85.9%

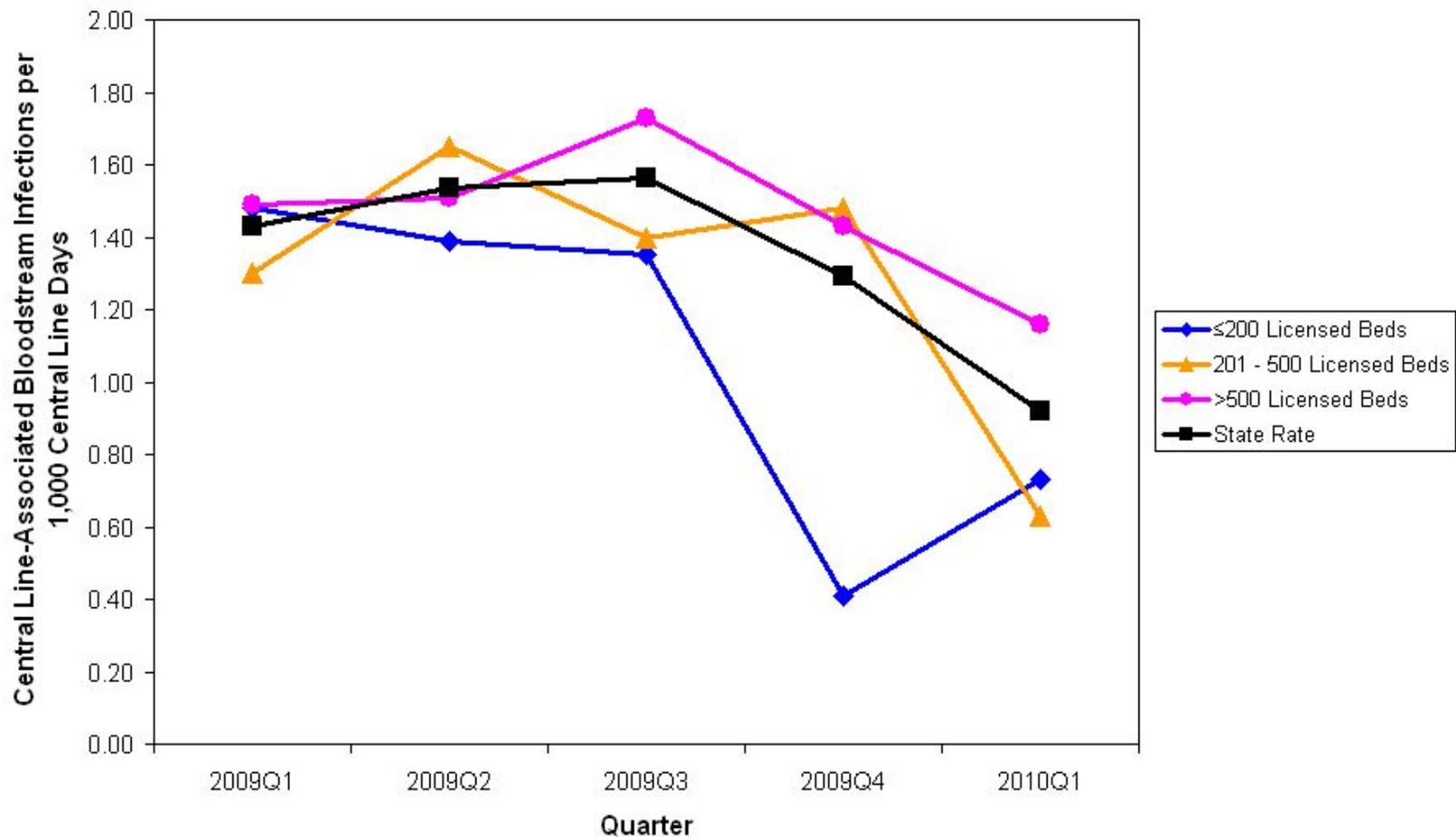


# Hospital Compare - Virginia vs. US vs. Top



# Virginia Hospitals Reducing Infections

Central Line-Associated Bloodstream Infection Rate by Hospital Bedsize, Virginia, January 2009 - March 2010

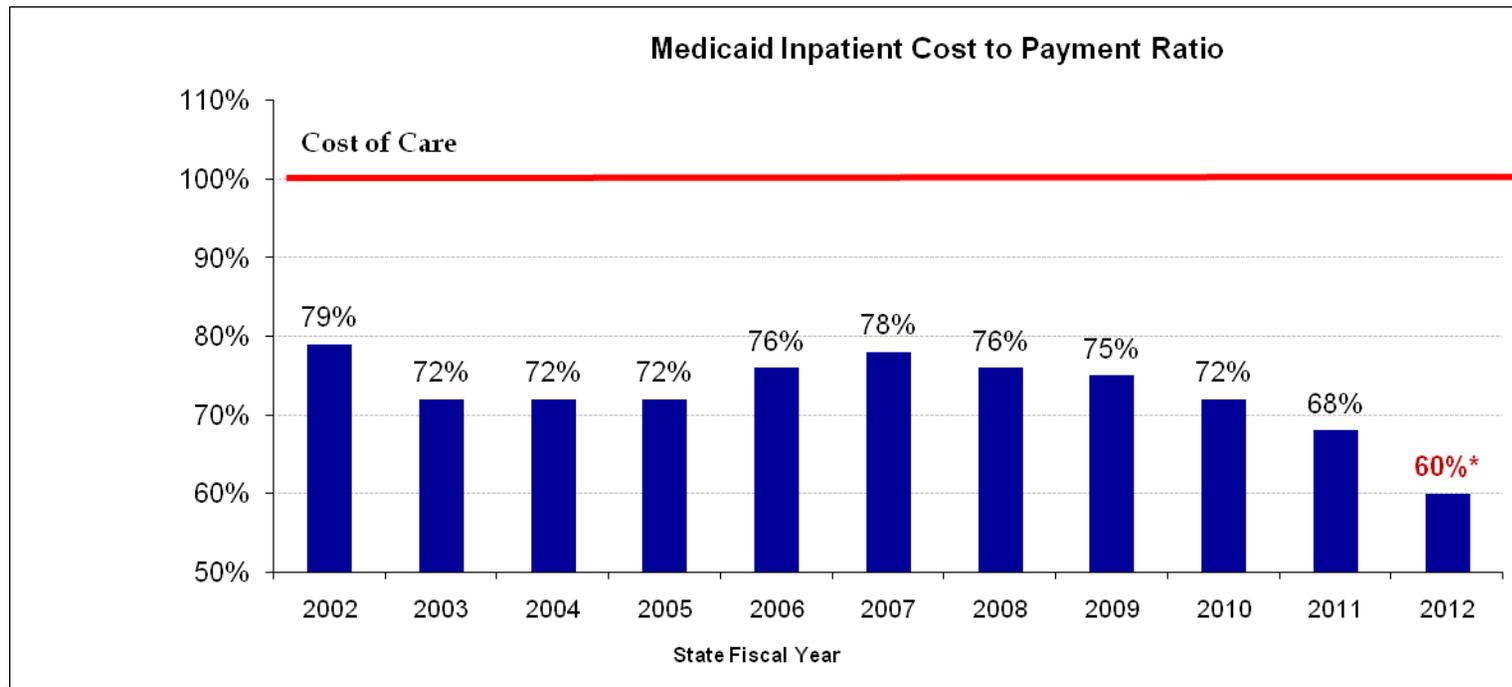


# Variation's Core lessons

- **Higher quality = Lower costs (more often than not)**
  - Health care is not exempt from the lessons of Deming and Drucker
- **Variation = Opportunity for learning and improvement**
  - Opportunities are pervasive (everyone and everywhere)
  - And perpetual (innovation and evidence base changes)
- **High performance requires effective teamwork**
  - Health care = team sport
  - Culture trumps strategy

# Virginia Medicaid Realities

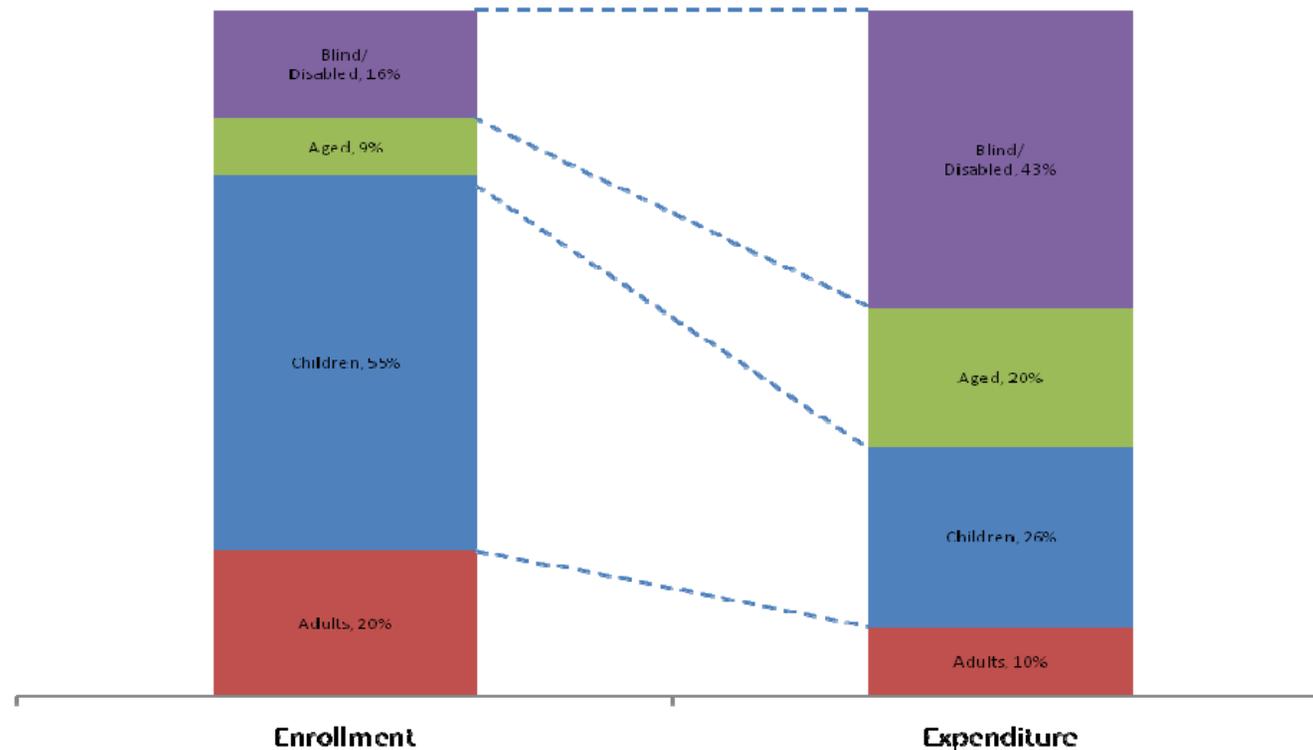
- **Counter-cyclical spending growth**
  - Medicaid/FAMIS enrollment now > 900,000
- **Virginia Medicaid one of the leanest in the nation**
  - Tight eligibility (with further tightening now prohibited)
  - Tight criteria for nursing home admission (and hospital)
  - Low payments to physicians, nursing homes and hospitals



\* With 4% reduction per budget

# Medicaid Enrollment vs. Spending

*Most spending related to aged and disabled*

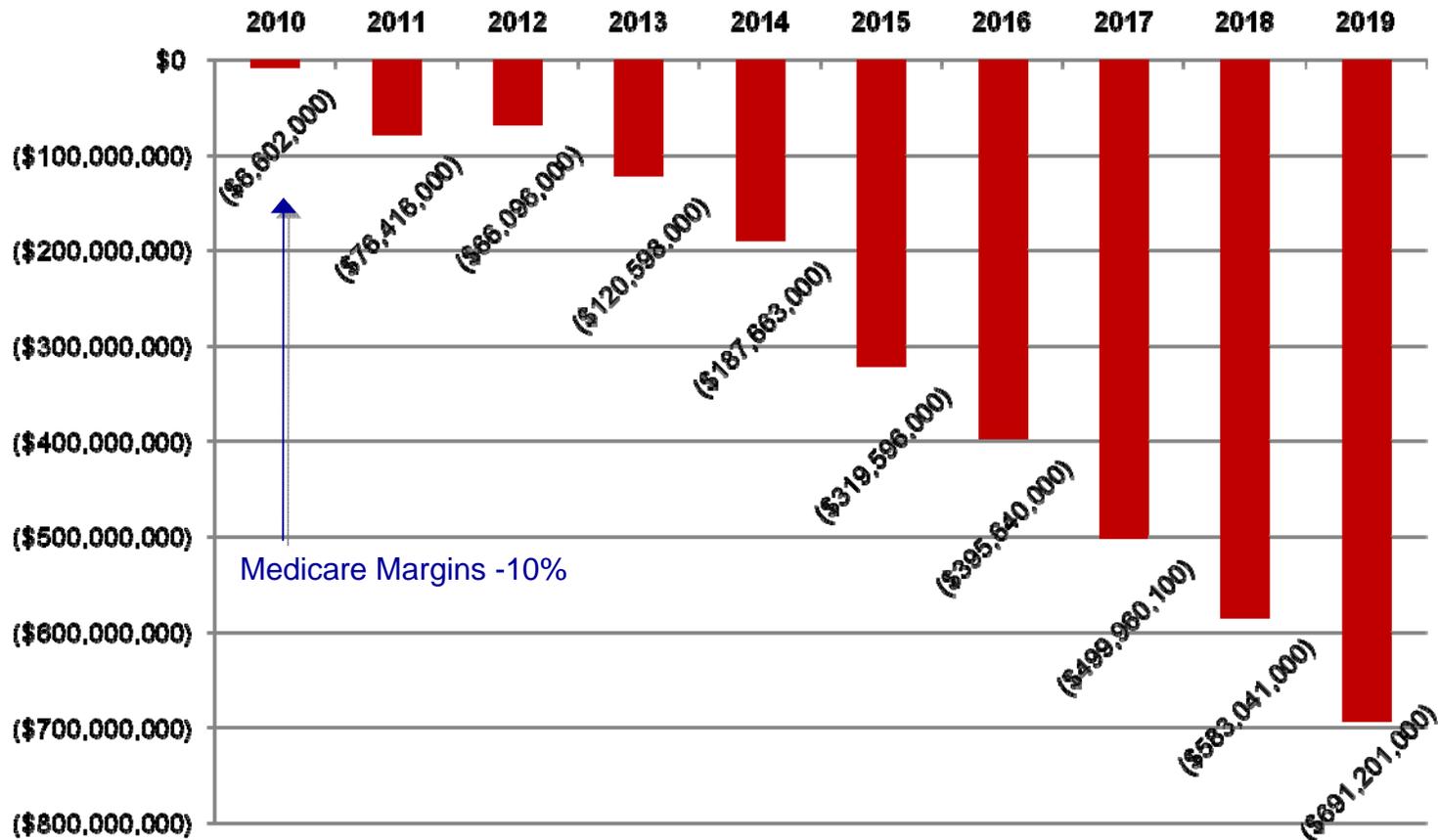


# Medicaid Eligibility Levels

Eligibility Guidelines for Virginia's Medicaid Program	
Eligibility Categories	Financial Criteria – Income Level
Children (ages 0-18)	< 200% of Federal Poverty Level*
Aged, Blind, Disabled (ABD)	< 80% of Federal Poverty Level
Adult (with Medicaid-eligible Child)	< 24% of Federal Poverty Level
Pregnant Women	< 200% of Federal Poverty Level*
<b>Medicaid Optional Groups:</b>	
Medically Needy, with higher income	Monthly income of \$449-\$592 for family of four
Home and Community Based Waivers	< 300% of Social Security income
Certain ABD without Social Security Benefits	< 300% of Social Security income
<b>Individuals/Childless Adults</b>	Not Eligible for benefits
<p>* By state regulation, Children and Pregnant Women are covered up to 133 percent of the federal poverty level (FPL) through Medicaid. However, Virginia also participates in the federally supported State Children's Health Insurance Program, providing additional federal matching dollars if the state provides coverage to Children and Pregnant Women up to 200 percent of the FPL. Though technically a separate program, Virginia operates it as part of Medicaid.</p>	

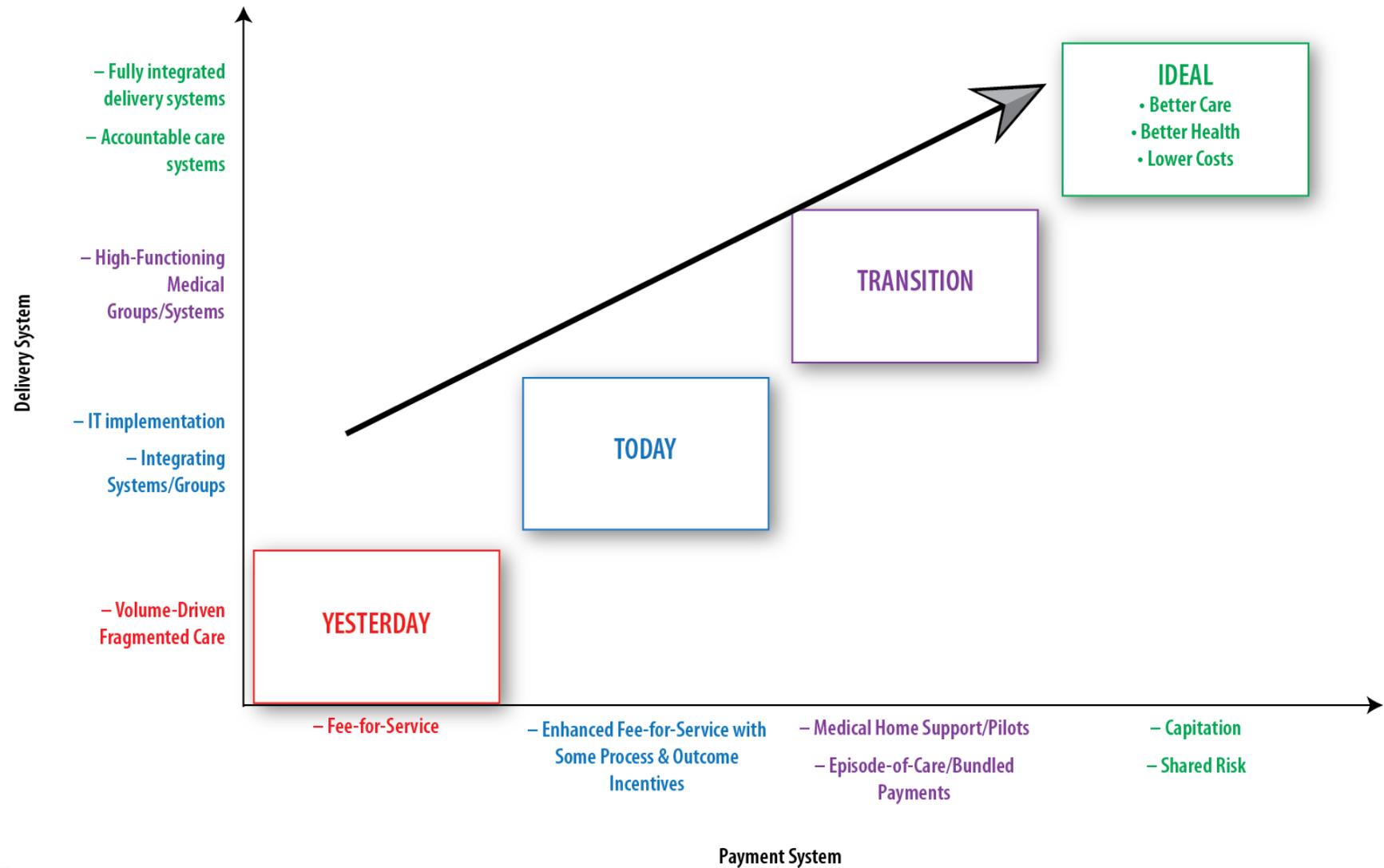
# Medicare Hospital Payment Reductions

Virginia Total Reductions vs. Baseline  
Including PPACA reductions and PPS Regulatory Actions



*For providers the cuts are certain and start right away, benefits of reform start later and are less clear.*

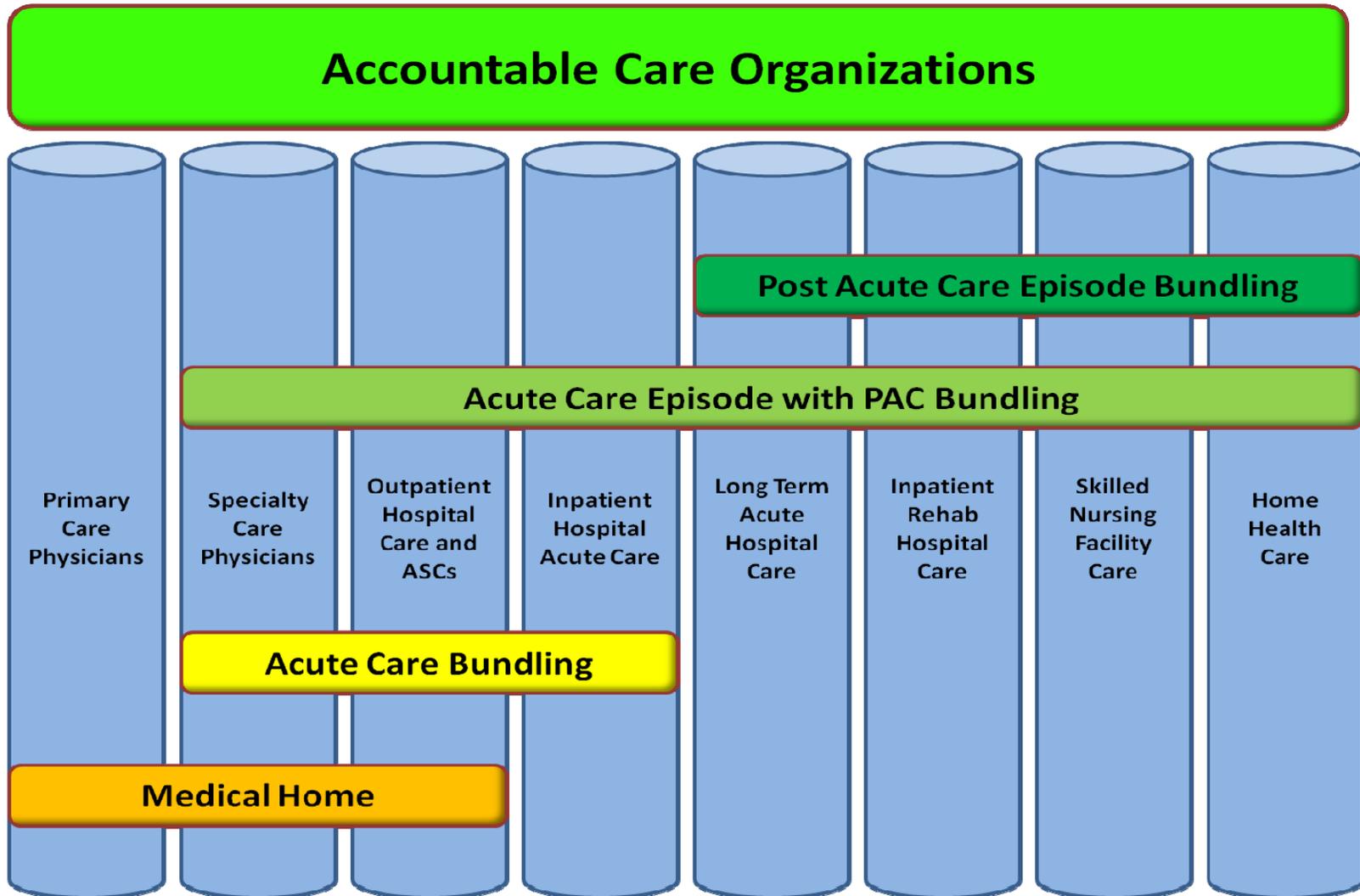
# Co-evolution of delivery system & payment reforms



# Triple Aim Goals

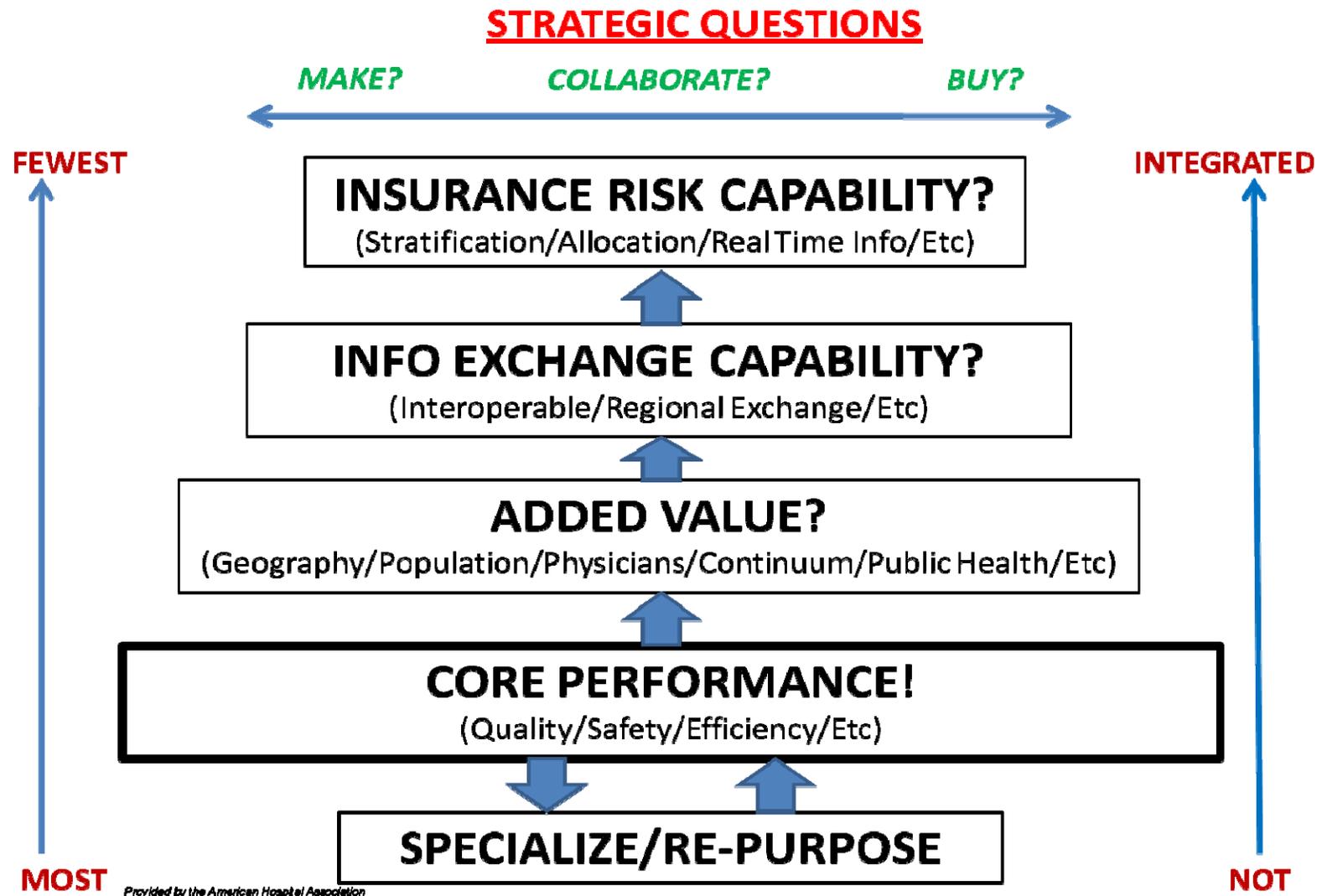
- **Better care for patients**
  - Our primary responsibility (all providers)
  - Committed to achieving top-tier performance
- **Better health for populations**
  - Shared responsibility, public and private
  - Patient/employee engagement, support and incentives critical
  - Major driver of productivity and cost
- **Lower trajectory on total health care costs**
  - Delivery system and payment reform essential
  - Everyone will need to do business differently

# ACOs and Bundling



*Provided by the American Hospital Association*

# Strategic Choices



# Key questions/implications of reform

## *For Virginia Health Care Providers and Systems*

- **With front-loaded Medicare cuts, well in advance of coverage expansions, where will the financial means come from to comply with higher performance expectations and regulatory burden?**
- **What scale will be necessary for a hospital or system to achieve the needed economies and skills to succeed under the new rules?**
- **As both an employer and a provider, what new cost burdens will we sustain that do nothing to improve care?**

# Key questions/implications of reform

## *For Virginia Health Care Providers and Systems*

- **To address ongoing state and federal budget challenges, will Medicare and Medicaid payment adequacy be further compromised?**
- **With major new oversight/regulation of the private insurance, what will happen to the market that has helped offset unfunded costs?**

# Key Reform Implications for Virginia

- **Profound changes to insurance market regulation**
  - accommodate federal rate review requirements?
  - plan for insurance exchange(s) implementation?
- **Major Medicaid expansion**
  - Albeit with significant federal support
- **Payment and delivery reform opportunities**
  - Multi-payer collaboration?
  - Tools, infrastructure to advance improvement?

# Key Near Term Priorities (2011-13)

## *To Advance Healthcare Innovation and Value*

- **Strengthen Medicaid value**
  - Improve systems and tools to root out fraud and abuse
  - Streamline eligibility and administrative systems
  - Pursue Medicaid medical home and payment reform options
  - Expand effective care management systems to high-need groups
  - Avoid degradation in provider payments to preserve access
- **Expand workforce capacity and flexibility**
  - Continue supports for medical, nursing and other provider training
  - Expand scope of practice flexibility for key professionals
- **Establish partnership on necessary system reforms**
  - Authorize the creation of an all payer claims data set
  - Launch a partnership on health care quality, innovation and value

# Longer Term Priorities (2014 +)

- **Implement necessary insurance market changes without undermining strength of the underlying market**
  - Easier said than done (need to begin preparations 2012)
- **Accelerate delivery system and payment reforms**
  - Insist on pursuit of broad value improvement goals
  - Promote innovation and partnerships
  - Expand transparency and patient engagement
  - Lead by example with state employee plan and Medicaid
- **Manage Medicaid expansion/program changes**
  - Redirect state DSH reductions to operating payments
  - Work to preserve key Medicaid providers and access points
  - Adapt care management systems for high-need populations