JCHC Workplan Meeting

May 18, 2021

Agenda Overview

2021 JCHC Legislative Impacts (slide 3)

JCHC Health Care Dashboard (slide 6)

Overview of JCHC Workplan

- Affordability in the individual market (slide 25)
- Nursing facility workforce (slide 34)
- Aging in place (slide 44)

Stakeholder Briefings

NOTE: Click on each agenda item to jump to that section

2021 JCHC Legislative Impacts

Expanding pharmacy statewide protocols (HB2079 – Rasoul)

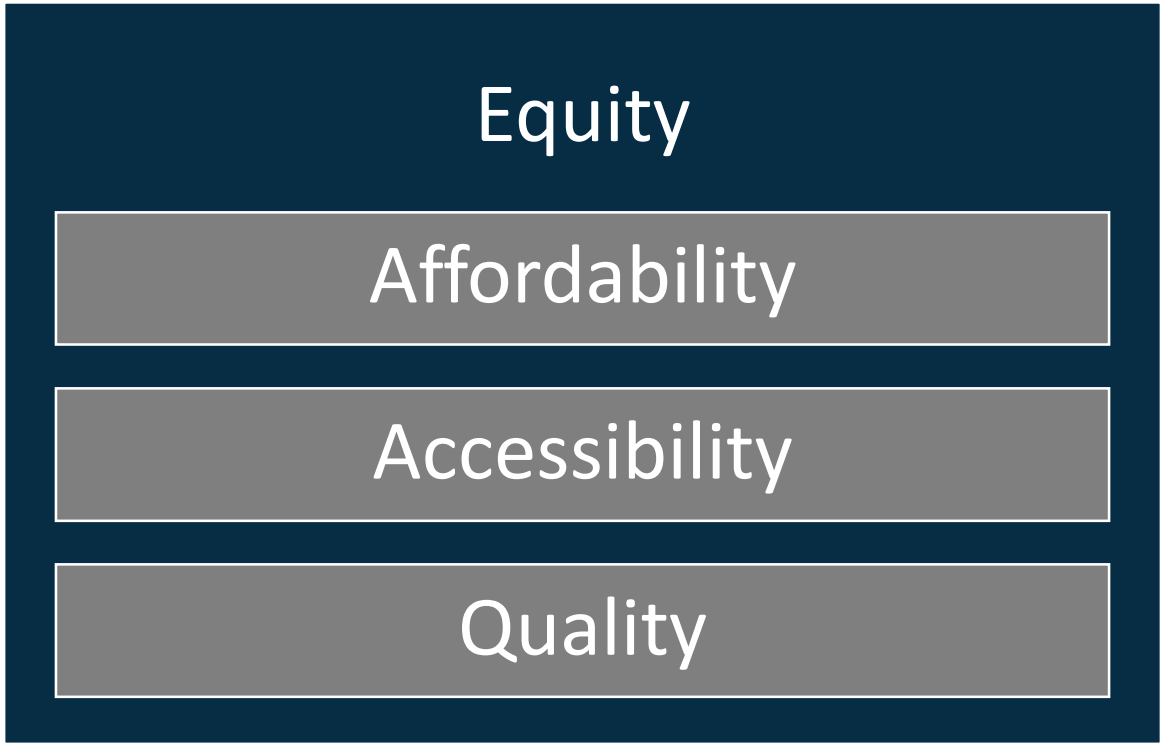
- JCHC recommended expanding statewide protocols with the goal of increasing access, to include:
  - Devices and supplies when less expensive with a prescription
  - Vaccines on the CDC immunization schedule
  - Tuberculosis tests
  - HIV PREP and PEP
- Legislation passed with support from all stakeholders

Repealing JCHC sunset clause (SB1408 – Barker)

- JCHC recommended making the Commission a permanent body, by repealing the sunset clause
- Legislation passed unanimously

JCHC Health Care Dashboard

JCHC Members identified four strategic priorities

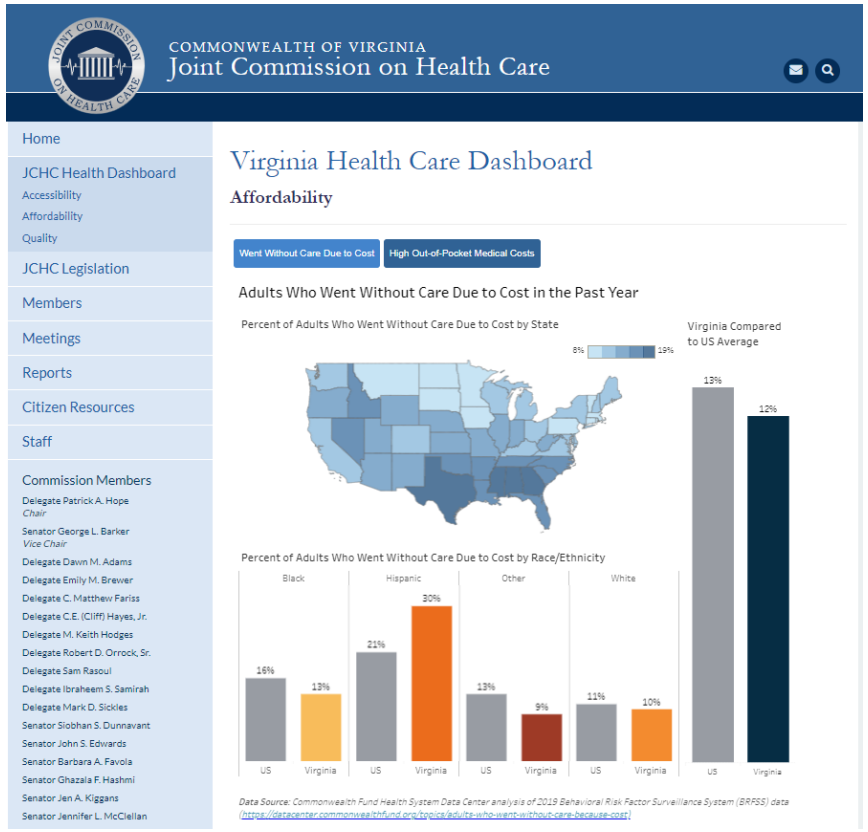


NOTE: Equity is a cross-cutting objective, so each metric includes an equity view where data was available.

Goals for the Health Care Dashboard

- Assess Virginia's current state in relation to the four strategic objectives
- Track trends and changes in the metrics over time
- Identify opportunities for future JCHC studies

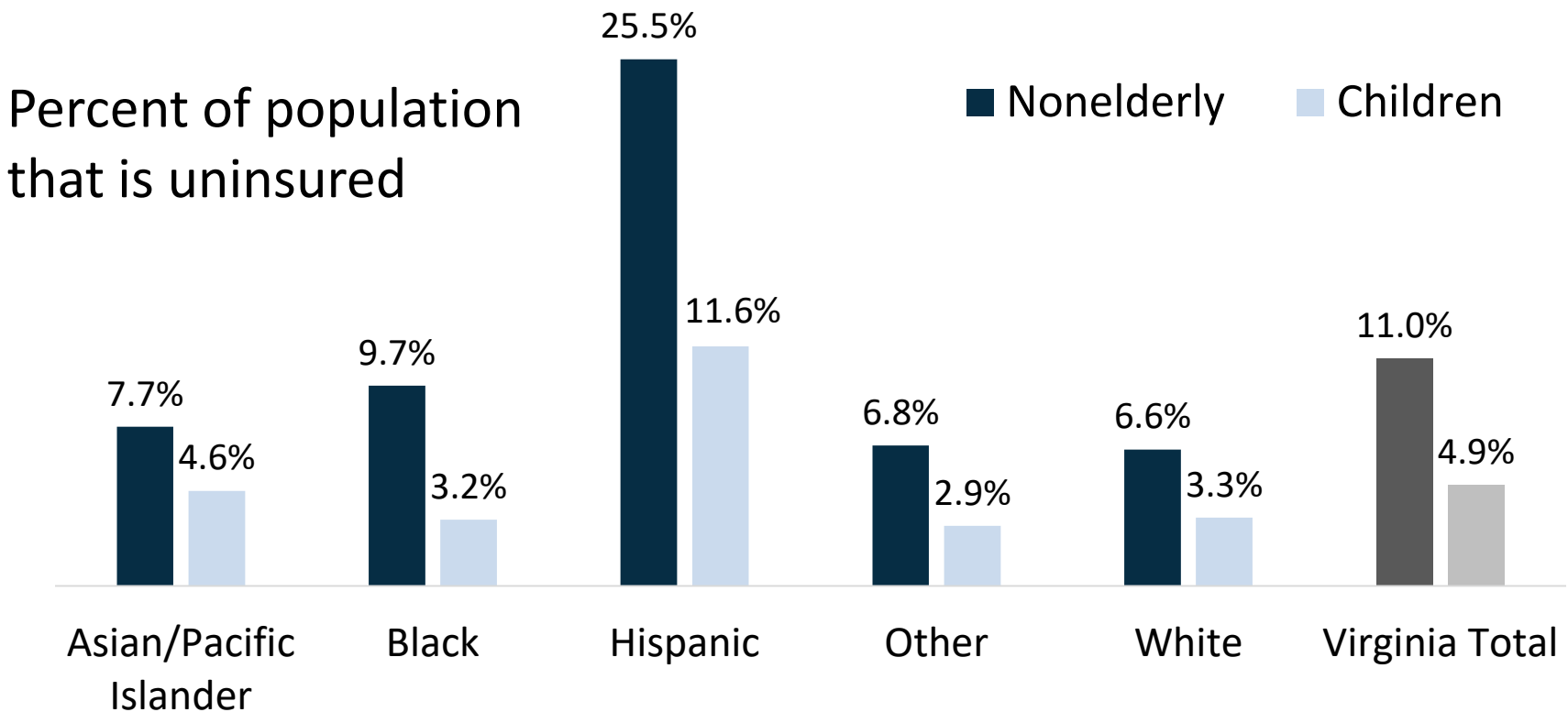
DEMO: Virginia Health Care Dashboard



Accessibility Metrics Snapshot

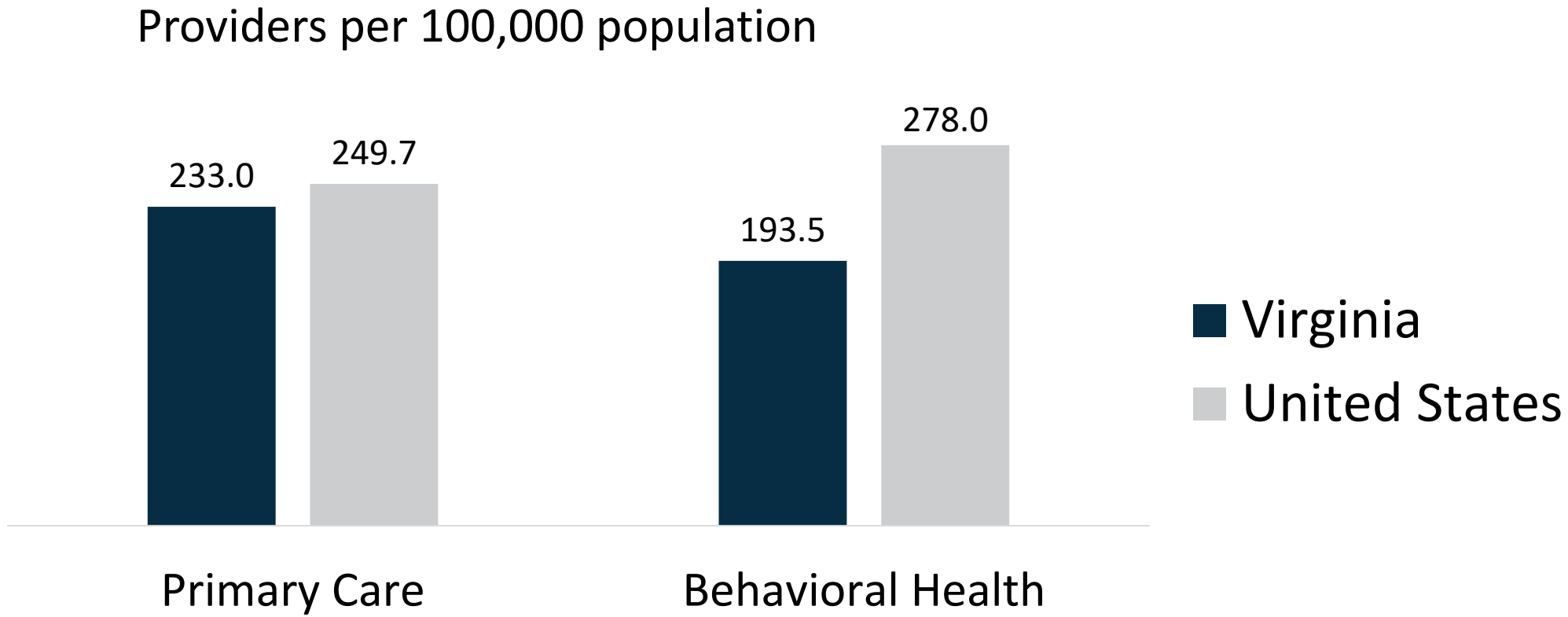
Accessibility metric	Virginia score (national rank)
Health insurance coverage	
Percent of adults who are uninsured (19-64 years old)	11.0% (25 of 51)
Percent of children who are uninsured (0-18 years old)	4.9% (26 of 51)
Provider availability	
Number of primary care providers per 100,000 population	233.0 (36 of 51)
Number of behavioral health providers per 100,000 population	193.5 (39 of 51)
Percent of moms who received late or no prenatal care	5.3% (18 of 51)
Percent of ED visits that were potentially avoidable	12.5%

Hispanic Virginians are more likely to be uninsured



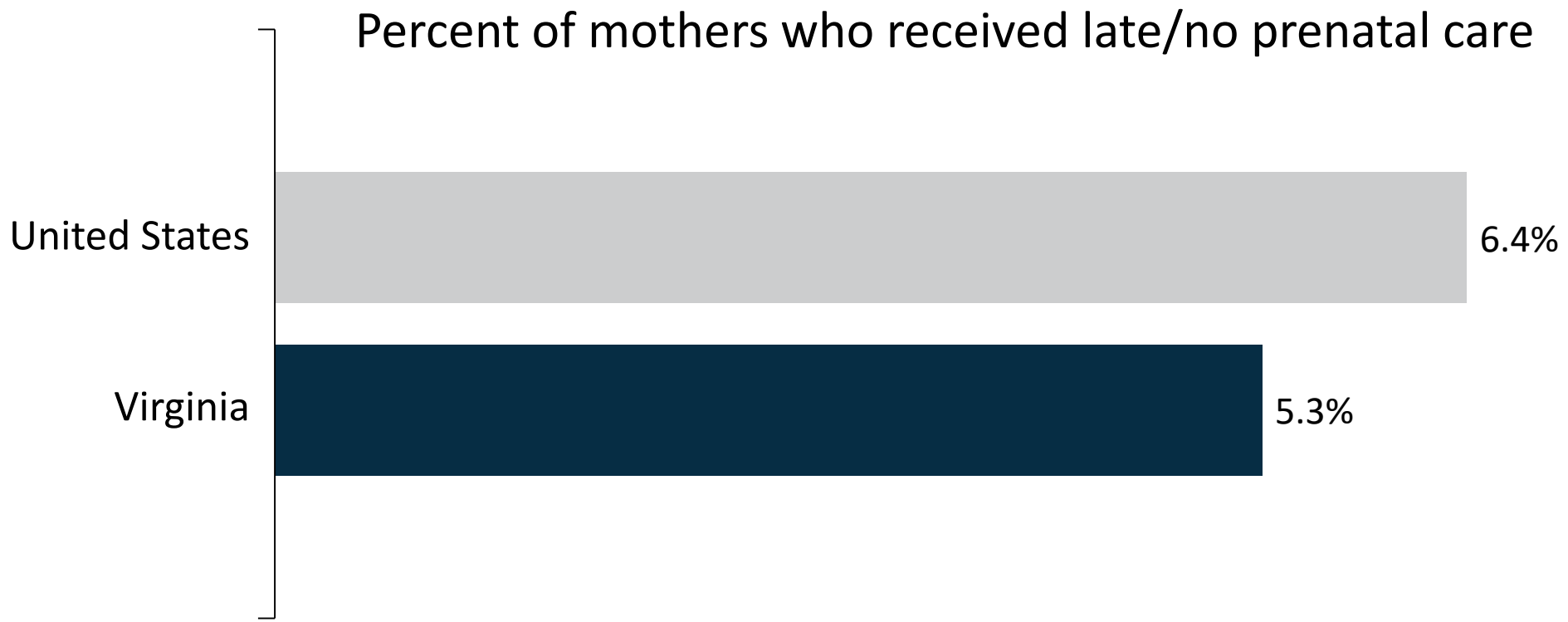
SOURCE: Urban Institute analysis of 2019 American Community Survey (ACS) data on behalf of the Virginia Health Care Foundation.

Virginia has fewer key providers than most other states



SOURCE: JCHC staff analysis of 2021 National Plan and Provider Enumeration System (NPPES) data, March 2021.

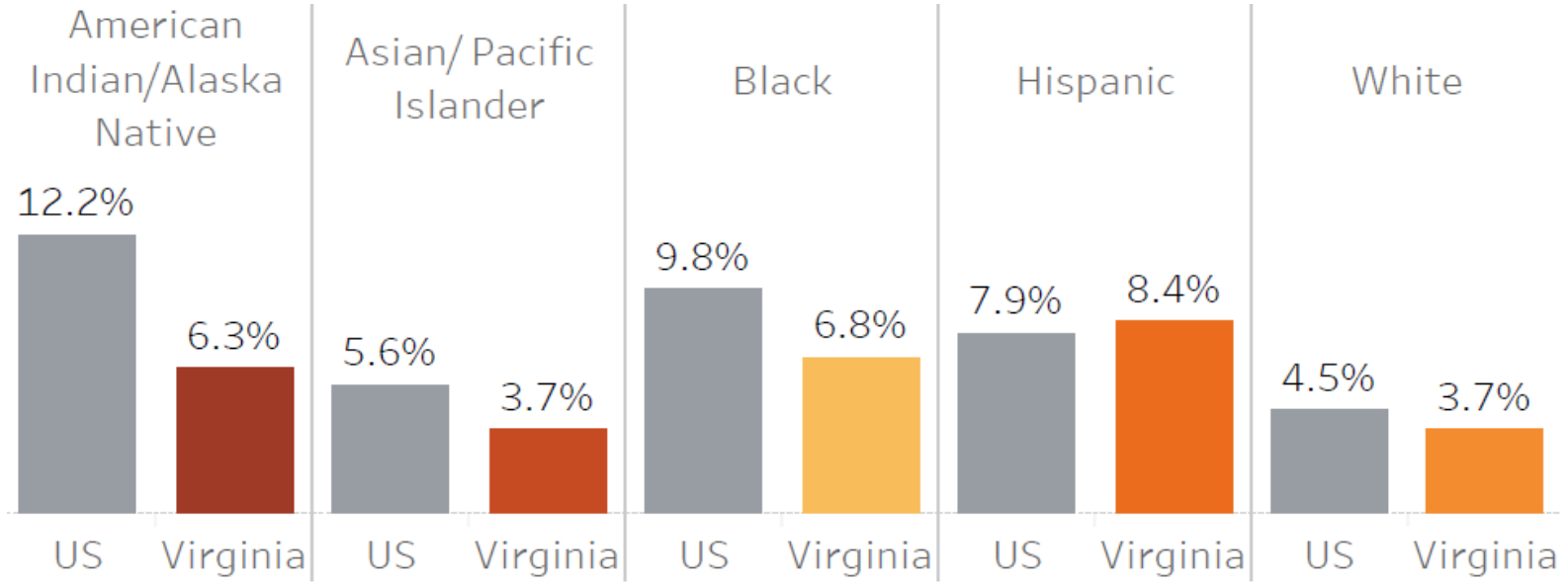
Mothers in VA more likely to receive timely prenatal care than other states



SOURCE: March of Dimes Perinatal Data Center analysis of National Center for Health Statistics, 2019 final natality data.

Non-white mothers are more likely to receive late or no prenatal care

Percent of mothers who received late/no prenatal care by race and ethnicity (2017-2019 average)



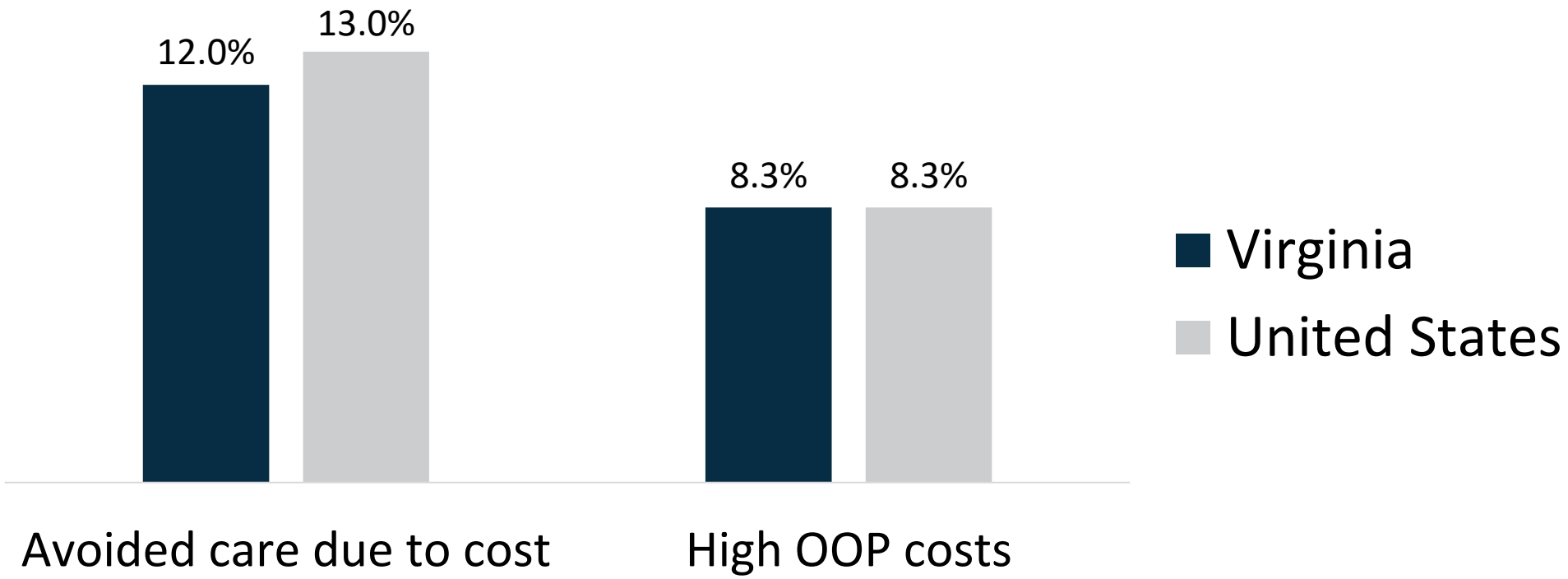
SOURCE: March of Dimes Perinatal Data Center analysis of National Center for Health Statistics, 2017-2019 final natality data.

Affordability Metrics Snapshot

Affordability metric	Virginia score (national rank)
Percent of adults who needed to see a doctor but could not because of cost	12.0% (17 of 49*)
Nonelderly with high out-of-pocket medical costs relative to annual household income	8.3% (20 of 50)

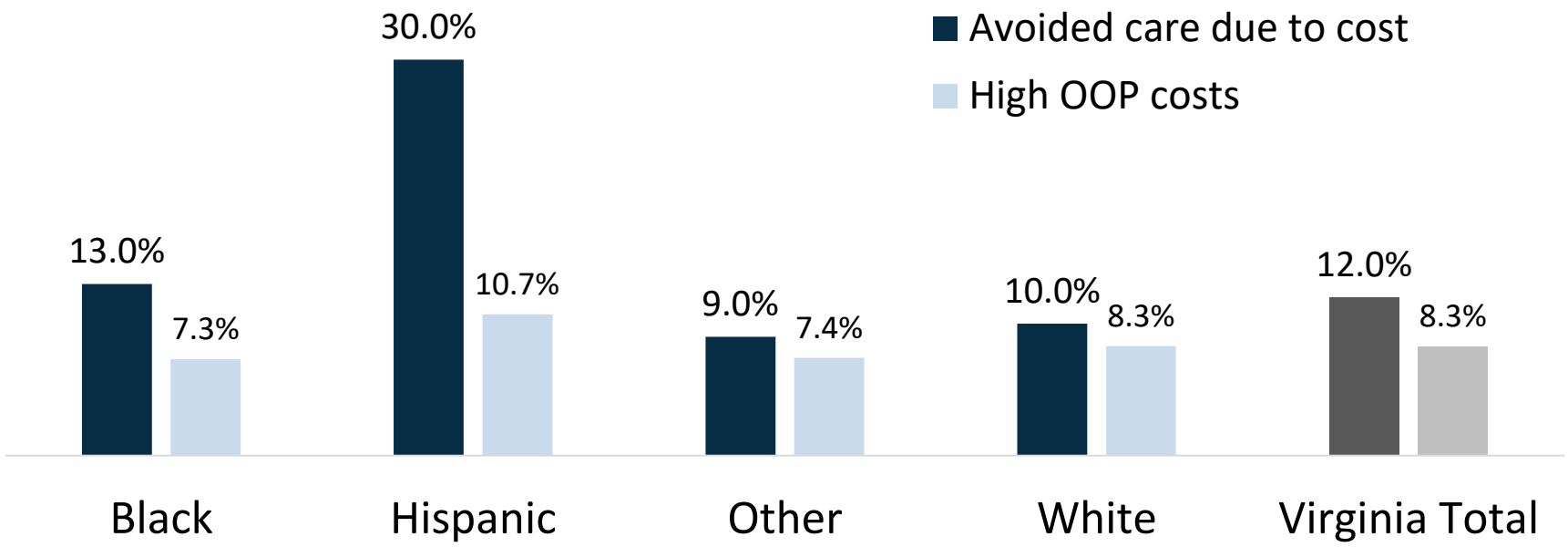
NOTE: Adults are Virginians age 18-64. High out-of-pocket costs are defined as 10% or greater of total household income, 5% or greater for those earning less than 200% of FPL.
*Data was not available for New Jersey

Virginia is similar to other states for high out-of-pocket costs



SOURCE: Commonwealth Fund Health System Data Center analysis of 2019 Behavioral Risk Factor Surveillance System (BRFSS) and 2017-2018 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) data.

Hispanic Virginians are more likely to have high medical costs



SOURCE: Commonwealth Fund Health System Data Center analysis of 2019 Behavioral Risk Factor Surveillance System (BRFSS) and 2017-2018 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) data.

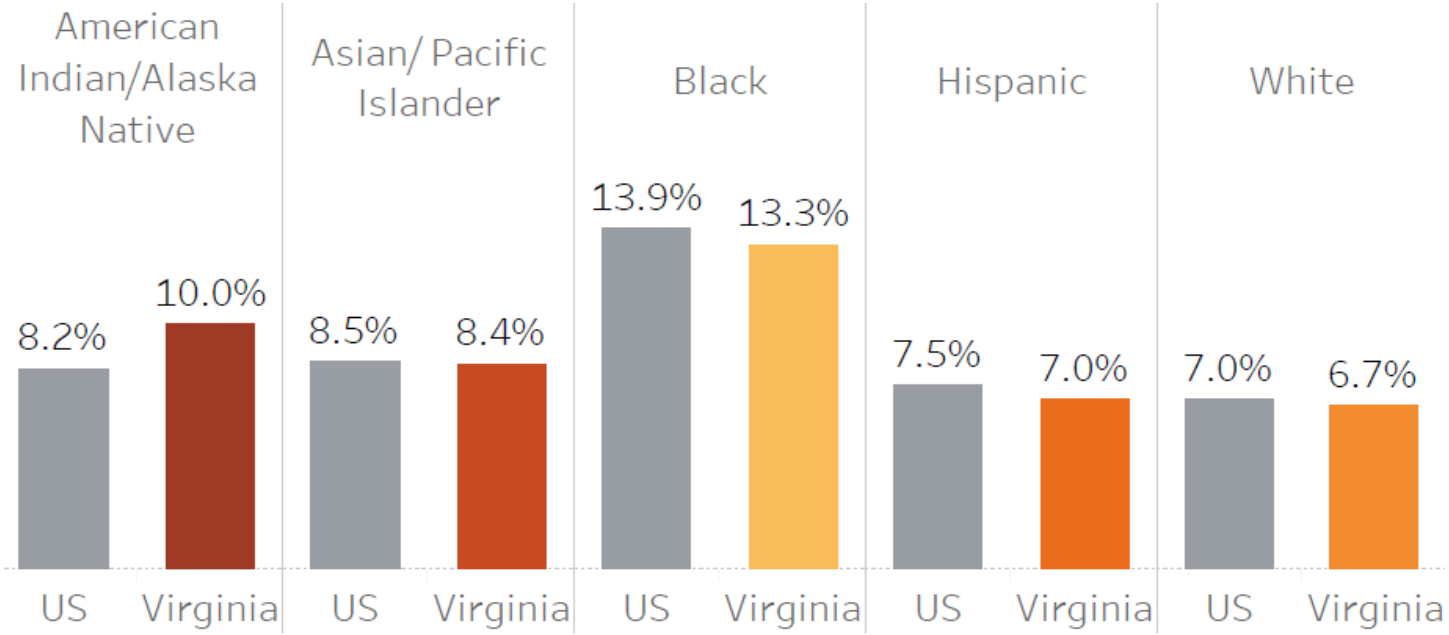
Quality Metrics Snapshot

Quality metric	Virginia score (national rank)
Percent of babies born with low birthweight	8.4% (26 of 51)
Overall preventable hospital admissions	1,258.7 (unavailable)
Preventable hospital admissions for acute conditions	271.0 (unavailable)
Preventable hospital admissions for chronic diseases	987.3 (unavailable)

NOTE: All metrics are admissions per 100,000 population. Acute conditions include dehydration, bacterial pneumonia, and urinary tract infections. Chronic conditions includes hypertension, asthma, and diabetes. Overall preventable admissions is a composite score that includes both chronic and acute conditions.

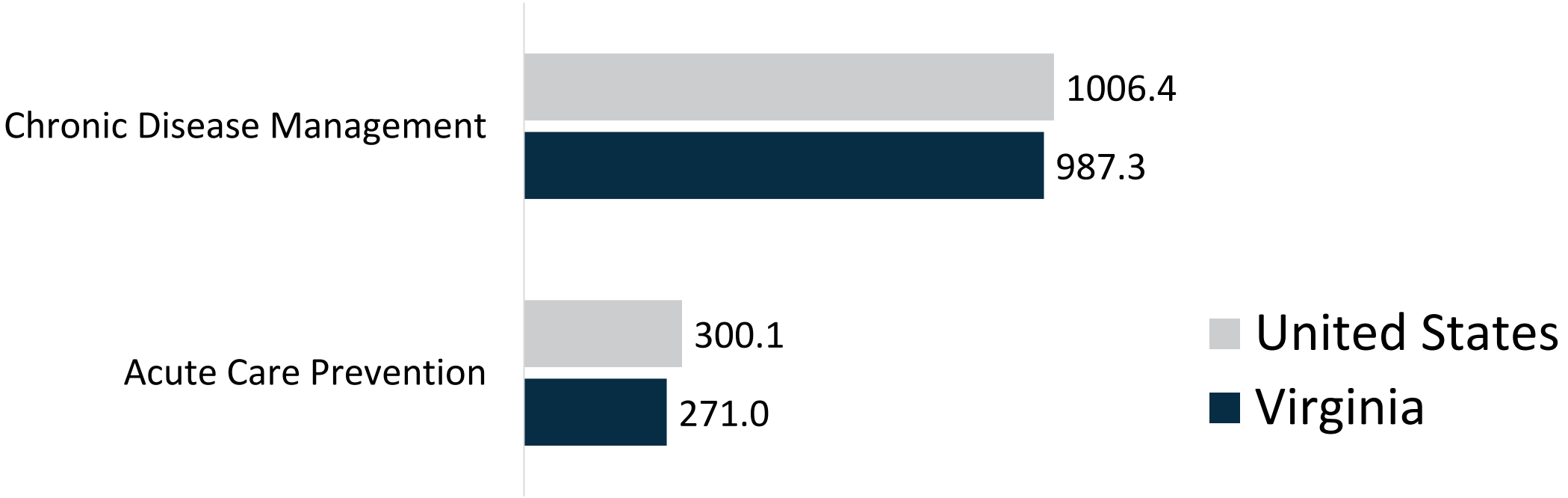
Non-white babies are more likely to have low birthweight

Percent of babies born with low birthweight by race and ethnicity (2017-2019 average)



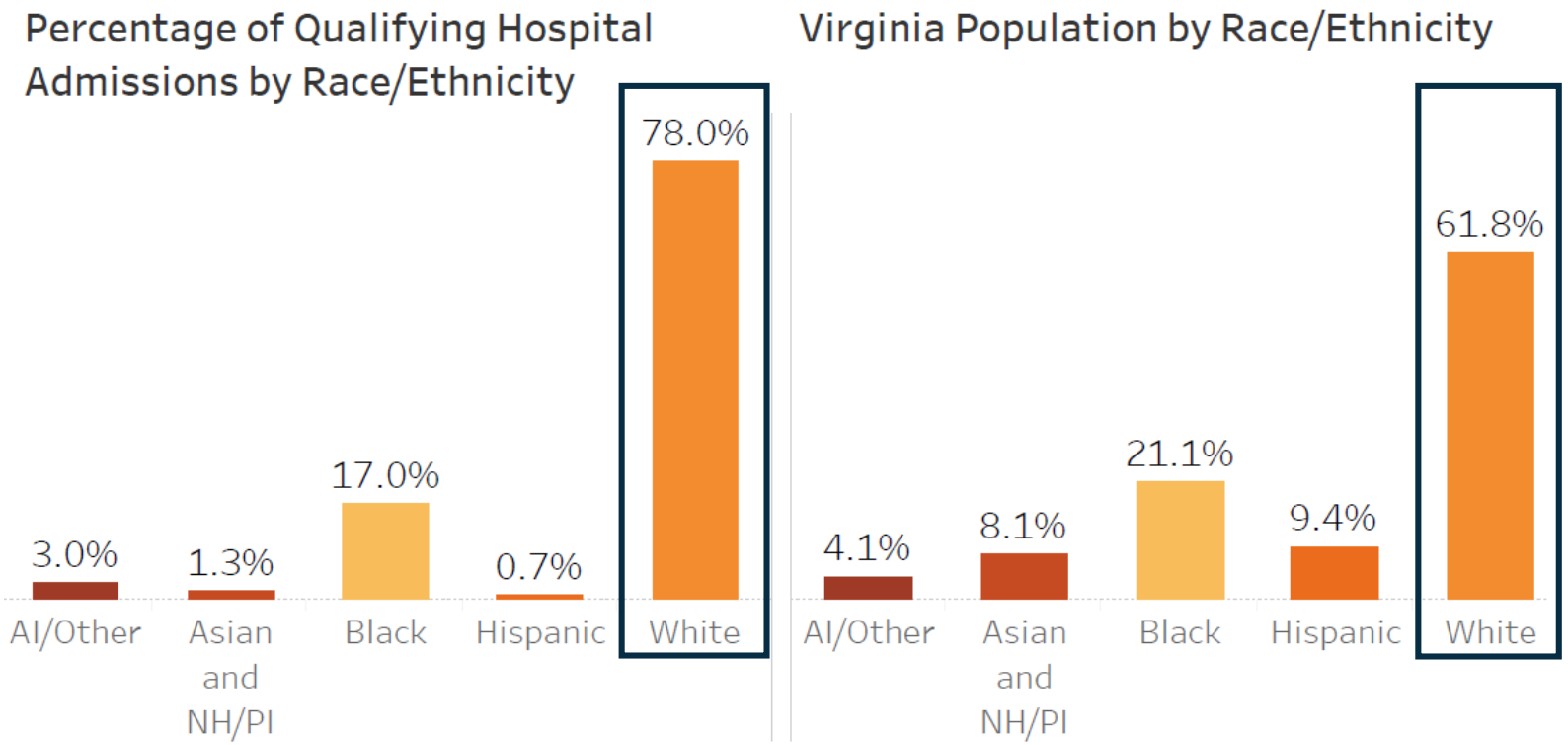
SOURCE: March of Dimes Perinatal Data Center analysis of National Center for Health Statistics, 2017-2019 final natality data.

Virginia has better quality scores than the national average



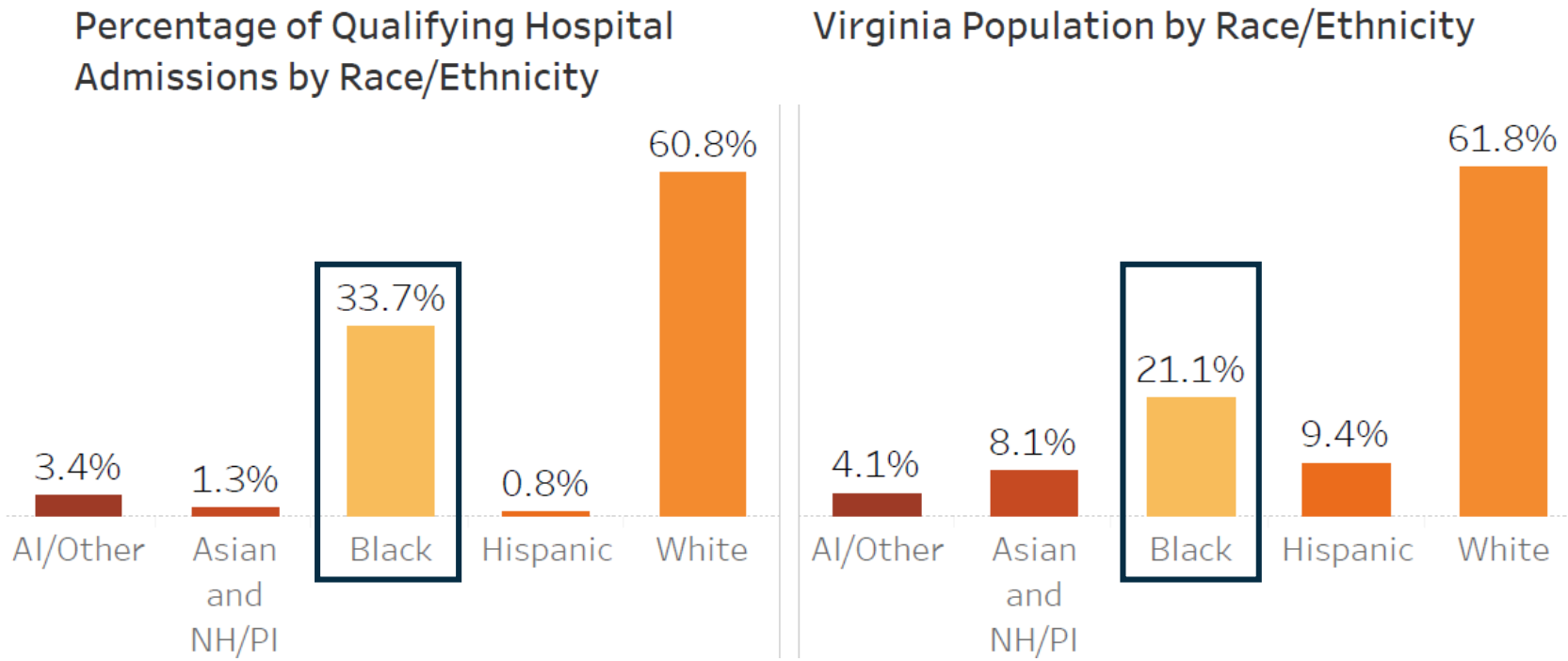
SOURCE: VHI analysis of 2019 VHI's patient level data using the Quality Indicators (QI) software developed by the Agency for Healthcare Research and Quality (AHRQ).

Preventable admissions for acute conditions higher for white Virginians



SOURCE: VHI analysis of 2019 VHI's patient level data using the Quality Indicators (QI) software developed by the Agency for Healthcare Research and Quality (AHRQ); Virginia population estimates from JCHC analysis of 2019 Census data.

More black Virginians admitted for manageable chronic conditions



SOURCE: VHI analysis of 2019 VHI's patient level data using the Quality Indicators (QI) software developed by the Agency for Healthcare Research and Quality (AHRQ); Virginia population estimates from JCHC analysis of 2019 Census data.

Visit the JCHC Health Care Dashboard (coming soon)

http://jchc.virginia.gov/

JCHC Workplan Overview

Health insurance affordability in the individual market

Analyst: Stephen Weiss

Study purpose

- Health coverage in the individual market became less affordable over time
  - Average premium for single 40-year old increased 96.7% between 2014 to 2018
  - Recent premium stabilization has not offset past increases
  - Median medical deductible increased 34%
- Increases impacted both low and high income consumers

NOTE: Study mandate approved by the Commission on December 15, 2020.

State and federal changes impact marketplace coverage and cost

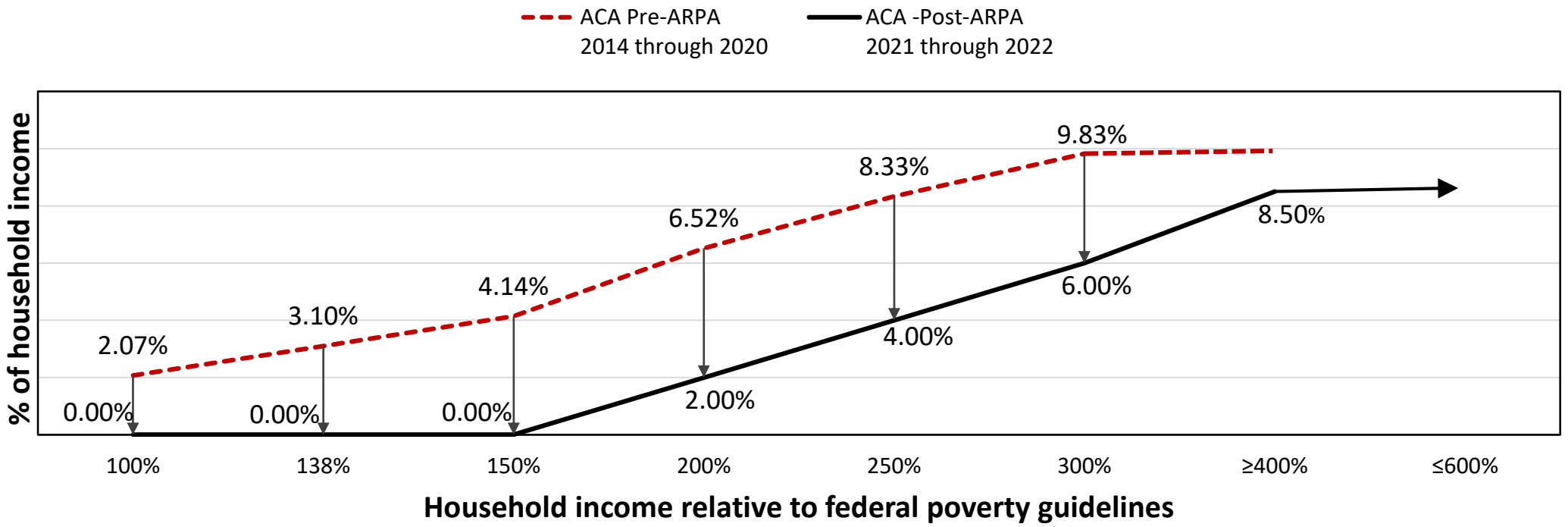
- Virginia Medicaid expansion shifted low-income individuals out of the individual market (2019)
- Federal changes to cost-sharing assistance (2018); end of individual mandate penalty (2019)
- Families First Coronavirus Response Act temporarily ended churn between Medicaid and individual market (2020)
- American Rescue Plan Act increased premium subsidies (2021)

ARPA temporarily makes marketplace premiums more affordable

- Tax credit subsidies increased for two years to reduce premiums
  - Zero premium contribution for those earning between 100% 150% of FPL
  - Subsidies available for those earning more than 400% of FPL
- Does not address out-of-pocket expenses/cost sharing
- Does not define “affordable”

FPL = federal poverty level

ARPA lowered the maximum household income contribution for premiums



NOTE: ACA premium tax credits are calculated based on the maximum percentage of household income compared to the cost of the 2nd lowest silver plan premium available to a consumer on the marketplace. Co-pays, deductibles and maximum out-of-pocket calculations are calculated separately and were not changed.

Example of annual premiums and tax credits for individuals post-ARPA

	Premium Calculations using 2021 Poverty Guidelines		
Percent of FPL	150%	250%	500%
Income	$19,320	$32,200	$64,400
Premium (2021)	$5,651	$5,651	$5,651
Maximum amount of income paid toward premium	0.00%	4.00%	8.50%
Individual responsibility for premium	$0	$1,288	$5,474
Premium tax credit for 2021	***$5,651***	***$4,363***	***$177***
Premium tax credit w/o ARPA	*$4,851*	*$2,968*	*$0*
Annual Savings due to ARPA	*-$800*	*-$1,394*	*-$177*

NOTE: Examples are based on a 40-year old individual health insurance plan purchased in Loudoun County, VA. Household income and premiums are based on 2021 plan year guidelines and marketplace data.

ARPA did not change out-of-pocket cost sharing requirements

	Cost Sharing Calculations using 2021 Poverty Levels			
Percent of FPL	150%	250%	300%	500%
Income	$19,320	$32,200	$38,640	$64,400
Maximum out-of-pocket	$1,400	$6,800	$8,550	$8,550
Maximum out-of-pocket as % of income	*7.25%*	*21.12%*	*22.13%*	*13.28%*
Medical Deductible	$50	$2,400	$6,250	$6,250
Maximum Deductible as % of income	*0.3%*	*7.5%*	*16.2%*	*9.7%*

NOTE: Examples are based on a 40-year old individual health insurance plan purchased in Loudoun County, VA.
Household income and premiums are based on 2021 plan year guidelines and marketplace data. ACA cost sharing reductions are only available to people under 250% of poverty, only through silver plans, and vary from plan to plan.

Study questions

- What level of premiums and out of pocket expenses are affordable to consumers in the individual market?
- What are other states implementing to improve affordability?
- What is the impact of potential policy changes on:
  - Premiums and out-of-pocket expenses
  - The number of uninsured
  - Insurers, providers, and other stakeholder

Research methods

- Data analysis
  - Premiums and deductibles
  - Enrollment
  - Plan availability
- Review of other state policy initiatives
- Contract with Urban Institute to model policy impacts using their Health Insurance Policy Simulation Model (HIPSM)

Impact of LTC workforce needs on nursing facility care

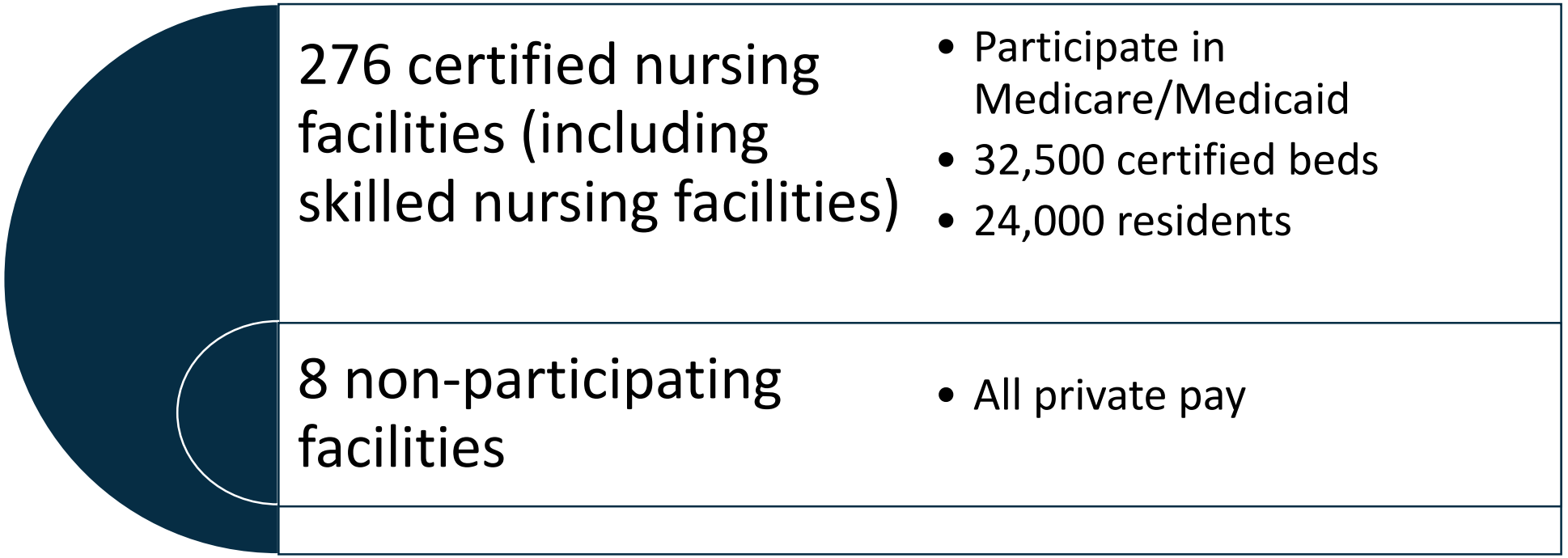
Analyst: Kyu Kang

Study purpose

- Quantify nursing facility workforce needs in Virginia
- Analyze how staffing impacts quality of care
- Identify policy opportunities to address issues related to:
  - Workforce availability
  - Quality of care
  - Regulation and oversight
  - Financing

NOTE: Study mandate approved by the Commission on December 15, 2020.

There are 284 nursing homes in Virginia



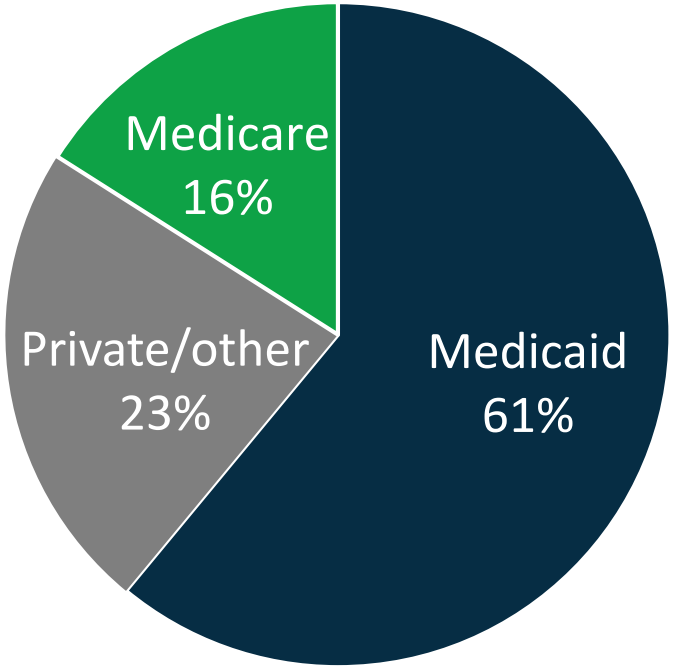
NOTE: Facility counts are as of May 2021.

Medicaid is the largest payer for nursing home care

Distribution of certified NF residents in Virginia by primary payer source (2019)

Medicare covers:

- Medically necessary short-term care
- Skilled nursing / rehabilitation
- Up to 100 days of care after a hospitalization



Medicaid covers:

- Long-term care
- Medical/skilled nursing services
- Custodial care (e.g., bathing, dressing, eating)

SOURCE: Kaiser Family Foundation analysis of 2019 Certification and Survey Provider Enhanced Reports (CASPER) data.

Multiple agencies oversee nursing facility care and management

- **VDH** – Office of Licensure and Certification licenses facilities and conducts surveys and inspections
- **DMAS** – Multiple offices manage provider enrollment, facility reimbursement, rebase facility rates, and develop value based payment policies
- **DARS** – Long Term Care Ombudsman program receives and manages care complaints

DARS = Department for Aging and Rehabilitative Services DMAS = Department of Medical Assistance Services VDH = Virginia Department of Health

CMS uses a 5-star rating system for all nursing facilities

Star Rating	Percent of VA nursing facilities	Percent of all nursing facilities
5 star	23%	24%
4 star	20%	22%
3 star	22%	18%
2 star	15%	19%
1 star	19%	15%

1. Health inspection rating
2. Quality measures rating
3. Staffing rating

SOURCE: JCHC analysis of CMS Nursing Home Compare data, April 2021. Percentages do not sum to 100% because a small number of facilities do not have ratings.

Major study questions

- To what extent are there staffing shortages in nursing facilities and how do they impact quality of care?
- Are different populations disproportionately affected by nursing facility workforce challenges?
- How does Virginia identify and address staffing and quality issues?

Major study questions (cont'd)

- How can nursing facilities improve recruitment and retention?
- What policies could improve staffing and quality and how much would they cost to implement?

Research methods

- Data analysis
  - CMS Nursing Home Compare data
  - DARS complaint data
  - DHP workforce data
  - Financial information from DMAS and VHI
- Review of policies adopted by other states

DARS = Department for Aging and Rehabilitative Services
DHP = Department of Health Professions

DMAS = Department of Medical Assistance Services
VHI = Virginia Health Information

Research methods (cont'd)

- Stakeholder Interviews
  - Professional associations
  - Advocacy organizations
  - Nursing home administrators
  - Clinical staff
- Nursing facility site visits

Strategies to support aging Virginians in their communities

Analyst: Estella Obi-Tabot

Study purpose

- Identify necessary services to support aging in place
- Evaluate whether state and local programs are effectively coordinated to deliver necessary services
- Identify gaps in community-based supports across different regions of Virginia
- Identify effective programs and strategies in Virginia and other states to support aging in place

NOTE: Study mandate approved by the Commission on December 15, 2020.

Most older adults want to age in their community

- 1.3 million (15%) of Virginia's population is over 65 and projected to increase to 1.7 million by 2030
- Administration for Community Living estimates that adults turning 65 in 2020 have a 70% chance of needing LTSS in their lifetime
- About 80% of older adults want to remain in their community, but only 60% believe they will be able to

LTSS = long-term services and supports

Older adults need a network of supports to age in their community

Health Care

Housing

Care coordination

Community supports and services

Nutrition

Personal assistance

Transportation

Multiple state agencies coordinate aging services

- DARS oversees 25 AAAs that administer aging services at the community level
- VDSS oversees adult day centers, and LDSS provide screening for community-based services
- Medicaid pays for home and community-based services for eligible adults

DARS = Department of Aging and Rehabilitative Services
AAA = Area Agency on Aging

VDSS = Virginia Department of Social Services
LDSS = Local departments of social services

Virginia spent about $740 million in HCBS in FY20

Funding source	Examples of covered services	FY 2020 total spending (in millions)
Medicaid HCBS	Adult day care, attendant care, skilled/private duty nursing, habilitation services	$666.2
Older Americans Act	Care coordination, communication, referral information assistance, transportation, legal assistance, nutrition services	$55.5
DARS State General Funds	Home-delivered meals, transportation, homemaker, personal care, adult day care, checking and chore, options counseling	$16.8
Block Grants and Awards	Nutrition, falls prevention, respite care	$1.8
Total		**$737.6**

SOURCE: Department of Medical Assistance Services. Department of Aging and Rehabilitative Services.
NOTE: Block Grants and Award total includes Nutrition Services Incentive Program.

Unpaid caregivers are a critical source of support for older adults

- Family members and friends who care for loved ones are considered caregivers
- There are an estimated 1 million caregivers in Virginia
- Virginia caregivers provide over 950 million hours of unpaid care which is valued at over $11 billion annually

SOURCE: Family Caregiving in Virginia: A Survey of Registered Voters Ages 40 And Older, AARP 2019

Major study questions

- What are the characteristics of Virginia's aging population and what services are necessary to support them in the community?
- What programs are available to older Virginians in their communities and are they adequate to meet current needs?

Major study questions (cont'd)

- What key operational challenges and opportunities exist to improve community supports?
- What programs in Virginia and other states are shown to be effective at keeping older adults safely in the community?

Research methods

- Data analysis
  - State agency and AAA financial reports
  - Eligibility screening data to understand level of need
- Stakeholder interviews
  - State agency, local agency, and AAA Staff
  - Community advocates
- Surveys of AAA Directors and service navigators
- Literature Review

Commission will hear from experts on three additional topics

Topic	Meeting date
Disparities in maternal and child health	September 21st
Behavioral health workforce challenges	September 21st
Unnecessary emergency department utilization	November 16th

Executive subcommittee actions on referred legislation

Referred legislation	Executive subcommittee action
Interstate Medical Licensing Compact (HJ531)	No staff study; staff provide memo to patron
Assisted Living and Auxiliary Grants (SJ293)	Include as a top study priority for 2022
Universal, Single-Payer Health Care (HB2271)	Consider following the completion of affordability study
Association Health Plans for Realtors (SB1341)	Staff to analyze as part of the affordability study

NOTE: Executive Subcommittee met and voted on April 19, 2021.

2021 JCHC Meeting Schedule

- **May 18th** – Workplan meeting (with breakout sessions)
- **September 21st** – Stakeholder briefings
- **October 5th** – Long-term care staff studies
- **November 16th** – Insurance affordability staff study
- **December 7th** – Members vote on policy options

NOTE: Executive subcommittee will meet at least once in the fall for 2022 study planning.

Joint Commission on Health Care

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