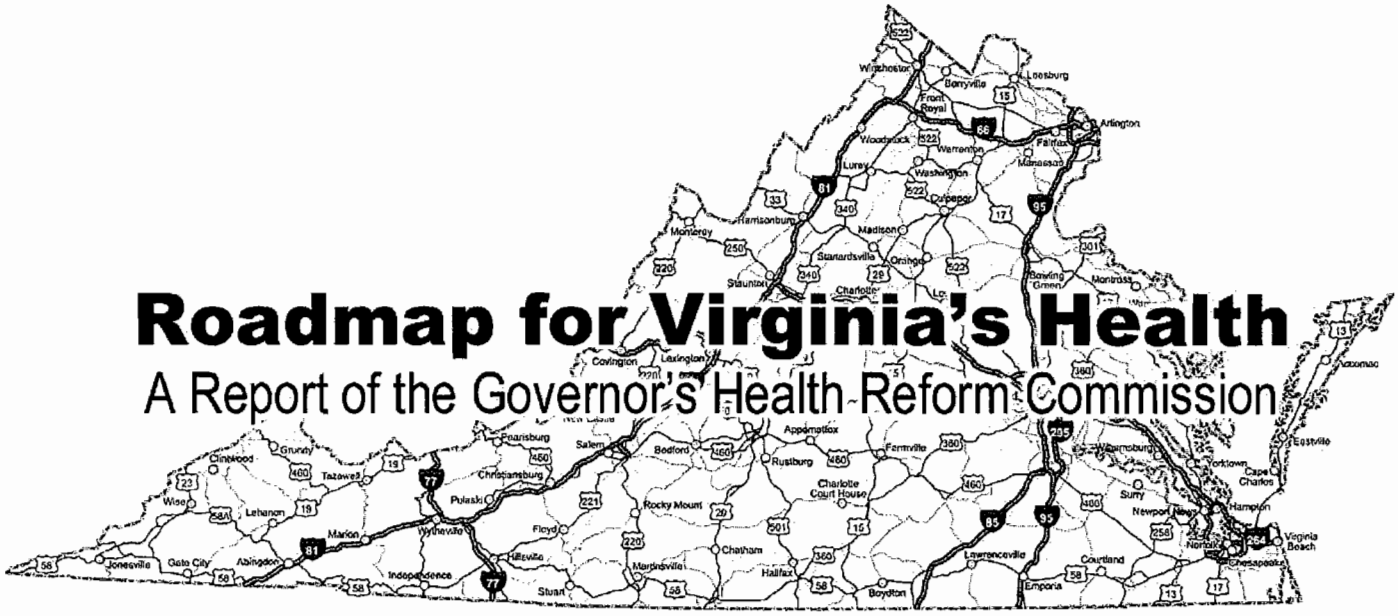

Roadmap for Virginia's Health

A Report of the Governor's Health Reform Commission

September 2007

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ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY FOR A HEALTHIER VIRGINIA

In August 2006, Governor Kaine issued Executive Order 31 (see Appendix A) creating a Health Reform Commission tasked with recommending ways to improve the healthcare system in the Commonwealth. The Commission's tasks have included examining the healthcare workforce, affordability, quality, and accessibility of healthcare in the Commonwealth, the transparency of health information, prevention and wellness efforts, and long-term care. This is the final report of the Health Reform Commission. It lays out a *Roadmap for Virginia's Health* that will ensure success in improving the health status of our citizens.

The executive summary and following report cover in depth the way Virginia must travel in order to improve its health status. The first road to be traversed is enhancing the healthcare workforce. Next, the Commonwealth must address expanding access to care for all Virginians. Then the Commonwealth must focus on improving quality, increasing transparency, and promoting prevention. The final road discussed in this report is advancing long-term care.

The Commonwealth is a successful and highly competitive state. Virginia is ranked as the 7th highest state in per capita income.[1] In 2007, *Education Week* ranked Virginia as the state where "a child is most likely to have a successful life."[2] In addition, the Commonwealth has an attractive business climate, being named the Best State for Business by *Forbes Magazine* in 2006 and 2007.[3] Despite this, the overall health status of the citizens in the Commonwealth does not mirror these accomplishments. In 1998 Virginia was 10th overall among the states in health rankings. Since 1998, Virginia's overall health rankings have declined, dropping to as low as 24 in 2005. In 2006, the Commonwealth was ranked 21st.[4]

Health and wellness across the U.S. and the Commonwealth have been and continue to deteriorate at a significant rate. Americans have typically had one of the highest life expectancies. However, over the past decades the U.S. has begun slipping in the international rankings of life expectancies. The U.S. life expectancy is currently ranked 42nd in the world, down from 11th two decades ago.[5] As has been stated time and time again, it does not make sense that one of the richest countries in the world that spends the most on healthcare has such a low ranking. Researchers have found that several factors affect life expectancy as well as general health status.

- One million Virginians are uninsured or 15 percent of our population. Across the nation estimates of the number of uninsured range from 45 to 48 million.
- In the Commonwealth the statistics about obesity and overweight are alarming; nearly 60 percent of adults are overweight or obese, while 39.2 percent of children are overweight or at risk of becoming overweight.[6] The U.S. has one of the highest obesity rates in the world, with nearly one third of the population aged 20+ being obese and nearly two thirds being overweight.[7]
- Racial disparities persist across the country and in the Commonwealth. Virginia is taking a closer look at these disparities with a new Office of Minority Health and Public Health Policy.

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[1] U.S. Census Bureau. (February 2006). *State Rankings – Statistical Abstract of the United States.* Retrieved June 27, 2007, from: http://www.census.gov/statab/ranks/rank29.html.

[2] Education Week. *From Cradle to Career.* Retrieved August 2, 2007, from: http://www.edweek.org/media/ew/qc/2007/17shr.va.h26.pdf.

[3] Badenhausen, K. (2007). *The Best States for Business.* Retrieved August 2, 2007, from: http://www.forbes.com/2007/07/10/washington-virginia-utah-biz-cz_kb_0711bizstates.html.

[4] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

[5] National Center for Health Statistics. *U.S. Life Expectancy Lags Behind Other Countries.*

[6] Virginia Department of Health, Office of Family Health Services.

[7] National Center for Health Statistics. *U.S. Life Expectancy Lags Behind Other Countries.*

- Virginia is ranked 32nd among the states for its infant mortality rate of 7.4 deaths per thousand live births.[8] The U.S. has a much higher infant mortality rate compared to other industrialized countries, with 6.8 deaths per thousand live births.
- Virginia's and the nation's population are aging at a fast rate. The segment of the population with fastest growth rate is 85+.[9] This is projected to be the fastest growing segment across the state and nation until 2050. Currently, 12 percent of Virginia's population is 65+, compared to 11 percent for the nation.[10]

The Health Reform Commission members believe the time for Virginia's policymakers to act is now. This report lays out the steps necessary to reduce infant mortality, racial disparities, obesity, the number of uninsured, and make many other changes that will improve our healthcare system. Each chapter of the report outlines a new mile that must be traversed on our healthcare highway to create a healthier Commonwealth.

This is a call to action for the Commonwealth. The Commission challenges the Commonwealth, business community, advocates, public health, payors, providers, lobbyists, schools, and the citizens of the Commonwealth to make Virginia one of the top ten healthiest states in the nation. This report puts forward strategies that if implemented and funded appropriately will ensure the Commonwealth is successful in raising its overall health ranking and ensuring a healthy future for all Virginians.

The 32-member Health Reform Commission convened in October 2006 and broke into four Workgroups to examine the issues outlined in the executive order. The Workgroups were: (1) Access to Care, (2) Quality, Transparency, and Prevention, (3) Healthcare Workforce, and (4) Long-Term Care. Members of the Workgroups were either Governor-appointed Commission members or invited to participate in the Workgroup because of their expertise. For a full listing of Commission and Workgroup members, please see Appendices B and C. Each Workgroup was given a particular charge as detailed below. The Commission did not address mental healthcare services and delivery because of the work of Chief Justice Hassell's Commission as well as the Commission addressing the tragedy at Virginia Tech in April 2007.

Table 1: Workgroup Descriptions

Workgroup	Mission
Access to Care	• Identify age groups, regions, populations where un-insurance rates are high • Identify methods to improve access to health and health insurance for these groups • Recommend Medicaid changes, funding opportunities, innovative pilots, demonstrations, or small group/individual market reforms to foster change
Quality, Transparency, & Prevention	• Recommend ways to increase transparency of healthcare information for consumers • Improve quality of care for citizens through innovative programs • Identify innovative approaches to improving infant mortality rates, reduce obesity, and reduce tobacco use
Healthcare Workforce	• Bring together stakeholders to examine physician, nursing, and direct support professional workforce shortages in Virginia • Identify ways to increase the number of highly qualified physicians, nurses, and direct support professionals in all areas of the state
Long-Term care	• Understand Virginia's current long-term care system • Identify ways to improve access to long-term care services for all Virginians,

[8] Virginia Department of Health, Office of Family Health Services.

[9] Joint Legislative Audit and Review Commission. (January 2006). *Impact of an Aging Population on State Agencies.* House Document No. 10. Retrieved July 16, 2007, from: http://jlarc.state.va.us/Reports/Rpt329.pdf.

[10] Weldon Cooper Center for Public Service. (2006). *Demographic Profile of Virginia.* Retrieved August 17, 2007, from: http://vaperforms.virginia.gov/VirginiaProfile2006.pdf.

regardless of age group, ability pay, or disability
- Seek out innovative models to enhance consumer and flexibility in choosing care

ENHANCING THE HEALTHCARE WORKFORCE

The U.S. Government Accountability Office noted in their February 2006 report "*Health Professions Education Programs – Action Still Needed to Measure Impact*," that regular reassessment of future health workforce supply and demand is crucial to setting policies as the Nation's healthcare needs change.[11] There are numerous factors affecting the adequacy and quality of the healthcare workforce in the Commonwealth including: demographics of the Commonwealth, demographics of the healthcare workforce, changes in technology, rate of the uninsured, and the deteriorating health status of the citizens of Virginia. In order to provide access to quality care, it is imperative that there be a healthcare workforce in the Commonwealth that is not only currently strong and of high quality, but that has a pipeline of individuals ready to take on responsibilities as the current workforce begins retiring.

A basic component of Virginia's infrastructure imperative for regional economic growth is a sound healthcare system. Healthcare providers contribute significantly to regional economic conditions as employers. Presently in the Commonwealth, the healthcare industry is very strong, ranking 7th among the state's industrial sectors. For the 4th quarter of 2006, there were 12,462 healthcare employers in Virginia or 5.8 percent of the state's 215,201 employers. In addition, in 2006 the state's 245,000 healthcare jobs comprised about 6.2 percent of all state jobs and there were approximately 9,600 annual job openings. Health facilities have a greater likelihood of reduced revenues and an increased risk of closing when they are short staffed. When these facilities are not adequately supplied, employees are not capable of providing sufficient access and quality health services within their communities. Therefore, the healthcare workforce shortage not only has implications for the quality of healthcare provided to Virginians, but also affects the Commonwealth's ability to attract and retain employers.[12][13]

Physicians

It is estimated that by 2020 there will be a shortage of approximately 1,500 physicians in the Commonwealth. Physician retention is the primary issue in the supply of the physicians in the Commonwealth. Table 2 below depicts some glaring statistics that show the Commonwealth must improve its retention of medical students, residents, and fellows if there is to be an adequate supply of physicians in the future.

Table 2: Physician Workforce Statistics[14][15]

	U.S.	Virginia	Virginia's Rank
Active physicians 100,000 population	245.6	238.3	21
Physicians in residencies and fellowships per 100,000 population	34.3	27.5	23
Number of current medical students educated per 100,000 population	26.6	25.0	22
Active physicians in-state who completed a residency or fellowship in state	44.7%	28.0%	35
Active physicians in-state that attended in-state medical schools	29.6%	25.0%	30
Retention of residents and fellows	47.6%	38.0%	38

[11] Bureau of Health Professions. (2006). *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand*.

[12] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth*. Richmond, VA.

[13] Virginia Employment Commission. (2006).

[14] Mick, S. (2007). A *Physician Shortage: Will It Exist in Virginia by 2010 and 2015? Preliminary Findings for the Virginia Workforce Committee*. Virginia Commonwealth University: Richmond, VA.

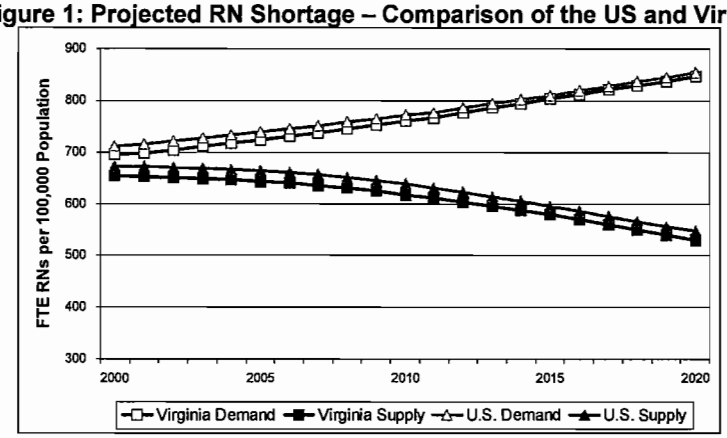
[15] Center for Workforce Studies. (2006). *Key Physician Data by State with Virginia Highlights*. Association of American Medical Colleges.

Retention of medical students	39.0%	36.0%	29

Nurses

The demand for full-time equivalent RNs in Virginia is expected to increase by roughly 43 percent between 2000 and 2020, meanwhile supply of RNs is not expected to keep pace. By 2020, it is expected that in the Commonwealth there will be a shortage of 22,600 RNs or 32.6 percent. To meet this demand it is expected that RN supply will have to increase by 60 percent. As seen in Figure 1 below, Virginia is projected to have a significant shortage of nurses, one that mirrors the shortage nationwide.[16] Not only is there a shortfall between RN demand and RN supply, but due to the shortage in educators and facilities, there is also a shortfall between the number of students Virginia can currently educate each year and the level of interest in pursuing a career as an RN. This is particularly unfortunate given the high number of qualified applicants that are denied admission to nursing programs due to program capacity limitations. In 2003, programs throughout the Commonwealth had to turn away more than 1,300 qualified applicants. This problem persists today, and the number of qualified applicants being turned down continues to grow both across the country and in Virginia.[17]

Figure 1: Projected RN Shortage – Comparison of the US and Virginia



Data Source: National Center for Health Workforce Analysis, BHPr, HRSA

Direct Support Professionals

Direct Support Professionals (DSPs) take on many different roles including: certified nurse aides, orderlies, attendants, home health aides, personal care aides, home care aides, personal care attendants, psychiatric aides, direct care workers, direct services associates, paraprofessionals, medication aides, and community health workers. This segment of the workforce attends to the elderly, disabled, and others in long-term care settings. They work in hospitals, nursing homes, residential and assisted living facilities, adult day cares, people's homes, home health agencies, and other long-term care settings. They provide a significant amount of the care received by clients in long-term care settings and/or with long-term care needs. This care includes both physical care and emotional support and companionship.

Virginia's long-term care support system includes a network of institutions, federal and state funded community programs administered through various agencies, and over two hundred home health service providers. According to a survey by the American Healthcare Association in 2002, the statewide vacancy rate for Virginia certified nurse aides, was 8.2 percent, and the turnover rate was 73.2 percent. It is expected that these numbers will continue to worsen as the population ages.[18] Figure 2, shows the

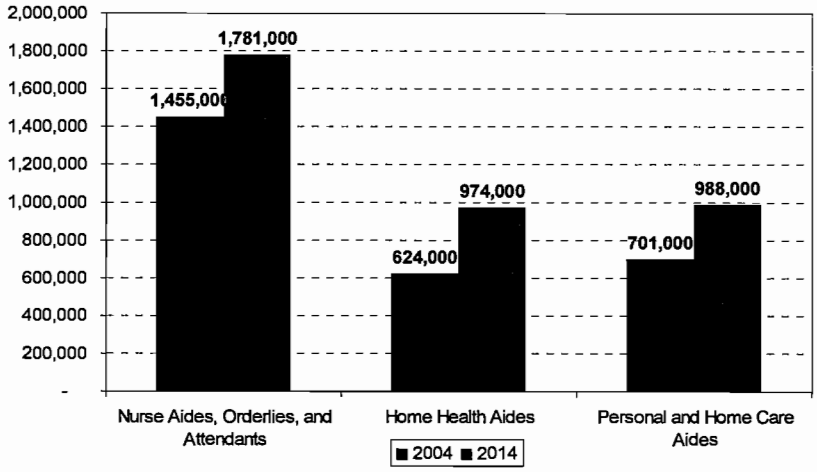
[16] Maddox, P.J. (2007). *Today is the 'Good 'Ole Days': Virginia's RN Workforce Trends.* George Mason University: Fairfax, VA.

[17] Health Reform Commission. (November 2006). *The Nursing Shortage: Workforce Subcommittee Meeting.* Richmond, VA.

[18] American Healthcare Association. (2003). *Survey of Nursing Staff Vacancy and Turnover in Nursing Homes.* Retrieved July 20, 2007, from: http://www.ahca.org/index.html. Washington, D.C.

distribution of some segments of the direct support professional workforce for Virginia. These numbers have been fluctuating and showing very little growth. Coupling this with the turnover and vacancy rates, the 'care gap' between those needing care and those available to care will widen.

Figure 2: Projected Growth in Direct Support Professional Jobs, 2004 - 2014



Source: U.S. Bureau of Labor Statistics May 2005

The Workforce section of the Health Reform Commission (Commission) Report covers at length the three areas, physicians, nurses, and direct support professionals, reviewed by the Commission. There is a segment dedicated to each of these areas. Each segment includes information regarding the national workforce shortages, the effects the shortages have on Virginia, and why the Commonwealth should pursue policy change to address these concerns. Each section ends with recommendations that the Commission believes the Commonwealth should begin implementing.

Recommendations and Estimated Costs

Table 3: Pricing of Workforce Recommendations (Annual Estimated Costs)

Overall Healthcare Workforce	
Establish a healthcare data workforce center housed within the Department of Health Professions charged with improving data collection and measurement of the healthcare workforce	$ 600,000
Physician Workforce	
1A. The Governor should increase the retention rates of both medical students and residents through: a. Provide funding to the Office of Minority Health and Public Health Policy (OMHPHP) to increase staffing so that OMHPHP can more aggressively market Virginia programs and the state as an option b. Increase funding for existing scholarship and loan repayment programs c. Increase the number of GME slots and salaries for residents	$ 2,864,377
1B. Provide funding for increased staff support for designations of Federal Health Professional Shortage Areas (HPSAs), Federal Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs)	$ 176,623
2A. Require all University Presidents submit strategic plans, with cost implications, that identify enrollment capabilities and resource requirements to increase medical school class size	$ 0
2B. Provide funding to cover increased teaching time	$ 2,500,000
2C. Provide grant funding to medical schools for implementing innovative practices that will change the medical educational model to produce additional and higher quality physicians	$ 10,000,000

2D. Increase physician productivity through use of physician extenders	$	1,000,000
3A. Maintain medical malpractice caps	$	0
3B. Incent EHR adoption through grants and help desk concept	$	1,000,000
Subtotal Physician Workforce Recommendations	$	17,541,000
Nursing Workforce		
1A. Require all University Presidents and the Chancellor of the Virginia Community College System to submit strategic plans, with cost implications, that identify enrollment capabilities and resource requirements to increase basic nursing programs (pre-licensure) by 50 percent and 100 percent.	$	0
1B. Provide funding to expand current and new masters programs	$	5,000,000
1C. Provide funding for educational capacity increase through: a. Increased general fund appropriations and block grants b. Formula funding systems to allocate appropriated funds	$	10,000,000
1D. Provide grant funding to nursing schools for implementing innovative practices that will change the nursing educational model to produce additional and higher quality nurses	$	2,000,000
2A. Develop legislation that removes barriers for retired state employee nurses so that they may reenter the workforce while collecting retirement	$	0
2B. Increase the number of doctoral and masters level students, who are focused on becoming educators, through increased funding to existing scholarship and loan repayment/assistance programs that have service requirements requiring teaching in the Commonwealth	$	500,000
3A. Modify reimbursement methodologies to the direct reimbursement of nursing care. This would include: a. Studying a Pay-For-Performance program that uses nurse sensitive indicators to pay hospitals and implement if appropriate.	$	0
Subtotal Nursing Workforce Recommendations	$	17,500,000
Direct Support Professional Workforce		
1A. Replicate the Department of Medical Assistance's Demonstration to Improve the Direct Service Community Workforce in six pilot sites across the Commonwealth*	$	1,036,800
1B. Provide funding for scholarship and loan repayment programs for the direct support professional workforce that includes one year service requirements	$	50,000
1C. Develop pilot programs to implement integration of Workforce Investment Boards, Social Services, and One Stops to place more TANF recipients in direct support professional roles	$	1,000,000
1D. Create a social marketing campaign that creates a positive image of direct support professionals and demonstrates the importance of this workforce	$	1,000,000
1E. Enable the WIBs, through legislation, to have a sector strategy for direct support professionals	$	0
Subtotal Direct Support Professional Workforce Recommendations	$	3,086,800
*This funding would be for three years for the six pilots and would all be appropriated in year one.		
Total for all Workforce Recommendations	**$**	**38,127,800**

EXPANDING ACCESS TO CARE

More than 1.1 million Virginians—15.5 percent of residents—are uninsured.[19] One in five adults lack coverage compared to one in eleven children. While the vast majority of privately insured Virginians secure their coverage through their employers, there has been erosion of employer-based coverage during the past ten years. Thus, despite the relatively healthy economy in the Commonwealth, some striking statistics indicate the need to examine new ways to provide health coverage for the uninsured:

- Nearly 70 percent of the uninsured live in households with at least one full-time worker (Figure 1).[20]
- The self-employed and those working in firms with fewer than 100 employees account for the majority of uninsured.[21]
- Nearly three-quarters of uninsured Virginians report they live in households where there is no offer of employer-sponsored health insurance.[22]
- Nineteen to 34 year olds have the highest rate of un-insurance among non-elderly adults—nearly 27 percent do not have health insurance.[23]
- Uninsured rates are significantly higher for those living in poverty compared to those with incomes above 300 percent of the Federal Poverty Level (FPL).[24]

The significant number of uninsured Virginians indicates an ongoing challenge for the Commonwealth. While safety net providers and the Medicaid and FAMIS programs are providing valuable services to low-income and/or uninsured Virginians, rising demand for these programs may soon outpace resources. The number of low-income working uninsured residents, young adults without health insurance, and the number of businesses that are not offering coverage to their employees indicates that the current network of safety net care, Medicaid, FAMIS, and private health insurance are not meeting the needs for a substantial group of Virginia's residents. New options and vehicles need to be developed to make health insurance and healthcare services accessible and affordable for all residents. Increased access to the most basic primary healthcare for Virginia's one million uninsured residents can improve worker productivity, reduce chronic illness, and improve overall population health outcomes in the Commonwealth.

The Access to Care Workgroup sought to identify options that will provide access to care or health insurance for the greatest number of people and will provide the greatest return on investment. The Access chapter of this report discusses these options in detail. Given the broad scope of the access problems in the Commonwealth and the limited time to formulate recommendations, the Workgroup advocates options that can be implemented effectively within a short amount of time and reach a significant number of the uninsured. The recommendations outlined, if fully implemented could reach over 100,000 uninsured Virginians during the first two years of implementation.

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[19] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[20] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[21] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[22] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[23] Joint Legislative Audit and Review Commission. (January 2007). *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population.* House Document No. 19. Retrieved July 16, 2007, from: http://jlarc.state.va.us/Reports/Rpt349.pdf.

[24] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

Recommendations and Estimated Costs

Table 4: Pricing of Access Recommendations (Annual Estimated Costs)

1A. Annually or biennially study Virginia's uninsured population	$ 0
1B. Evaluate Medicaid provider access biennially	$ 0
2A. Provide $10 million in state General Funds to the community-based healthcare safety net annually	$ 10,000,000
3A. Expand Medicaid eligibility to 100% FPL for parents and caretaker adults ages 19-64 (includes 3B)[25]	$ 84,000,000 - $ 127,500,000
3B. Include routine dental services as part of any Medicaid eligibility expansion for parents, or include routine dental services for existing parents enrolled in the Medicaid program	See 3A
3C. Expand FAMIS eligibility from 200% FPL to 300% FPL for children[26]	$ 2,000,000
3D. Increase FAMIS eligibility for pregnant women from 185% FPL to 200% FPL	$ 1,600,000
4A. Create a private health insurance product for uninsured Virginians with incomes less than 200% of FPL who have no other access to public or private health insurance	$ 20,000,000
Total	**$ 117,600,000 - $ 161,100,000**

[25] Joint Legislative Research and Audit Commission. (January 2007). *Range Reflects Preliminary DMAS Estimates Based on CPS Data.* House Document No. 19.

[26] Preliminary DMAS estimate. Does not include additional Medicaid and FAMIS costs associated with reaching currently eligible, but not enrolled children.

IMPROVING QUALITY

During the 2006-2007 legislative session, the Department of Medicaid Assistance Services (DMAS) was directed by the Virginia General Assembly (via HB 2290) to develop a Nursing Facility Quality Improvement Program. Similarly, the State Appropriation budget mandate further directed DMAS to develop a pay-for-performance (P4P) proposal for Medicaid nursing homes. In light of these legislative actions, the Quality, Transparency, and Prevention Workgroup focused on ways it could provide input to help shape this quality improvement effort; the Workgroup did not evaluate the merits of P4P methods in promoting quality in public sector care.

The use of pay-for-performance incentives is based on the premise that current payment systems do not promote quality and may at times reward poor performance and poor practices. Aligning payment incentives with desired outcomes creates opportunities to use financial rewards to encourage the use and adoption of evidence-based care processes and best practices. The success of a P4P program will be determinant upon its design, implementation, evaluation, and continued refinement. Key to each stage will be to ensure "buy-in" from participants, the use of meaningful metrics, and the provision of appropriate rewards linked to quality outcomes. A sustainable P4P system can be one tool used to steer individuals and entities towards valuing a culture dedicated to high performance, safety, and quality.

The implementation of P4P programs designed for nursing facilities has been pursued by at least eleven states, although not all remain active. States that have implemented quality reimbursement programs for nursing facilities have used a variety of measures to assess quality and reward high performance. The mix of measures typically used includes minimum data set (MDS) measures on resident outcomes, staffing measures, certification survey deficiencies, and resident and family quality of life or satisfaction scores. The reward structures from each state program also vary and include both non-financial and financial incentives.

Recommendations and Estimated Costs

Table 5: Pricing of Quality Recommendations (Annual Estimated Costs)

1. Include the use of meaningful metrics linked to quality improvements that balance both absolute and relative scales A. Begin as a voluntary program B. Pilot test the proposed measurement system	
2. Incorporate, at a minimum, MDS, staffing, satisfaction, and survey criteria into the measurement components for quality A. Update, modify, and improve the P4P system over time to include additional metrics targeting specific areas the Commonwealth would like to address, such as avoidable hospitalization rates.	
3. Fund through new monies A. Incorporate both financial and non-financial incentives B. Reward innovation, modernization, and culture change that promote quality in resident care	
4. Evaluate and monitor the program regularly to assess effectiveness, with an annual report due to the Secretary of Health and Human Resources	
5. Increase transparency between consumers and nursing facilities by making quality performance scores publicly available through a website or other accessible means A. Provide consumers with an additional tool to compare and select nursing facilities	
Total*	**$ 7,000,000 – $16,000,000**

* Based on other state programs, the incentive payment budget is generally 1-2 percent of reimbursement rates. In Virginia, this would equate to $7-8 million or $14-16 million.

INCREASING TRANSPARENCY

Over the last decade, there has been a push for increased transparency and accountability in the healthcare sector, yet pricing and quality often remain a mystery to most consumers. This is due to the complex nature of the pricing system found in the sector. When discussing healthcare pricing, charges are often discussed, yet most people do not pay based upon charges. For those with insurance, their insurer may have negotiated a specific discount on the charges, or may pay based on a percent of charges, a per diem rate, or other negotiated rate. For those without insurance, most providers are working to provide similar discounts or care is provided for free. This makes pricing transparency extremely challenging because providing information on charges does not really mean anything to most consumers, and asking insurers and providers to provide detailed information on what is actually paid gets at the heart of contract negotiations and may be considered proprietary information.

In addition, defining transparency and its intent has often been a challenge. Simply presenting cost information may not be that meaningful to consumers. Consumers need information that helps them understand their financial obligation for an episode of care, not just a procedure. In addition, quality information must be a part of the equation or consumers may be driven to go the highest cost provider, assuming that higher cost means better quality. The converse could also happen, i.e. the consumer could opt for lowest cost provider with no information on the quality of the provider. In essence, being transparent on prices does not mean much if that pricing is not put into context with quality and episode of care information.

The push for transparency is occurring for many reasons including a greater focus on increased consumerism and personal responsibility in healthcare. This has been evidenced through the development of high deductible health plans, health savings accounts, and higher co-pays and co-insurance. In addition, the rising costs and inflation rates seen in healthcare indicate that something must be done or the "system" we currently have will not be maintained. Pricing, quality, and information transparency is believed to be one method that could begin to help control/reign in costs.

Recommendations and Estimated Costs

Table 6: Pricing of Transparency Recommendations (Annual Estimated Costs)

1.	Develop and implement a single portal (through VHI) for the dissemination of useful, transparent information on healthcare costs and quality to consumers
2.	Use the best practices identified by the AQA alliance and support efforts by the Virginia Healthcare Alliance to obtain AHRQ grants to develop Virginia's quality measures
3.	Require public and private payors provide VHI a reasonable range of amounts paid by the payor for specific procedures by geographic areas within the Commonwealth
4.	Convene a stakeholder group to work with VHI and the Health IT Council to determine the best method for securing the appropriate and most useful pricing information from public and private payors
5.	Include general healthcare information and links to other important sites for information, in order to create a true one-stop-shopping portal for Virginians to access important healthcare information
6.	Develop and implement a public-private marketing plan to make Virginians aware of the new transparency portal and the valuable healthcare information that can be accessed through the VHI portal
7.	Ensure the portal developed is accessible to all Virginians
	Total* **$ 454,750**

* Total estimated cost for three years not including a marketing plan and the additional insurer information

PROMOTING PREVENTION

In 1998 Virginia was 10th overall among the states in health rankings. Since 1998, Virginia's overall health rankings have declined. The following chart displays the steady down turn in the quality of health of Virginians:

Table 7: Virginia's Overall Health Ranking Among the Fifty States (1998 – 2006)[27]

Year	Rank	Year	Rank
1998	10	2003	21
1999	14	2004	20
2000	14	2005	24
2001	15	2006	21
2002	18		

Virginia's ranking has been fluctuating since 2003. This inconsistency is unacceptable. The quality of health, specifically reducing the infant mortality rate, the prevalence of obesity, and the use of tobacco, must be improved. Virginia was ranked 33rd in the nation in 1990 and 32nd in 2006 for its infant mortality rate. The Commonwealth has remained steady in this category; however, due to increased access to prenatal care and the economic status of the state, infant mortality should be waning at a much more significant rate. Obesity is on the rise in the Commonwealth. In 1990, Virginia ranked 9th among the 40 states in having the lowest prevalence of obesity. In just one year, from 2005 to 2006, Virginia's ranking dropped from 24th out of 40 states in the prevalence of obesity to the current 28th position. The obesity epidemic is widespread and adversely affecting the quality of health in the Commonwealth. Finally, in 1990 Virginia ranked 42nd in prevalence of tobacco use. In 2006 the state improved to the 25th position. This is an area where Virginia has made substantial progress over the past fifteen years, but there is still much to be done.[28]

Virginia is a leader among states in many areas. The vision for the Commonwealth is to be consistently ranked in the top ten healthiest states for the overall ranking. In 2004 and 2005 the infant mortality rate in Virginia was 7.4 deaths per 1,000 live births. The goal is to reduce this to 7.0, a 5 percent reduction in infant deaths, by the end of FY 2009. In 2004, 24 percent of Virginians were obese and the goal is to reduce this number to a maximum of 20.5 percent, a 15 percent reduction, by the end of FY 2009. In 2006, Virginia was ranked 25th for tobacco use with 20.6 percent of adults over the age of eighteen smoking. By the end of FY 2008, Virginia should reduce its adult smoking rate to 19 percent and its youth smoking rates to 14.5 percent.[29]

Recommendations and Estimated Costs

Table 8: Pricing of Prevention Recommendations (Annual Estimated Costs)

Overall Prevention Recommendations	
Establish a non-profit foundation that will leverage public and private funds to focus on promoting clinical preventive services and healthy lifestyle choices across the Commonwealth	$ 5,000,000
Infant Mortality Recommendations	
1A. Provide the Board of Health with the authority in the Code of Virginia to develop criteria to identify and establish perinatal underserved areas	$ 65,763
1B. Implement one screening tool for pregnant women for all publicly funded programs and make training available to all providers	$ 33,800
1C. Provide additional funding to effective public and private prenatal home visiting programs that meet those criteria established for publicly funded home visiting	$ 6,800,000

[27] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

[28] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

[29] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

1D. Develop, evaluate, and replicate intensive evidence-based interconception care and care coordination models for women at high social and medical risk	$ 631,000
1E. Provide funding to DMAS for dental care to pregnant women in Medicaid and FAMIS Moms	$ 3,100,000
1F. Educate parents and providers regarding SIDS and safe sleep environment	$ 156,000
Subtotal Infant Mortality Recommendations	$ 10,786,563
Obesity Recommendations	
1A. Develop additional incentives to increase school participation in the Governor's Nutrition and Physical Activity Scorecard program	Covered through CHAMPION
1B. Create a bulk purchasing model for healthy foods initially targeting school divisions with the intent to expand to all state agencies	$ 0
1C. Establish state performance benchmarks/goals for physical fitness and BMI through the VA Wellness Related Fitness Test (VWRF)	$ 50,000
1D. Increase funding for the school breakfast and school lunch programs to encourage greater participation and increase nutritional value and nutritious food options	$ 8,005,000
1E. Encourage VDH and DOE to partner to develop lesson plans and instructional tools for nutrition and physical education based upon the health education SOL	$ 104,000
1F. Implement CDC's coordinated school health programs and Youth Risk Behavior Survey to receive additional federal funding	$ 0
2A. Fund the CHAMPION program	$ 676,824
3A. Improve nutritional offerings in all state agency cafeterias, public school cafeterias, public higher education institutions, mental health facilities, correctional facilities, juvenile justice facilities, etc. to follow the American Dietary Guidelines	TBD
Subtotal Obesity Recommendations	$ 8,835,824
Tobacco Use Recommendations	
1A. Promote and create incentives for 24/7 tobacco-free K-12 school grounds	$ 90,000
1B. Promote and create incentives for 24/7 tobacco-free higher education campuses	$ 500,000
2A. Introduce legislation to amend the Virginia Clean Indoor Air Act by prohibiting smoking in indoor spaces within restaurants throughout the state	$ 0
2B. Provide additional funding to the new non-profit prevention collaborative and VDH to enhance QuitNow	$ 3,000,000
3A. Create a benefits package that rewards non-tobacco using state employees for living a healthy lifestyle by offering a discount on the employee portion of their premium	Price neutral
3B. Expand nicotine replacement therapy in State Health Plan	$ 5,800,000
3C. Increase the number of opportunities for state employees to participate in smoking cessation programs from two to four opportunities	$ 30,000
3D. Educate both State Employees and Medicaid beneficiaries about smoking cessation benefits available to them	$ 0
Subtotal Tobacco Use Recommendations	$ 9,420,000
Total for all Prevention Recommendations	**$ 34,042,387**

ADVANCING LONG-TERM CARE

The number of older Virginians is expected to increase substantially over the next 25 years. By 2010, persons over aged 60 will comprise 18 percent of the state's population.[30] By 2030, one in four Virginians will be over the age of 60; this is a 120 percent increase from 2000.[31] At the same time, the population of people with both physical and mental disabilities continues to grow; creating additional care needs, with higher morbidity.[32] In addition, Virginia's population as a whole continues to see increases in the number and types of co-occurring preventable conditions such as diabetes, obesity, and cardiovascular disease, all of which contribute to higher disability rates. Collectively, these growing needs will be a significant challenge for the Commonwealth and the nation.

This momentous population shift is just beginning and it will significantly change the ways the Commonwealth, localities, and long-term care providers offer care in Virginia. Today, long-term care consumers are choosing to remain in their homes or their community as long as possible. The demographic trends and continued drive toward home and community-based services has created and will continue to be a significant challenge for Virginia.[33] The Long-Term Care (LTC) Workgroup members believe all citizens of Virginia, regardless of age or income, have the right to make an informed choice about where to live and receive services whether it be in an assisted living facility, their own home, or a nursing facility. The availability of services such as case management, wellness programs, and other community support programs are critical for people live in community-settings as long as possible.

The LTC Workgroup's recommendations are intended as roadmap for an improved long-term care system. There are items that should and can be implemented now with appropriate performance benchmarks to measure future impact. Other recommendations could be reasonably tied to key benchmarks and implemented over the next five, ten, and fifteen years. The Workgroup evaluated long-term care system gaps in several areas:

a. ***How can Virginia improve the information platform for long-term care consumers, families, and providers?*** Consumers of long-term care services and their families should have easy access to information about all care options. Providers should be able to access information about complementary services or options when consumers are in need.

b. ***How does Virginia encourage people to plan for their future long-term care needs?*** More effort should be placed on educating Virginians about long-term care planning to increase overall awareness and reduce further pressure on public resources.

c. ***How can providers, localities, and the State provide better care coordination?*** The integration of Medicaid and Medicare acute and long-term care through managed care is a critical step in improving care coordination and financing for long-term care.

d. ***How can the Commonwealth increase access to affordable housing and improve housing supports?*** There are inadequate supports and unaffordable housing options for seniors and persons with disabilities who wish to live in the community.

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[30] Joint Legislative Audit and Review Commission. (January 2006). *Impact of an Aging Population on State Agencies.* House Document No. 10. Retrieved July 16, 200, from: http://jlarc.state.va.us/Reports/Rpt329.pdf.

[31] Joint Legislative Audit and Review Commission. (January 2006). *Impact of an Aging Population on State Agencies.* House Document No. 10. Retrieved July 16, 200, from: http://jlarc.state.va.us/Reports/Rpt329.pdf.

[32] Braddock, D. et al. (October 2006). "Morbidity and Mortality in People With Serious Mental Illness." *The State of the States in Developmental Disabilities.* University of Colorado: Boulder, CO.

[33] Home and community-based options identified by the LTC Workgroup include, but are not limited to, home care, personal care services, assisted living, home healthcare, adult day healthcare, and Program for All-Inclusive Care for the Elderly (PACE).

e. ***Can the state and localities increase mobility in the community for long-term care consumers through more accessible and available transportation?*** Without accessible transportation, seniors and people with disabilities find it difficult to live in the community.

f. ***How can providers, the educational system, and the Commonwealth foster the development of a qualified and adequate LTC workforce?*** There are an inadequate number of geriatricians, physician extenders, nurses, nursing support, and direct care workers in the long-term care sector in both rural and urban areas.

g. ***How can Virginia, in concert with providers and localities, increase the number of community-living options?*** More community options must be made available to <u>all</u> seniors and persons with disabilities.

The recommendations of the LTC Workgroup are outlined in detail in the Long-Term Care Chapter as well as Appendix O. The recommendations will help Virginia maximize alternative funding streams and bolster the state's commitment to innovation in long-term care. The recommendations, if effectively implemented, will:

- Reinforce Medicaid's current pathway to more integrated and consumer-driven long-term care;
- Expand the availability of the most fundamental aspect of community living—housing;
- Dramatically increase the number of people planning for their future long-term care needs;
- Provide consumers, providers, and caregivers with access to a seamless coordinated system of information and decision-making tools;
- Provide additional support to families as caregivers;
- Provide options to enhance quality of life and delay unnecessary or premature institutionalization; and
- Significantly increase the availability and scope of integral services for all seniors and persons with disabilities such as transportation, case management, and respite care.

Recommendations and Estimated Costs

Table 9: Pricing of Long-Term Recommendations (Annual Estimated Costs)

1A. Support continued integration of Medicaid acute and LTC through PACE and managed care models	$ 0
1B. Maximize consumer choice for Medicaid LTC consumers by continuing to provide consumer-directed options (support Money Follows the Person)	($ 975,000)
1C. Provide annual inflation adjustment to all Medicaid home and community-based providers	$ 26,345,078
1D. Rebase personal care 10% and skilled/private duty nursing 10%	$ 15,789,908
1E. Add assisted living to the Medicaid EDCD waiver	$ 15,671,476
1F. Establish case management for low-income seniors and persons with 2+ ADLs as a state plan option	$ 29,022,924
1G. Improve the AG program	$ 500,000
2. Support the creation of a state housing partnership revolving fund with incentives to build housing and supportive services for people with disabilities or frail elderly	$ 5,000,000
3A. Expand No Wrong Door statewide by 2010	$ 2,000,000
3B. Develop an ongoing social marketing campaign to encourage LTC planning and support the LTC Partnership	$ 100,000
3C. Support family and consumer rights though the LTC Ombudsman Program	$ 913,000
4A. Provide funding to AAAs to increase transportation options for seniors and persons with disabilities	$ 1,250,000
4B. Increase support and funding for family caregivers and study the current network of community-based caregiver support organizations	$ 2,500,000
5A. Gubernatorial designation of the Secretary as the LTC point of accountability	$ 0

5B. Establish a LTC Coordination Council	$	0
5C. Establish a LTC Advisory Council	$	0
5D. Require local long-term care councils to include housing, transportation, and other representatives in their LTC planning processes and establish a mechanism for reporting to the Long-Term Care Advisory and Implementation Councils	$	0
Total	**$**	**98,117,386**

HEALTH REFORM COMMISSION PRIORITIES

The Health Reform Commission's year-long deliberations generated over 40 recommendations. Given the many critical issues facing the Commonwealth, resources for improving the health and human services systems must be balanced with other priorities. This report should serve as a Roadmap for Virginia's Health. Table 10 and 11 lay out several priorities for the Governor and General Assembly's consideration.

The Commission recommends reconsideration of the other priorities identified in this report prior to the next biennium. In addition, some priorities in lower tiers should be reevaluated if the federal climate changes. The most prominent example of this is the recommendation to expand eligibility in the FAMIS program. Currently, there is a federal SCHIP reauthorization debate underway. Once it is resolved the Governor and General Assembly may wish to move the Tier 2 FAMIS Expansion priority to a higher priority to advantage of any new federal matching funds available to Virginia.

Table 10: Priorities of the Health Reform Commission (Annual Estimated Costs)

First Tier Priorities		
Workforce	Healthcare Workforce Data Center	$ 600,000
	Physician Retention – Increased staff support for federal designations	$ 176,623
	Direct Support Professional Loan Repayment Program	$ 50,000
	Replicate DMAS PCA Grant in 6 sites*	$ 1,036,800
Access	Working Uninsured Option	$ 20,000,000
	Increase Safety Net Funding	$ 10,000,000
All Prevention	Prevention Collaborative	$ 8,000,000
Quality	Medicaid Pay for Performance Program for Nursing Homes	$ 8,000,000
Long-Term Care	Obtain Funding to Implement Money Follows the Person Demonstration	($ 975,000)
	Continue support of Acute and Long-Term Care Integration	$ 0
	Subtotal First Tier Priorities	*$ 46,888,423*
Second Tier Priorities		
Workforce	Physician Retention – Loan Repayment (50 additional awards)	$ 2,500,000
	Nurse Retention – Masters/PhD Loan Assistance/Scholarship (30 additional awards)	$ 600,000
Access	Medicaid Expansion to 65% FPL (with routine dental services)[34]	$ 39,700,000
	FAMIS Expansion from 200% to 300% FPL [35]	$ 2,000,000
Infant Mortality	Designate Perinatal Underserved Areas	$ 66,000
	Home Visiting Programs	$ 6,800,000
	Universal Risk Screen	$ 33,000
Obesity	School Breakfast / Lunch	$ 8,050,000
	PE Benchmarks (software cost)	$ 50,000
	Healthy Food Bulk Purchasing - Schools**	$ -
Tobacco Use	Increase State Employee Smoking Cessation Attempts	$ 30,000
	Healthy Lifestyle Insurance Discount***	$ -
Long-term care	Increase Medicaid Personal Care Reimbursement Rate 10%	$ 15,700,000
	Subtotal Second Tier Priorities	*$ 78,499,000*
Third Tier Priorities		
Access	Medicaid Dental Coverage for Currently Enrolled Caretaker Adults	$ 3,200,000
	FAMIS MOMS Expansion (200% FPL)	$ 1,600,000
Transparency	One portal providing transparent information on healthcare costs and	$ 200,000

[34] Preliminary DMAS estimate based on CPS data.

[35] Preliminary DMAS estimate. Does not include additional Medicaid and FAMIS costs associated with reaching currently eligible, but not enrolled children.

	quality to consumers	
Infant Mortality	SIDS Campaign	$ 156,000
Long-term care	Continue No Wrong Door Implementation	$ 2,000,000
	Subtotal Third Tier Priorities	*$ 7,156,000*
	Total	**$129,573,423**

*This covers three years of costs for 6 pilot sites. The funds are all appropriated in year 1.
**Charge school divisions a fee to have access to bulk prices which can cover the cost of the program.
***Renegotiate Anthem contract to include at no additional cost to the state.

Table 11: Priorities of the Health Reform Commission, Legislation and Other

Area	Legislation
Workforce	Expand scope of practice for physician extenders Remove barriers for State Employees to reenter nurse workforce Enable WIBs to have sector strategy, specifically nursing and direct support professionals
Access	Evaluate Medicaid provider access biennially Annually or biennially study Virginia's uninsured population
Prevention	CDC School Health Program Amend Clean Indoor Air Act
Long-Term Care	Establish a LTC Coordination Council Establish a LTC Advisory Council Require local LTC councils to include housing and transportation agencies Study the current network of community-based caregiver support organizations
Area	**Other**
Prevention	Through EO, require all state agencies and institutions to have x% of healthy food options by 2009 Develop additional incentives and support mechanisms to increase school participation in the Governor's Nutrition and Physical Activity Scorecard program