Overview of the Joint Commission on Health Care

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Background

The Joint Commission on Health Care (JCHC) was created by the 1992 session of the General Assembly "to study, report, and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services." JCHC seeks to ensure that the greatest number of Virginians receives quality cost-effective health care and long-term care services.

Note: JCHC is not "the Joint Commission" (formerly known as the Joint Commission on Accreditation of Healthcare Organizations – JCAHO) which is a national organization based in Illinois.

Mission of the JCHC

- **JCHC focuses on five main policy areas:**
  - **health insurance and access to care for the uninsured**
  - **health care cost and quality**
  - **health workforce issues**
  - **behavioral health care and**
  - **long-term care.**

Membership of the JCHC

- **Ten members of the House of Delegates, appointed by the Speaker of the House.**
- **Eight members of the Virginia Senate, appointed by the Senate Committee on Rules.**
- **The Secretary of Health and Human Resources is an *ex officio* member.**

JCHC Members in 2009

Sen. R. Edward Houck, Chair
Del. Phillip A. Hamilton Vice-Chair

Del. Clifford L. Athey, Jr.
Del. David L. Bulova
Del. Rosalyn R. Dance
Del. Harvey B. Morgan
Del. John M. O'Bannon, III
Del. Robert H. Brink
Del. Benjamin L. Cline
Del. Algie T. Howell
Del. David A. Nutter

Sen. George L. Barker
Sen. L. Louise Lucas
Sen. Linda T. Puller
Sen. William C. Wampler, Jr.
Sen. Harry B. Blevins
Sen. Ralph S. Northam
Sen. Patricia S. Ticer

The Honorable Marilyn B. Tavenner
Secretary of Health and Human Resources

Role of JCHC Staff

- **JCHC has a full-time staff of five: an executive director, 3 health policy analysts and a publications/operations manager**
  - **Provide impartial, apolitical analysis of issues involving health care, behavioral health care, and long-term care**
  - **Identify a range of policy options for consideration by the Joint Commission**
  - **Assist in supporting legislation and budget amendments that the members introduce on behalf of JCHC.**

Study Process

- Studies are referred:
  - By the General Assembly via study resolution or letter,
  - By individual General Assembly members for JCHC approval, &
  - By authority of JCHC as a standing legislative Commission.
- Staff research and presentation of Studies (May-October)
  - Public comments received (after briefing of study)
  - Received public comments are summarized and presented at the next JCHC meeting
- JCHC consideration of decision matrix and vote on legislative package (November)
- General Assembly Session (January through February or March)

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Primary Legislative Committees Addressing Health, Behavioral Health, and Insurance Issues

- Senate Education and Health
- Senate Rehabilitation and Social Services
- Senate Courts of Justice
- Senate Commerce and Labor
- Senate Finance (Subcommittee on Health and Human Resources)
- House Health, Welfare, and Institutions
- House Courts of Justice
- House Corporations, Insurance, and Banking
- House Appropriations (Subcommittee on Health and Human Resources)

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Health Access for Uninsured Virginians

Joint Commission on Health Care
Healthy Living/Health Services Sub-committee
September 1, 2009

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Topics

- Child Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
- Health Access Improvements Recommended by this and other Commissions

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One Million Uninsured Virginians

- Over 60% work full-time
- Over 50% are low income with family income under 200% FPL ($36,620 / yr for a family of 3; $44,100/yr for a family of 4)
- Average Family Insurance Premium -$11,497 / yr (increased 80% since 2000)
- Virginia has the 4th largest drop in employer-based insurance coverage over the past 15 years.
- Virginia workers now pay the highest % of total premium cost for single coverage in the US (3rd highest for family coverage).

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Children's Health Insurance

- Medicaid ("FAMIS Plus")
  - 133% FPL - $24,353/yr family of 3
  - Over 400,000 currently enrolled
- FAMIS
  - 200% FPL - $36,620/yr family of 3
  - Over 90,000 children currently enrolled.
- Over past 7 years, enrollment has grown 41%
  - Legislative and policy changes
  - Effective marketing
  - Targeted outreach / retention activities
- 187,000 children still uninsured (100,000 eligible but not enrolled)

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CHIPRA
Child Health Insurance Program Reauthorization Act of 2009

- Enacted February 2009
- Contains numerous opportunities and state options to improve programs and assist more children and pregnant women.
- Substantial new federal funding is available to states
- Virginia's future federal allocations will depend on whether / how the state chooses to grow its program.

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CHIPRA Funding

- Virginia gets 65% federal match
- New funding formula is based largely on states' actual use of and projected need for CHIP funds.
- FY '09 Virginia appropriations

  $75.4 million state + $140.1 federal = $215.5 million
- New Federal allotment for Virginia:
  - FFY 2009 - $175 million
  - FFY 2010 - $188 million

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CHIPRA Funding

- FFY 2011 – rebased allotment based on prior years spending
  - States using all federal funding will lock in/get more
  - Others get reduced allotment – unused $ is redirected
- To draw down entire new CHIPRA federal allocation, Virginia could spend approximately $94 million gf (FFY 2009); $101 million gf (FFY 2010).
- CHIPRA also provides:
  - 20% contingency fund to address any state shortfalls
  - Performance Bonus to help states cover more Medicaid children
    - Federal match for children enrolled above baseline can rise from Virginia's regular 50% match to over 80%
    - Only available to states that implement 5 out of 8 specified administrative simplifications

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CHIPRA Recommendation #1

- Provide access to coverage for ALL children by increasing FAMIS eligibility to 300% fpl ($54,930 family of 3) with a full buy-in at higher incomes.
- "Cover All Kids" campaigns in other states find most new enrollment is for kids already eligible under previous standards.
- 32 states already cover – or plan to cover - children above 200% FPL.
  - Alabama – 300% (implementation10/1/09)
  - Arkansas – 250% (enacted, awaiting CMS approval)
  - Maryland – 300%
  - North Carolina – 250% (approved, not implemented)
  - West Virginia – 250% (300% approved, not implemented)
  - D.C. – 300%
- Cost: $5.1 million gf to implement in 2010 - approximately $15 million gf when fully phased in by 2012. (12,000-20,000 more children covered)

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CHIPRA Recommendation #2

- Implement option to provide coverage to legal immigrant children and pregnant women during the first five years they are in the U.S.
  - DMAS is adopting this option for Medicaid-eligible legal immigrant children. Since Virginia has covered them with state funds, the state will save over $700,000 gf.
  - Use these savings to cover Medicaid-eligible pregnant women who are legal immigrants. Additional cost - $70,000 gf in 2010; $316,000 gf in 2011 and $367,000 gf in 2012.
  - These pregnant women already qualify for emergency Medicaid for labor /delivery services. Prenatal care will reduce some expenses for complicated births / sick babies.
  - Consider this option for FAMIS-eligible legal immigrant children and FAMIS-Moms eligible pregnant women. $250,000 gf in 2012.

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CHIPRA Recommendation #3

- Enact enrollment simplifications to remove barriers to coverage and qualify for a performance bonus.
  - "Express-lane" option expedites enrollment
    - coordinate with other public benefits programs - school lunch, food stamps, subsidized childcare.
    - Avoid unnecessary and repetitive requests for information
  - Administrative renewal improves retention and prevents coverage gaps.
    - Use pre-filled renewal applications and require changes to be reported
    - Use existing information from other program records or data bases
    - Reduce administrative costs, postage, paper, staff time
  - 12 month continuous eligibility
    - Stable enrollment
    - Reduce administrative costs

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CHIPRA Recommendation #4

– Adopt option to use Social Security Administration electronic data exchange to verify U.S. citizenship

- 2006 law requires documentary evidence of U.S. citizenship for all Medicaid applicants
- Greatest barrier to enrollment & significant increased workload at DSS and Central Processing Unit
- CHIPRA extends requirement to FAMIS applicants in January 2010
- SSA option will streamline the application process for both Medicaid and FAMIS
- Enhanced federal match is available

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Virginia's Medicaid Program

- Virginia National Rankings
  - per capita personal income - 9th
  - per capita total Medicaid expenditures – 48th
  - per capita federal grants, such as Medicaid – 50th

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Inadequate Medicaid Coverage for Very Low-income, Working Parents

Monthly Income Eligibility Limits for Parents (rounded)

Family Size	Rural Areas	Urban Areas	N. Virginia
1	$160	$192	$269
2	254	283	360
3	325	356	434
4	394	425	502

* The income level is $90 higher when one parent works.

If the parent receives TANF cash assistance and participates in VIEW work program, s/he may earn income up to 100% FPL and keep Medicaid.

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- Middle group (30% FPL for workers) ranked 6th lowest in U.S.
- Rural group (27%FPL) (91 localities) ranked 4th lowest
  - Tied with Texas, and slightly higher than Alabama, Louisiana & Missouri
- No significant increase in Virginia in 20+ years
- Others do better:
  - D.C. 207%
  - Tennessee 134%
  - Maryland 116%
  - S.C. 90%
  - Kentucky 62%
  - NC 51%
  - WV 34%

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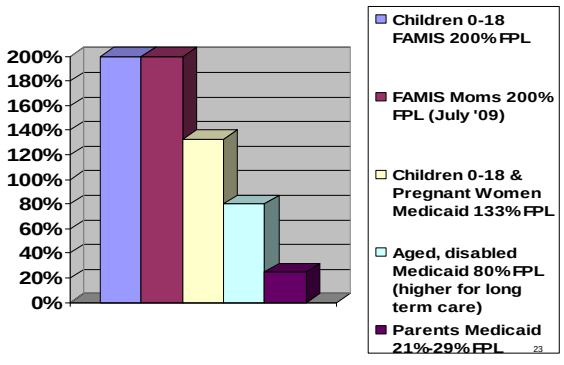
Parent Coverage Compared to other Categories



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Inadequacy of Medicaid Parent Coverage has been Documented for Many Years

- 2000 JCHC Plan to Eliminate the COPN - recommended raising parent eligibility to 100% FPL to address escalating indigent care costs
- 2007 JLARC – expansion of Medicaid parent coverage to 100% FPL is "a logical first step", if Virginia expands insurance to more low-income adults.
- 2007 Governor's Commission on Health Reform recommended a phased-in increase in Medicaid eligibility for parents up to 100% FPL.
- Cost - $35 million gf to increase to 65% FPL
  - $5.6 million gf to establish single eligibility level at 30% FPL

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Medicaid for Legal Immigrants

- Federal law bars most legal immigrants from Medicaid for their first 5 years in the U.S.
- After 5-year bar, legal immigrants, such as Legal Permanent Residents (LPRs), can usually receive Medicaid if they meet other eligibility rules.
- But Virginia is one of only 9 states that continue to bar legal immigrants from Medicaid after 5-year bar.
- Virginia Medicaid will cover costly emergency services for this population.
- Regular coverage would be more cost effective:
  - 50% federal matching dollars
  - Preventive care to reduce health emergencies
  - Avoid state-only & indigent care costs at hospitals, health depts. & clinics
- The 2008 Commission on Immigration recommended ending Virginia's post 5-year Medicaid restrictions. $9.2 million gf

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Medicaid Services

- Adult Dental:
  - Only emergency extractions are now covered
  - Poor oral health is linked to a multitude of health problems
  - Preventive dental care is essential part of overall health care.
  - Many JCHC studies /recommendations on dental care
  - 2007 Commission on Health Reform recommends expanding Medicaid dental coverage to pregnant women & other adults
- Provider rates:
  - Hospitals reimbursed 72% costs
  - Physicians reimbursed 50-60% costs
  - Nursing homes lose $12.45/day for Medicaid patients

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Why Act Now?

- Needed Now – more than ever
  - Recession →unemployment →loss of health insurance
  - 2/3 bankruptcies due to medical debt
  - Support hospitals, community health centers and providers
    - Insurance reimbursements instead of uncompensated/charity care
    - Diverts patients from over-stressed safety net providers to private practitioners
  - Smart investment –
    - Significant federal matching dollars provide new money for Virginia's economy – multiplier effect
    - Virginia taxpayers deserve a better return on their federal tax payments
    - Medicaid /FAMIS are proven programs with low administrative costs
    - Avoid costs – One ER visit /admission for Asthma = annual cost for 3 Medicaid/FAMIS kids
  - Reflects priorities and values of the Commonwealth
    - Especially important when addressing the current shortfall

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What about National Health Reform?

- Outcome unclear
- Most implementation will not happen until 2013

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Policy Options

☑ Option 1:

- A. ~~Introduce~~ Reconsider legislation and accompanying budget amendment to increase FAMIS eligibility from 200% to 300% FPL, and offer a full "buy-in" for uninsured children in families with higher income. Eventually, 20,000 more children would qualify at 300% FPL; unknown number of children would qualify through the buy-in. (Estimated Cost: $5 million GFs in first year of implementation, reaching $15 million GFs after three years – 65% federal match.)
- ~~Introduce~~ Reconsider legislation and accompanying budget amendment to increase FAMIS eligibility from 200% to 250% FPL to eventually reach 10,000 more children. (Estimated Cost: $2.5 million GFs in first year of implementation – 65% federal match.)

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Policy Options

☑ Option 2:

- Introduce a budget amendment (language and funding) to offer coverage to legal immigrants who are Medicaid eligible pregnant women. DMAS already covers their labor/delivery costs as an emergency service. This would provide needed access to prenatal care. (Estimated Cost: $770,531 GFs for 1st year, $1,016,148 GFs for 2nd year – at least an equal amount in FFP will be available each year.)
- ~~Introduce a budget amendment (language and funding) to offer coverage to legal immigrants who are FAMIS-eligible children. (Estimated Cost: $140,000 GFs – 65% federal matching.)~~
- Introduce a budget amendment (language and funding) to offer coverage to legal immigrants who are FAMIS-eligible pregnant women. (Estimated Cost: $87,000 GFs – 65% federal matching.)

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Policy Options

- **Option 3:**
  Introduce a budget amendment (language only) directing DMAS to develop, to the extent that it is budget neutral or likely to result in cost savings, express lane eligibility provisions and other administrative procedures to simplify child health enrollment and improve retention. Any provisions that are estimated to be cost neutral or result in cost savings shall be implemented by December 1, 2010.

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Policy Options

- **Option 4:**
  ~~Introduce~~ Reconsider a budget amendment (language and funding) to adopt a single income eligibility level for Medicaid eligible parents, set at 30% FPL. The eligibility limit would increase to 30% FPL for about 3,000 extremely impoverished parents in 117 Virginia counties and cities. (Estimated Cost: $5.6 million GFs – this would be matched with an equal amount of FFP.)

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Policy Options

- **Option 5:**
  ~~Introduce~~ Reconsider a budget amendment (language and funding) to provide dental coverage to pregnant women who are eligible for Medicaid and/or FAMIS Moms. (Estimated cost to be determined.)
- **Option 6:**
  ~~Introduce~~ Reconsider a budget amendment (language and funding) to provide dental coverage to other Medicaid adults. (Estimated cost to be determined.)
- **Option 7:**
  Take no action.

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References

- **U.S. Census Bureau, 2006-07 Averages from Current Population Survey, Annual Social and Economic supplement, 2008**
- **Kaiser Family Foundation, State Health Facts; Average Family Premium for Employer-Based Health Insurance, 2006**
- **Agency for Healthcare Research and Quality - Medical Expenditures Panel Survey**
- **Virginia Joint Legislative Audit and Review Commission, "A Compendium of State Statistics", Jan. 2008, Tables, 4, 14 and 21**
- **Joint Commission on Health Care, , "A Plan to Eliminate the Certificate of Public Need Program Pursuant to SB 337" Senate Document 0A (2001), pp. 23,31,32**
- **Joint Legislative Audit and Review Commission, "Options to extend Health Insurance Coverage to Virginia's Uninsured Population". HD 19 (2007), p. 47.**
- **"Roadmap for Virginia's Health – A Report of the Governor's Health Reform Commission" (2007), pp. 18-19.**
- **Report, Governor's Commission on Immigration (2009), pp 22-23**

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Joint Commission on Health Care

JCHC Internet website:

http://jchc.state.va.us

Includes meeting schedules, studies, reports, and legislation.

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