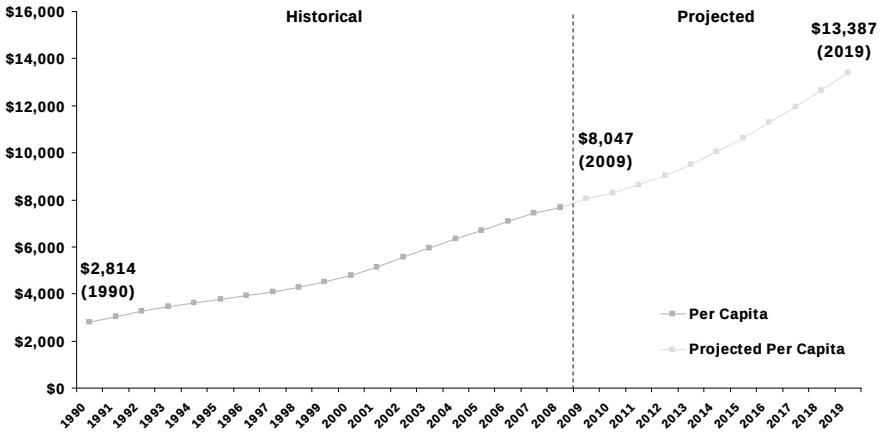
National Conference of State Legislators

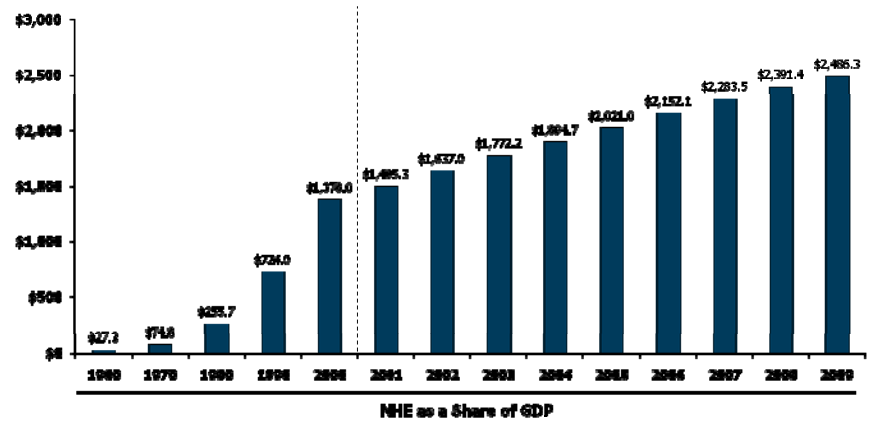
Secretary of Health and Human Resources, Virginia
Dr. Bill Hazel
December 6, 2012

National Health Expenditures Per Capita, 1990-2019



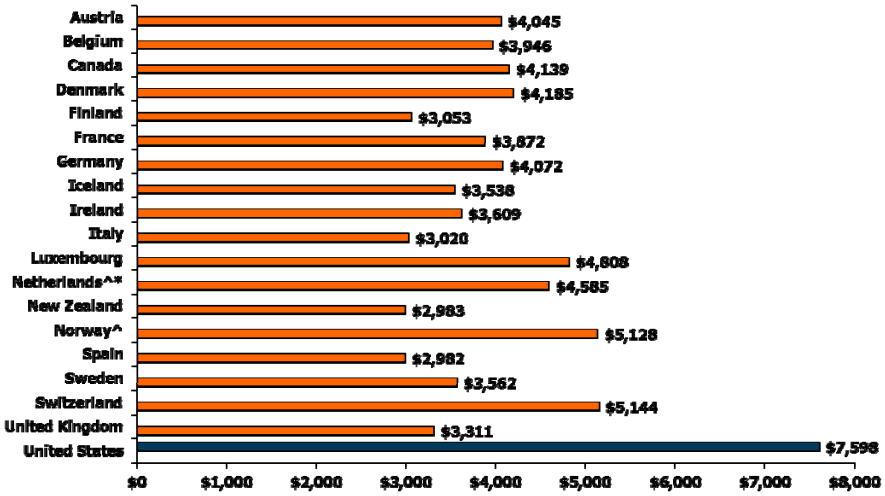
Source: Kaiser Family Foundation, VIA Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (Historical data from NHE summary including share of GDP, CY 1960-2008, file nhegdp08.zip; Projected data from NHE Projections 2009-2019, Forecast summary and selected tables, file proj2009.pdf).

National Health Expenditures and Their Share of Gross Domestic Product, 1960–2009



Source: Kaiser Family Foundation via CMS, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2009; file nhegdp09.zip

Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2009



^OECD estimate.

*Break in series.

Notes: Amounts in U.S.$ Purchasing Power Parity, see http://www.oecd.org/std/ppp; includes only countries over $2,500. OECD defines Total Current Expenditures on Health as the sum of expenditures on personal health care, preventive and public health services, and health administration and health insurance; it excludes investment.

Source: Organisation for Economic Co-operation and Development. "OECD Health Data: Health Expenditures and Financing", OECD Health Statistics Data from internet subscription database, http://www.oecd-ilibrary.org, data accessed on 01/10/12.

FISCAL CLIFF

Foundational Thinking

- Fiscal Cliff is very real
  - There are a lot of financial "promises" made in the PPACA…little trust they will remain untouched
  - States will bear the impact associated with unfulfilled financial obligations
- Can it be accomplished?
  - Aggressive timelines
  - Few final and proposed rules
  - Moving deadlines
  - State legislature resistance

"[a]s we move forward on health reform, it is not sufficient for us to simply add more people to Medicare or Medicaid to increase the rolls, to increase coverage in the absence of cost controls and reform… Another way of putting it is we can't simply put more people into a broken system that doesn't work."

– President Obama

Medicaid

3 Variables

Populations Covered	Optional Benefits	Provider Rates
PPACA Restricts	PPACA Restricts	Cutting rates – less providers

- No consideration of expansion without substantial reforms
  - **Value Based** (e.g. Medicaid EHB = commercial product, incentives to primary care utilization, co-locate behavioral health and primary care, tight provider networks)
  - **Shared Responsibility** (e.g. co-payment reductions for healthy behaviors, penalties for inefficient use of health system, cost share for preferred drugs, dental benefits for premium,

Health Benefits Exchange

2 Key Components

1. Technical Build
2. Insurance Market Management

State Based Exchange – too late to develop unless pursue HBE in a box

Federally Facilitated – await technical build and systems connector details

Hybrid – not in PPACA, essentially FFE with state running either Outreach and/or Plan Management

NEED: federal rules and IT tools in order to determine best option for states

Innovation

Cost and Value problems in the healthcare arena can't be solved without significant innovation

- Innovation opportunities within PPACA are lost in the messiness of Exchange and Medicaid messaging.
- Unfortunately, innovation funding also politically packaged as a result of forcing innovation funding opportunities through Governor's offices.
- Virginia has created the Virginia Center for Health Innovation (501 (c)3 housed out of the Chamber of Commerce) and invested $3million of its own funding to begin looking at 5 core innovation areas.

VCHI

- Mission: To work in partnership with multiple stakeholders to accelerate the adoption of value-driven models of wellness and health care throughout Virginia.

- Vision: The Virginia Center for Health Innovation is envisioned as a nonprofit, nonpartisan, consumer-centered, trustworthy vehicle for sparking and sustaining health innovation in Virginia. The Center will advance the vision of Virginia as a national leader in individual health, community health, health care, and economic growth.

VCHI Innovation Portfolio

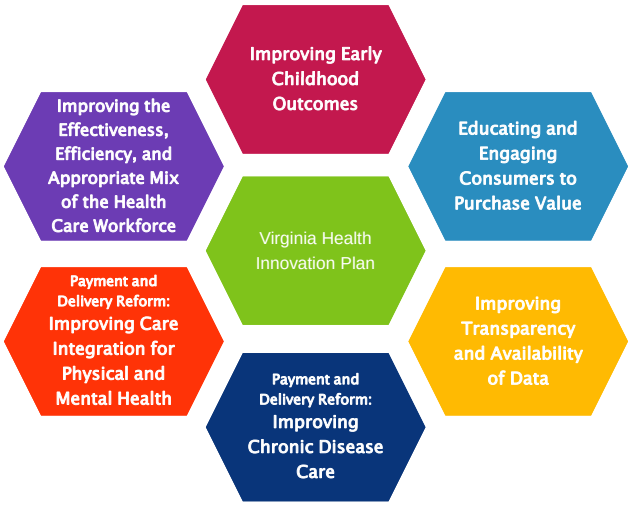
Nine broad innovation areas

1. Measurement of employee health and productivity;
2. Value-based purchasing;
3. Value-based insurance design;
4. Focused delivery and payment reform;
5. Patient-centered care models;
6. Price and quality transparency;
7. Reducing overutilization;
8. Strategic wellness design; and
9. Patient safety improvement

Virginia Health Innovation Priorities

Each priority will have a dedicated workgroup assigned to explore pilot programs and to reach consensus on a recommended three-year implementation plan.

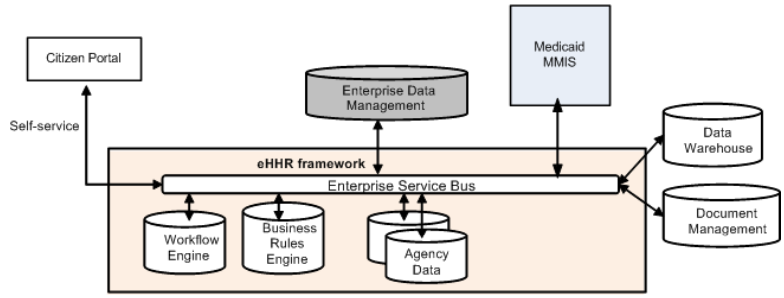
Workgroups will include members of the VHRI Advisory Board, the VCHI Board of Directors, as well as any key thought leaders in each particular priority area.



electronic Health and Human Resources (eHHR)

- Modernize Eligibility and Enrollment services; create a self-service environment to improve service quality and reduce costs
- Create a business framework where new functions can easily be added. Prepare for Medicaid Expansion and HBE options.
- Leverage existing systems that work well
- Recognize that social service policy and workflow are dynamic; need to be flexible
- Reduce paperwork through automation
- Fight fraud and abuse with modern citizen identification tools

eHHR Technology Vision



15

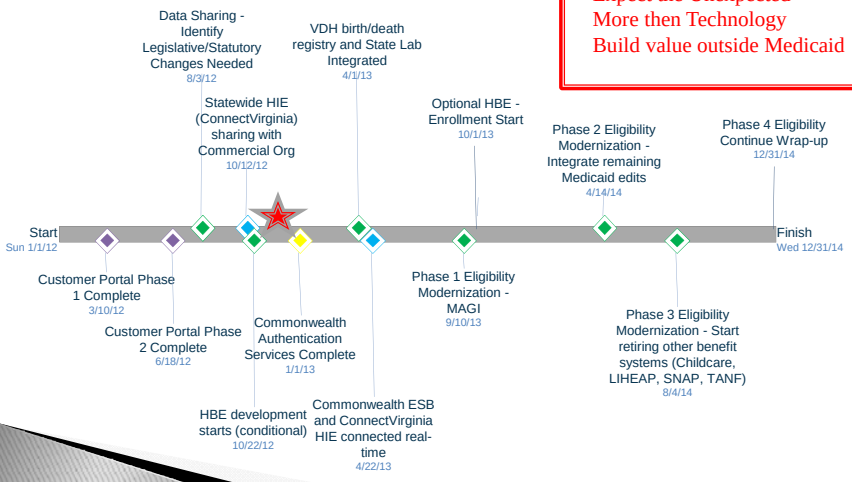
Holistic Implementation

Hazel

4

eHHR Timeline

Phased Effort
Parallel Execution
Expect the Unexpected
More then Technology
Build value outside Medicaid



6

Contact Information
Secretary Hazel
bill.hazel@governor.virginia.gov