JOINT COMMISSION ON HEALTH CARE

2022 INTERIM EXECUTIVE SUMMARY

TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT # 849

COMMONWEALTH OF VIRGINIA
RICHMOND
2022

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

Joint Commission on Health Care

Members

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The Honorable Senator George L. Barker

Vice Chair

The Honorable Delegate Robert D. Orrock, Sr.

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Senator John S. Edwards
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Senator Ghazala F. Hashmi
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Delegate Patrick A. Hope
Delegate Sam Rasoul
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JOINT COMMISSION ON HEALTH CARE

Senator George L. Barker, Chair *Delegate Robert D. Orrock, Sr., Vice Chair*

December 15, 2022

The Honorable Glenn Younkin
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
Pocahontas Building
Richmond, Virginia 23219

Dear Governor Younkin and Members of the General Assembly:

Please find enclosed the interim executive summary of the Joint Commission on Health Care. This report, which summarizes the activities of the Commission in 2022 fulfills the requirements of § 30-168.5 of the Code of Virginia.

This and all other reports and briefings of the Joint Commission on Health Care can be accessed at jchc.virginia.gov.

Respectfully submitted,

George L. Barker, Chair

Jeff Lunardi, Executive Director
Joint Commission on Health Care
P.O. Box 1322 / Richmond, VA 23218

Interim Executive Summary 2022

The Joint Commission on Health Care (JCHC) was established in 1992 to continue the work of the Commission on Health Care for All Virginians. The JCHC authorizing statute in the Code of Virginia, Title 30, Chapter 18, states in part: "The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care." The Commission undertook the following activities during 2022 to implement this purpose.

Staff Reports and Legislative Recommendations

During 2022, JCHC staff completed four studies as directed by the Commission. At the conclusion of each study, Members received a report and briefing from staff, then voted during the December meeting on which policy options to endorse as recommendations for legislative action.

Provider Data Sharing to Improve Quality of Care

The Joint Commission on Health Care directed staff to study ways that Virginia can improve health care data sharing in Virginia. Below is a summary of the findings from this study.

Providers can improve patient care and reduce unnecessary services with access to patient medical records

When providers are able to access a patient's medical history quickly and efficiently, they are able to make better clinical decisions and reduce unnecessary or duplicative tests. To accomplish this goal, the most important pieces of information are a complete prescription history for the patient, and the results of any recent lab or diagnostic tests.

Public programs that share data are meeting some data sharing needs, but require expansion or improvement to be effective

Two primary data sharing programs overseen by state agencies are the Prescription Monitoring Program (PMP) and the Emergency Department Care Coordination (EDCC) program. The PMP is an effective tool to collect and share with providers some prescription data, but is limited to a narrow subset of drugs that present a risk for addiction or over-prescribing. Creating a similar program that includes all prescriptions would address the number one piece of a patient's medical history that providers need. The EDCC program is a useful case management tool to assist individuals who frequently use hospital

emergency rooms, but more non-hospital providers need to be added to maximize its benefits.

Multiple, fragmented programs and systems make it difficult for many providers to efficiently share data

There are a litany of private data sharing programs both within Virginia and nationally. Large health systems are often able to integrate these programs into their electronic medical records, but many smaller providers have to use multiple systems to access disparate pieces of a patient's medical history. This makes the data harder to access, and often discourages providers from using them at all. Bringing more of this data into one platform would enable easier access for providers.

Members voted to endorse the following policy recommendations (Options 1 & 5 were modified from the original language):

Option 1: Introduce legislation directing the development of a system to collect data on all prescriptions dispensed in Virginia and use the system to make a patient's medication history available to a provider with consent of the patient. The legislation will direct the necessary stakeholders to plan the implementation and report to the General Assembly prior to development.

Option 5: The Joint Commission on Health Care could endorse the implementation of the Strategic Plan proposed by Virginia Health Information to expand the EDCC system into a health data utility.

Option 6: Introduce legislation creating a grant program to pay for the initial costs of connecting community-based health care providers to the data sharing platforms operated by large health systems.

Reducing Unnecessary Emergency Department Utilization

The Joint Commission on Health Care directed staff to review emergency department utilization in Virginia and to provide options the Commonwealth may take to address unnecessary ED utilization. Below is a summary of the findings from this study.

Number of ED visits remained steady prior to COVID-19 pandemic, but severity of visits and costs increased from 2016-2020

The number of ED visits in Virginia remained steady from 2016-2019 before declining in 2020, reflecting the impact of the COVID-19 pandemic. The intensity of services for patients increased during this time, and the average cost of an ED visit increased by 41.5%. An increasing number of visits for mental health and substance abuse issues were a contributing factor to these trends.

Alternatives to an ED visit need to be available and accessible

People go to the ED for many reasons, some include the inability to get an appointment with a physician or limited hours and locations for urgent care centers. A bad experience in an alternative care setting often leads to ED use. Medicaid enrollees often have the most difficult time finding alternative settings. Additionally, primary care provider acceptance of Medicaid enrollees and scheduling practices are often barriers to access.

Some ED visits for patients with chronic conditions and frequent ED users can be prevented

Patients with chronic conditions that go unmanaged in the community present in the ED with an emergency, but those emergencies could have been prevented. Conditions such as diabetes, hypertension, and asthma can be treated and managed, but often result in ED visits if patients don't get the care they need. Additionally, the vast majority of high utilizers of the ED have mental health or substance abuse diagnoses. Hospital-based and ambulance-based care management programs can be effective at better managing these conditions in the community.

Freestanding EDs should be easily identified to consumers

Freestanding EDs generally serve a similar patient mix to hospital-based EDs, but consumers can confuse them for urgent care centers or hospitals. Improved awareness by consumers can ensure they seek care in the most appropriate setting and avoid surprise medical bills.

Members voted to endorse the following policy recommendations (Option 6 was modified from the original language):

Option 1: Introduce a Chapter 1 bill directing DMAS to modify its managed care contracts to require MCOs to collect and report on the number of claim denials, the reason for denials, and the number of claim resubmissions prior to payment by provider type. The bill could direct DMAS to report this information to the Joint Commission on the Health Care and the Joint Subcommittee for Health and Human Resources Oversight.

Option 3: Introduce legislation and an accompanying budget amendment to establish a grant program within the Virginia Department of Health, Office of Emergency Medical Services to establish and enhance hospital-based care management programs.

Option 6: Send a letter to the Secretary of Health and Human Resources requesting that a workgroup of stakeholders be convened to develop consensus on solutions to consumer confusion regarding free standing or off-campus emergency departments.

Affordablity of Assisted Living Facilities

The Joint Commission on Health Care directed staff to study strategies to increase the affordability and accessiblity of assisted living facilities. Below is a summary of the findings from this study.

The Auxiliary Grant rate is insufficient to cover the cost of assisted living in Virginia, resulting in limited access

The AG rate has remained relatively flat for the last 13 years with the exception of small cost of living adjustments to comply with federal requirements. During that time period, the AG rate increased just 28% while the typical cost of assisted living increased by 64%, after adjusting for inflation. As a result, there has been a 41% decrease in facilities that participate in the AG program and the number of AG recipients since 2010. ALFs that do accept AG often have to rely on outside services or financial support, and they are more likely to have licensing violations.

Leveraging Medicaid payments to cover services in assisted living would require significant changes

Medicaid can pay for services to eligible individuals who live in an assisted living facility, but it cannot pay for the cost of room and board. ALFs would have to meet federal criteria as a home and community-based setting for residents to be eligible for Medicaid funded LTSS. A limited number of ALF residents would be eligible for Medicaid-funded services, unless eligibility criteria are expanded.

Other community settings could be more cost-effective for individuals seeking AG payment in ALFs

Funding community-based services could meet the needs of the AG population with lower functional needs such as adult foster care. Adult foster care and AG supportive housing are already allowable community settings for AG recipients, but their availability is extremely limited. Other states allow residents to reside in more community settings, and modify their rates based on the setting.

Increased personal funds can improve quality of services for current AG recipients.

The personal needs allowance for AG residents has not increased since 2014, reducing individual's ability to pay for necessary personal items and services not provided by ALFs. These are the only personal funds AG residents have after paying the ALF.

Members voted to endorse the following policy recommendations (Options 3 & 6 were modified from the original language):

Option 1: Introduce a budget amendment to increase the base Auxiliary Grant rate to $2,500 per month.

Option 3: Introduce legislation amending the Code of Virginia to expand the list of eligible living arrangements for the Auxiliary Grant program to allow AG recipients to remain in the community and coordinate their own care as needed. The legislation should include an enactment clause directing DARS to submit changes to the AG Program's eligible living settings to the Social Security Administration for approval, including details on the eligible living settings and how recipients would access those settings.

Option 5: Introduce a budget amendment providing funds to increase the personal needs allowance for AG recipients, and include language that the AG personal needs allowance will increase at the same rate as future cost of living AG rate increases.

Option 6: Send a letter from the JCHC directing DSS to update ALF regulations to require ALF administrators to notify the appropriate DARS and local CSB staff at least 60 days prior to closure if they currently have residents on the Auxiliary Grant or Discharge Assistance Program.

Local Health Department Structure and Financing

The Joint Commission on Health Care directed staff to assess whether the current structure and financing of Virginia's LHDs is effectively supporting them to carry out their responsibilities. Below is a summary of the findings from this study.

State Code does not require all core, public health program areas and some are lacking at local health departments

Two of the five foundational public health Program Areas identified as national best practice are not required of local health departments in Virginia. These are the ability to ensure access to necessary services and link individuals to those services, and a focus on chronic disease and injury prevention. Neither of these areas are explicitly required in state Code, and only a few local health departments currently focus on them.

There are no systems for accountability or performance management across local health departments

Monitoring performance for local health departments is challenging, but improvements are needed to ensure VDH can assess effectiveness across the state. Current data focuses on process metrics, such as the number of health inspections or clinical encounters, with no data on quality of services or outcomes. Other states have implemented performance management models that could serve as a framework for Virginia.

Local health departments need additional support for information technology and workforce

The IT systems that local health departments use for their core functions are siloed and outdated. Additionally, recruiting and retaining qualified staff are persistent challenges, due

primarily to low salaries. Improving both of these administrative capabilities will improve local health department performance.

Funding allocations do not account for true service costs or need

Local health department budgets are primarily based on historical funding levels. This results in drastic variation across localities and means that budgets are not accounting for changes in need over time. Without a better understanding of the cost of core services and local performance, it is not possible to determine whether major funding changes are necessary. However, targeted investments to address identified shortcomings are necessary.

Members voted to endorse the following policy recommendations, including a new option that was not in the original report:

New Option – Send a letter to VDH indicating support for all of the policy options that were not otherwise endorsed, and requesting that VDH convene the appropriate stakeholders to develop an implementation plan to reform the local public health system that includes priorities and cost estimates based on the JCHC policy options and other recommendations from stakeholders.

Option 5 - Introduce a budget amendment to fund targeted increases for LHD staff base salaries to align with current industry salary benchmarks.

Commission Meetings

The full Commission met seven times this year, and the The Executive Subcommittee met twice. Below is a list of all JCHC meeting dates. All meeting materials and minutes are available on the JCHC website (http://jchc.virginia.gov/meetings.asp).

Full Commission

- April 27th
- May 18th
- August 17th
- September 21st
- October 5th
- November 2nd
- December 7th

Executive Subcommittee

- May 18th
- October 5th

Other Staff Activities

JCHC staff participated in several activities related to health policy both in Virginia and nationally. The Executive Director, Jeff Lunardi served on the VHI Board of Directors, Children's Health Insurance Program Advisory Committee (CHIPAC), and National Conference of State Legislators (NCSL) Health and Human Services (HHS) Standing Committee, where he served as a staff Vice-Chair. Staff provided presentations to the following groups or events: Virginia League of Social Services Adult Services Committee meeting, Williamsburg Health Foundation, House Health, Welfare, and Institutions Committee, the Virginia Quality Healthcare Network, and the Chapter 559 Acts of Assembly Workgroup. Additionally, staff attended the Pandemic Preparedeness Conference, served as a panelest for a William and Mary Policy Course, andprovided mentoring to a University of Virginia student intern and a Virginia Management Fellow (VMF).

JOINT COMMISSION ON HEALTH CARE

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