JOINT COMMISSION ON HEALTH CARE

2023 INTERIM EXECUTIVE SUMMARY

TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #765

COMMONWEALTH OF VIRGINIA
RICHMOND
2023

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.

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Vice Chair

The Honorable Delegate Robert D. Orrock, Sr.

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JOINT COMMISSION ON HEALTH CARE

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

December 19, 2023

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
General Assembly 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 2023 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

Interim Executive Summary 2023

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 2023 to implement this purpose.

Staff Reports and Legislative Recommendations

During 2023, JCHC staff completed three studies and two briefings as directed by the Commission. At the conclusion of each study, Members received a report and presentation from staff, then voted during the December meeting on which policy options to endorse as recommendations for legislative action. No policy options were presented for the *Vertically Integrated Carriers and Providers* study or the two briefings.

Team-based Care Approaches to Improve Health Outcomes

The Joint Commission on Health Care directed staff to study ways in which Virginia can further incentivize or promote effective models of team-based care. Below is a summary of the findings from this study.

Team-based care is evidence-based but reimbursement for behavioral health and pharmacy services is limited

Practice teams have a positive impact on chronic conditions and have evolved to integrate behavioral health and pharmacy services. Health care professionals cited lack of insurance coverage for integrated behavioral health services and medication therapy management delivered via telehealth as significant barriers to providing much-needed services to patients.

The impact of state-funded incentive programs to address primary care workforce shortages is unclear

Successful team-based care depends on a robust health workforce. Practices rated difficulty recruiting or retaining clinical staff as the top factor limiting optimal implementation. Virginia has invested state funds in multiple primary care work force incentive programs; however, the value and impact of these programs is unknown.

Practices need implementation support to transition from traditional to team-based primary care

Team-based care is cost-effective but requires up front investments in infrastructure, staffing, and training that may not be attainable for all practices. With additional resources, the existing structure of Virginia's regional Area Health Education Centers (AHECs) could be leveraged to provide implementation support to smaller or independently owned practices.

Current fee-for-service payment models are a barrier to team-based care sustainability

Stakeholders and survey respondents reported that the current fee for service payment models are a significant deterrent to sustaining team-based primary care. Virginia could support expansion of team-based care using value-based payment models with Medicaid beneficiaries.

Members voted to endorse the following policy recommendations:

Option 1 – Direct DMAS to establish a reimbursement rate and develop a Collaborative Care Model program. Adopted as a JCHC recommendation by a unanimous vote.

Option 2 - Direct DMAS to establish a reimbursement rate for medication therapy management provided via telehealth. Adopted as a JCHC recommendation by a 10-1 vote.

Option 3 (amended) – Send a letter to JLARC to evaluate state-funded health care workforce incentive programs. Adopted as a JCHC recommendation by a unanimous vote.

Option 4 – Fund Virginia Task Force on Primary Care to expand pilot programs on core team-based care criteria for payers. Adopted as a JCHC recommendation by a unanimous vote.

Option 5 – Fund staff at AHECs to support primary care practices transitioning to team-based care. Adopted as a JCHC recommendation by a unanimous vote.

Option 6 – Direct DMAS to develop a plan for participation in the Medicaid health home program. Adopted as a JCHC recommendation by a 10-1 vote.

Vertically Integrated Carriers and Providers

The Joint Commission on Health Care directed staff to study vertically integrated systems, where there is a joint ownership interest between insurance carriers and providers, specifically health systems, including hospitals in Virginia. Below is a summary of the findings from this study.

Vertical integration does not limit access to health care in Virginia

Most of Virginia's vertically integrated providers operate within limited geographic regions of the state. Eastern Virginia residents have the least choice between vertically integrated providers and other providers. All vertically integrated carriers in Virginia operate in markets where they face competition from other carriers. While Virginians generally have a choice among carriers, vertically integrated carriers have larger proportions of Medicaid and exchange enrollees than other carriers.

The impact of vertical integration on costs to patients, providers, and payers is variable and inconsistent across systems

In theory, vertically integrated systems can generate cost benefits for patients, providers, and carriers through better care management, reduced health care utilization, economies of scale in administration, and lower premiums. However, most stakeholders JCHC staff spoke with said that true savings and total impact on cost can be difficult to quantify. In addition, market dominance, along with a multitude of other factors, interacts with vertical integration to influence cost. Vertically integrated carriers reimburse their affiliated providers differently, though there are no consistent patterns across systems. They also do not report significantly different medical loss ratios from other carriers.

The relationship between vertical integration and quality is mixed

Vertically integrated providers in Virginia have significantly higher quality ratings than other acute care hospitals, and moderately higher patient satisfaction ratings. These findings are in alignment with research that indicates vertically integrated systems perform better than competitors in quality and member satisfaction. Vertically integrated carriers also spend a higher percentage of revenue from member premiums on quality improvement, though their plan quality ratings are not significantly different from those of other health plans.

This study was for informational purposes only and did not contain any policy options.

Obesity and Eating Disorders Prevention and Treatment in Virginia

The Joint Commission on Health Care directed staff to study prevention and treatment strategies for obesity and eating disorders. Below is a summary of the findings from this study.

Coverage of obesity prevention and early intervention services varies by insurer

Virginia Medicaid currently covers preventive services for children and adults, including physical exams and nutrition counseling. Two Medicaid MCOs piloted an evidence-based prevention program, the Diabetes Prevention Program, that successfully targets people who are at high risk for type 2 diabetes by promoting a change in lifestyle factors for modest weight loss. The program could benefit people with obesity; however, this program is not currently a covered Medicaid benefit. The Virginia EHB benchmark plan covers counseling services related to nutrition as a preventive health benefit but does not cover behavioral interventions for obesity. Some individual and small group plans also exclude medical nutrition therapy as a treatment for obesity.

Weight loss medications are not covered in the Virginia Essential Health Benefits (EHB) benchmark plan and allowed under strict criteria for Medicaid

The Virginia EHB benchmark plan outlines services which must be covered by individual and small group plans. Also, the Virginia EHB benchmark plan specifically excludes coverage for weight loss drugs. Consequently, there are no individual or small group plans that cover these services. Medicaid requires prior authorization for weight loss drugs.

Weight loss surgery is not covered in the Virginia Essential Health Benefits benchmark plan and allowed under strict criteria for Medicaid

The Virginia EHB benchmark plan specifically excludes coverage for weight loss surgery, which is similar to most states. Twenty-three states cover bariatric surgery through their state EHB benchmark. Coverage is limited to the individual and small group market. Virginia Medicaid covers bariatric surgery when medically necessary.

Limited reimbursement and coverage of eating disorder services are major barriers to treatment

Eating disorder treatment providers reported unsustainably low reimbursement rates and difficult rate negotiations with commercial insurance companies. Medicaid does generally cover some eating disorder treatment, but there is not an established rate for eating disorder services. Providers can participate in single-case agreements with Medicaid to provide services, when possible.

Lack of alignment in prior and continued authorization requirements and medical necessity among insurers can create administrative barriers and delay care

Eating disorder treatment usually requires prior authorization based on an insurer's medical necessity criteria before services will be covered. Insurers can use discretion on what clinical guidelines they use to authorize services, resulting in differences in eating disorder treatment coverage across plans and carriers. Additionally, insurers often require continued stay authorization and can deny coverage if the patient no longer meets their medical necessity criteria. However, when the insurer fails to provide their definition of medical necessity, providers find it challenging to justify ongoing treatment.

Methods to ensure compliance with federal and state mental health parity laws continue to evolve

Non-quantitative treatment limitations (e.g., prior authorization requirements) may not indicate a mental health parity violation, but current state processes for oversight and enforcement of parity may not effectively identify and reduce barriers to mental health treatment. Some states have updated their mental health parity laws to increase transparency and ensure behavioral health services are covered to the same extent as medical surgical benefits.

Members voted to endorse the following policy:

Option 1 – Direct DMAS to develop a plan to incorporate the National Diabetes Prevention Program as a covered service within the Medicaid State Plan. Adopted as a JCHC recommendation by a unanimous vote.

Option 2 - Request HIRC and BOI to define nutritional counseling in the EHB benchmark plan. Adopted as a JCHC recommendation by a unanimous vote.

Option 3 - Request HIRC and BOI conduct assessments to include medical nutrition therapy in the Essential Health Benefits benchmark plan when medically necessary. Adopted as a JCHC recommendation by a unanimous vote.

Option 4 - Direct DMAS to remove service limits for medical nutrition therapy when treating qualifying or eligible medical conditions. Adopted as a JCHC recommendation by a unanimous vote.

Option 5 (amended) - Request HIRC and BOI conduct assessments to include weight loss medication in the Essential Health Benefits benchmark plan when medically necessary, as determined by a healthcare provider. Adopted as a JCHC recommendation by a unanimous vote.

Option 6 (amended) - Request HIRC and BOI conduct assessments to include bariatric surgery in the Essential Health Benefits benchmark plan when medically necessary, as determined by a healthcare provider. Adopted as a JCHC recommendation by a unanimous vote.

Option 7 - Direct DMAS to conduct a rate study to develop reimbursement rates for residential, partial hospitalization, and intensive outpatient services for eating disorder services for adults over 21. Adopted as a JCHC recommendation by a unanimous vote.

Option 8 - Require all Medicaid MCOs and state-regulated health insurers to remove prior authorization for eating disorder services. Adopted as a JCHC recommendation by a unanimous vote.

Prescription Drug Affordability briefing

The Joint Commission on Health Care requested information on two topics: the impact of federal changes in the Inflation Reduction Act on prescription drug affordability in Virginia and the implications of federal court rulings on state regulation of ERISA plan. Below is a summary of the findings from this briefing:

Spending Trends

Total prescription drug spending continues to grow faster than income and inflation. Increased spending impacts out-of-pocket (OOP) costs for consumers. Out of pocket spending has been flat for most consumers, but a minority of consumers face significant financial challenges affording necessary medications.

Inflation Reduction Act (IRA) Provisions

The most significant impact on consumer out of pocket spending will come from the Medicare Part D benefit redesign. Medicare inflation rebates may slow price increases for some drugs for all payers, but the full impact is still unclear. Federal negotiating authority is likely to reduce the Medicare price of some of the highest cost medications.

Pharmacy Benefit Manager (PBM)

States have increasingly regulated PBMs in recent years by way of adding licensing and reporting requirements; auditing standards between PBMs and pharmacies; and setting contract provisions such as gag clauses and spread pricing. This has led to challenges of state laws by the PBM industry, particularly laws that seek to regulate PBMs working with or owned by ERISA plans.

ERISA preemption

The Supreme Court unanimously held in Rutledge v. PCMA that PBM cost-regulations, even if they increase costs or change incentives for plans, are not preempted. Mulready v. PCMA suggests that (at least in 10th Cir.) pharmacy network restrictions are preempted as a form of interference with benefit design. State laws should apply to PBMs generally, not to the ERISA plans. Any novel attempt at state regulation of ERISA plans or their contracted intermediaries is likely to face a legal challenge but whether the state law will survive the challenge is a separate question.

The briefing was for informational purposes only and did not contain policy options.

Health Care Workforce briefing

Virginia has invested in a variety of workforce development programs

There are currently a total of 64 health-specific workforce programs and 24 general workforce programs that include health careers in Virginia. Of those, 47 percent receive state funding.

State-funded recruitment and distribution programs target providers and support staff

The Virginia Department of Health receives nearly $5M in state funds annually to administer workforce scholarship or loan repayment programs which include primary care, dental, and behavioral health workforce. The Virginia Community College System receives $34.5M in state funds annually to provide tuition assistance through Virginia's G3 Program. The program assists with obtaining stackable credentials for medical assistants, home health aides, and pharmacy technicians, among others.

Evidence of workforce program effectiveness in Virginia is limited

Based on staff analysis of program data, only 30 percent of Virginia's health care workforce programs were collected data on implementation metrics (e.g., numbers of individuals served) and outcomes (e.g., number of credentials earned. In addition, no Virginia programs had been evaluated for effectiveness, although there are evaluations underway for some programs.

The briefing was for informational purposes only and did not contain policy options.

Stakeholder briefings

During the May meeting, invited staff from the Department of Medical Assistance Services and the Department of Social Services gave a presentation on Virginia's Medicaid requirement changes for coverage.

During the August meeting, invited staff from the Virginia Department for Aging and Rehabilitative Services and the Department of Medical Assistance Services each provided briefings on brain injury services that are available in the Commonwealth.

Invited staff from Virgina Health Information provided their annual update during the October meeting.

And lastly, invited staff from the Virginia Health Department presented on the Workgroup on Local Health Department Structure and Financing during the November meeting.

Commission Meetings

The full Commission met six times this year, and the Executive Subcommittee met three times. 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

- May 17th
- August 23rd
- September 20th
- October 18th
- November 13th
- December 6th

Executive Subcommittee

- May 17th
- October 2nd (This was a closed meeting to discuss candidates for the Executive Director position)
- October 18th

Other Staff Activities

Executive Director Jeff Lunardi resigned from his position in July and the Joint Commission on Health Care confirmed Sarah Stanton as the next Executive Director in December.

JCHC staff participated in several activities related to health policy both in Virginia and nationally. The former Executive Director, Jeff Lunardi, served on the VHI Board of Directors and the Children's Health Insurance Program Advisory Committee (CHIPAC), served as Vice-Chair on the National Conference of State Legislators (NCSL) Health and Human Services (HHS) Standing Committee. Staff served on the DMAS Hospital Payment Policy Advisory Council (HPPAC) as a Board Member. Staff provided presentation at the Commonwealth Council on Aging Quarterly meeting. Additionally, staff attended the Virginia Department of Health Workgroup meetings on Local Health Department Structure and Financing, and the National Legislative Program Evaluation Society (NLPES) conference. Lastly, staff mentored and supervised one PhD student intern from the University of Virginia, and a COVES Fellow from Virginia Commonwealth University during 2023.

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