The Affordable Care Act and the State of Oral Health in Virginia

Presentation to 2012 Oral Health Summit
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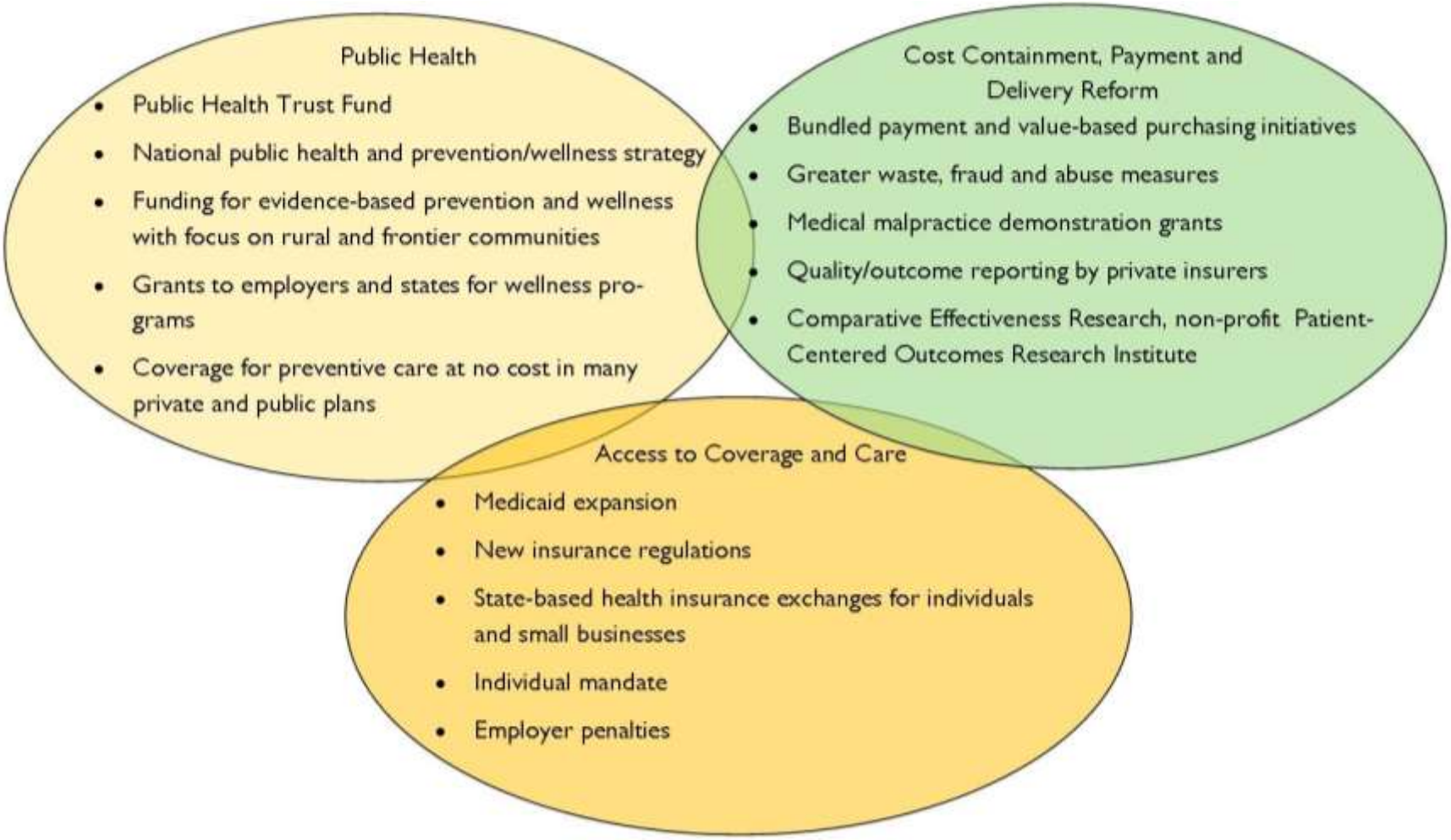
October 26, 2012

ACA - Three Primary Components



ACA – Overview

- Creates Health Benefit Exchanges by 2014
  - Small business (currently 50 employees or less, up to 100 employees in 2016)
  - Individuals 133%-400% FPL
  - Premium assistance and cost-sharing for individuals
- Opportunity to provide pediatric dental and medical coverage to individuals currently unable to afford it
- Provides significant momentum to examine and implement needed reforms

Coverage Changes Already in Place

Provision	Impact in Virginia
Dependent coverage to age 26	31,200 young adults young adult Virginians were covered through this provision
Preventive services at no cost	1,519,000 Virginians in private plans and 837,645 Virginians in Medicare have received free preventive care through this provision
Federal funding	Approx $72 million has been awarded to Community Health Centers to expand access to primary care
Lifetime limit prohibition	4.8 million Virginians no longer have lifetime maximum limits on their health insurance plans

ACA – Oral Health Provisions

- Coverage:
  - Pediatric dental “essential benefits” package for children under 21
  - Dental coverage is not required for adults
  - No co-pay for prevention; no lifetime or yearly limits
  - Stand –alone dental plans okay
  - Children enrolled in Medicaid/FAMIS 200% FPL and below will see no change in oral health benefits

ACA – Oral Health Provisions

- Prevention, Health Promotion & Infrastructure
  - CDC oral health infrastructure grants (VA is recipient)
  - National Oral Health Surveillance System
  - School-Based sealant programs
  - Research grants
  - Prevention and public health trust fund
  - Community transformation grants
  - Loan repayment programs

Medical & Dental Coverage in Virginia

Selected Access and Utilization Indicators (2010)	Estimate
Estimated Virginia population under 65 **without health coverage**	**889,000**
Estimated Virginia population **without dental coverage**	**3,800,000**
National percent of poor and low income population **with dental visit** in past 12 months	**27-30%**
National percent of middle and upper income population **with dental visit** in past 12 months	**42-58%**

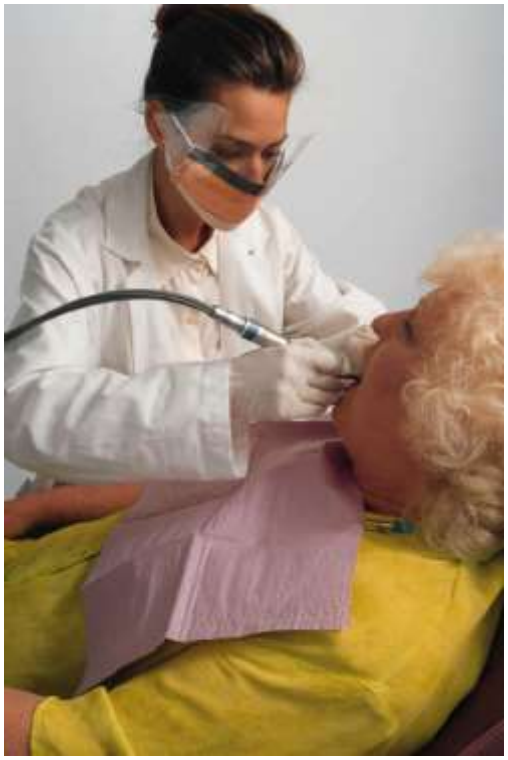
Source: Uninsured estimates from the Virginia Health Care Foundation at www.vhcf.org. National utilization estimates from MEPS Chartbook 17, Agency for Healthcare Research and Quality, 2007.

Dental Benefits in Virginia

- Medicaid:
  - Comprehensive benefit for children 200% FPL and below
  - Utilization rate below 50%
  - Emergency Extraction only for Adults
- Medicare:
  - No dental benefits
- Traditional Dental Benefit:
  - Preventive services free
  - Yearly cap

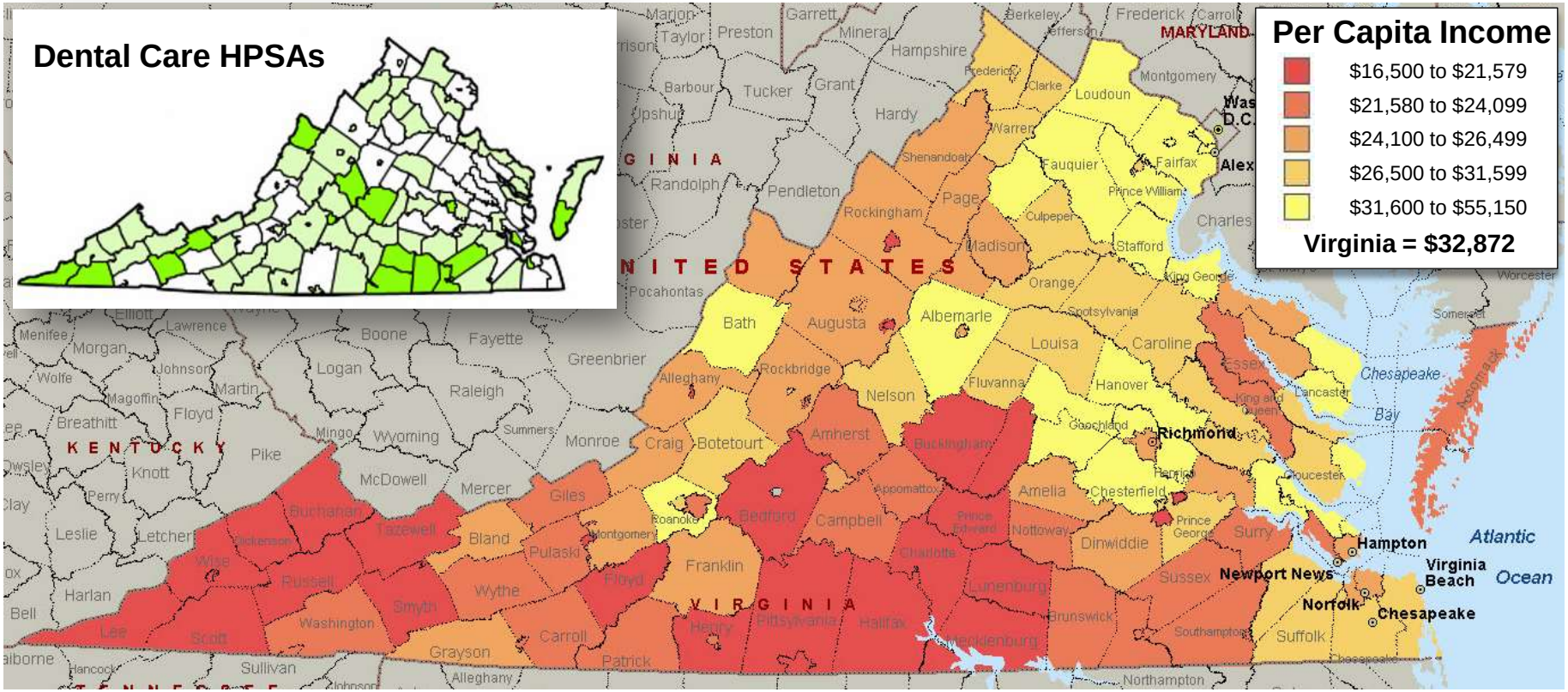
Snapshot of Oral Health Access in Virginia

- Private Practice Dentists
  - 4,000 licensed dentist in VA
- Dental safety net
  - Free Clinics
  - Community Health Centers
  - VDH Clinics
  - 14 localities have no Medicaid dentist
- VDH programs
  - School-based sealant programs
- Mobile clinics
  - MOM projects/Give Kids a Smile



Snapshot of Oral Health Access in Virginia

Disparities in dental access are a major concern



Source: Dental Care HPSA map from http://datawarehouse.hrsa.gov/hpsadetail.aspx. Per capita income map from Community Health Solutions analysis of data from Alteryx, Inc.

Dental Disease Costs Everyone

- Over $7 million dollars in OP OR for dental issues
- Over a million lost school hours in Virginia [2]
- 75,915 lost work days in Virginia [2]
- 52% of new armed forces recruits had dental problems that needed urgent attention and would delay overseas deployments [3]
- Dental problems were the leading reason why uninsured patients visited EDs [4]
- 21% of all adults in Virginia have lost all of their natural teeth[5]

Smiles for Children

- Virginia Medicaid dental program administered by DentaQuest for DMAS since July 2005
- Goals continue to be to increase utilization and access
- Ongoing collaboration among DMAS, providers, and oral health interests including VDA, Medicaid CHIP Dental Association, CMS, Virginia Department of Health and Virginia Oral Health Coalition
- Continued Dental Advisory Committee (DAC) Involvement

SFC - Coverage

Children:

Preventive

Restorative

Orthodontic

- Under 21 up to 200% FPL through Medicaid, FAMIS and FAMIS Plus

Adults:

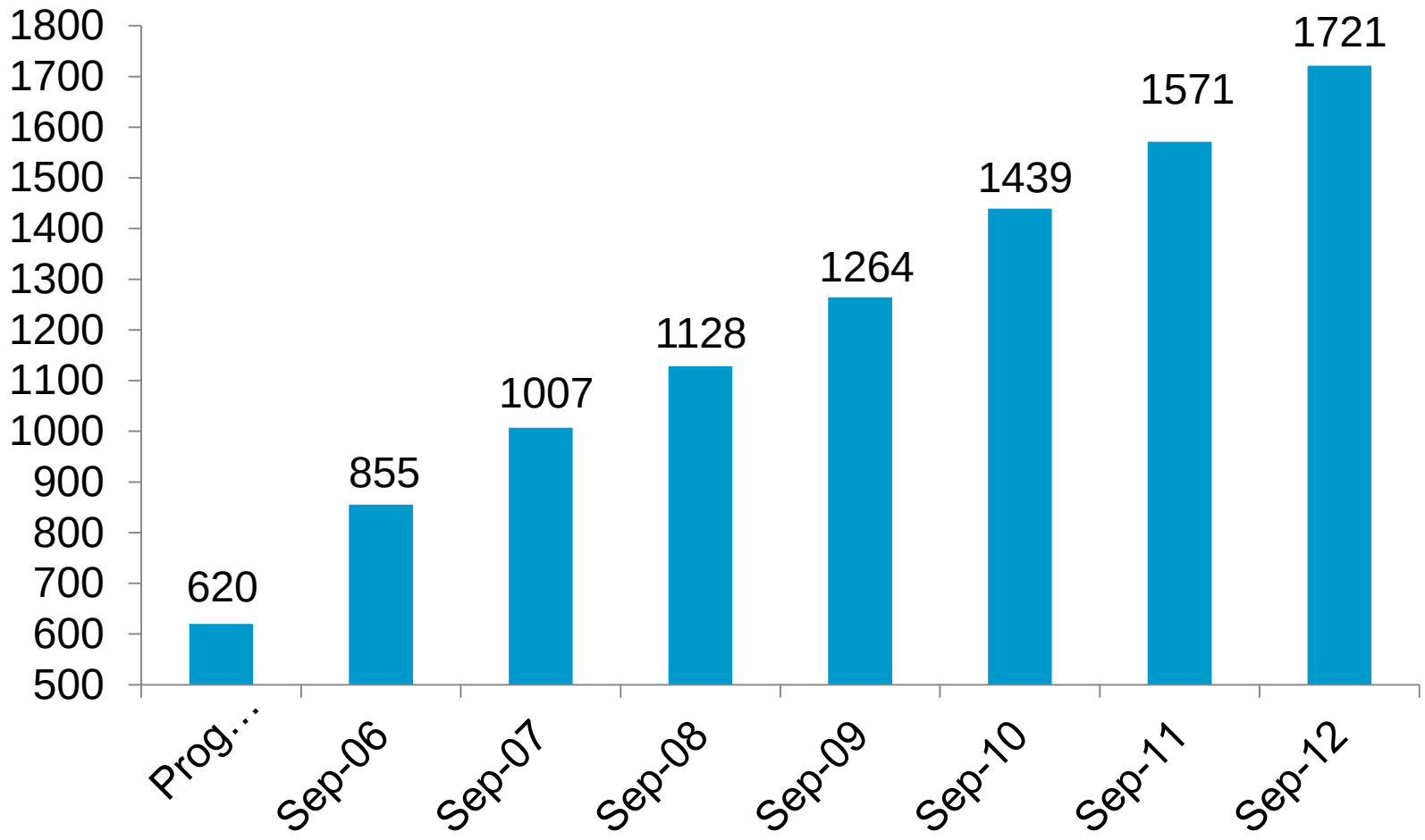
Emergency Extractions and Related Diagnostic services

- Parents up to 29% FPL;
- Aged, blind, or disabled up to 80% FPL

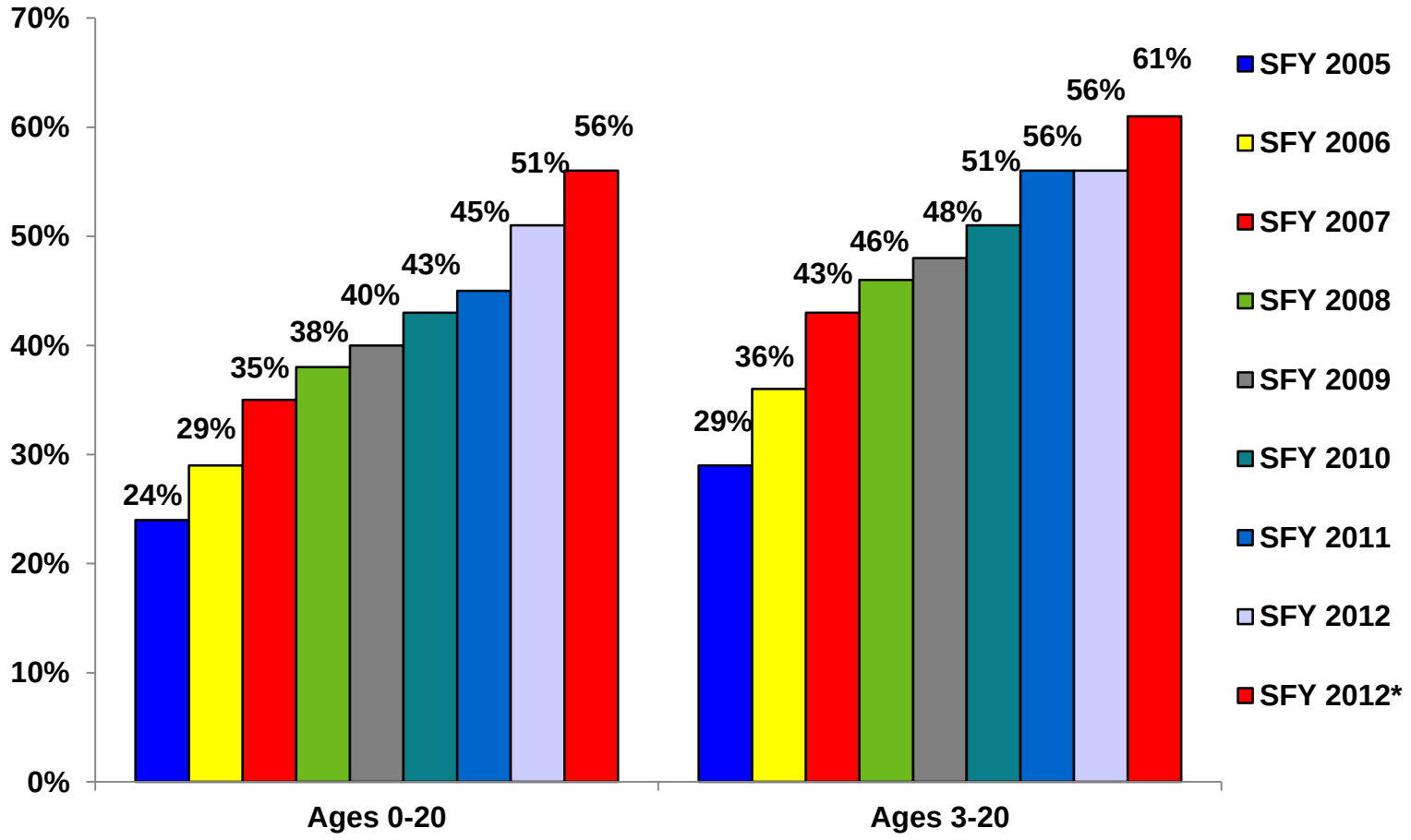
Continued Success

- 177% increase in number of SFC pediatric, specialty and general dentists
  - 1721 providers as of October 1, 2012
  - 80% submit claims regularly
  - Most take new patients
  - 99% provider satisfaction
- 128% increase in number of children accessing dental services
- Virginia Chairs the CMS Oral Health Technical Advisory Group

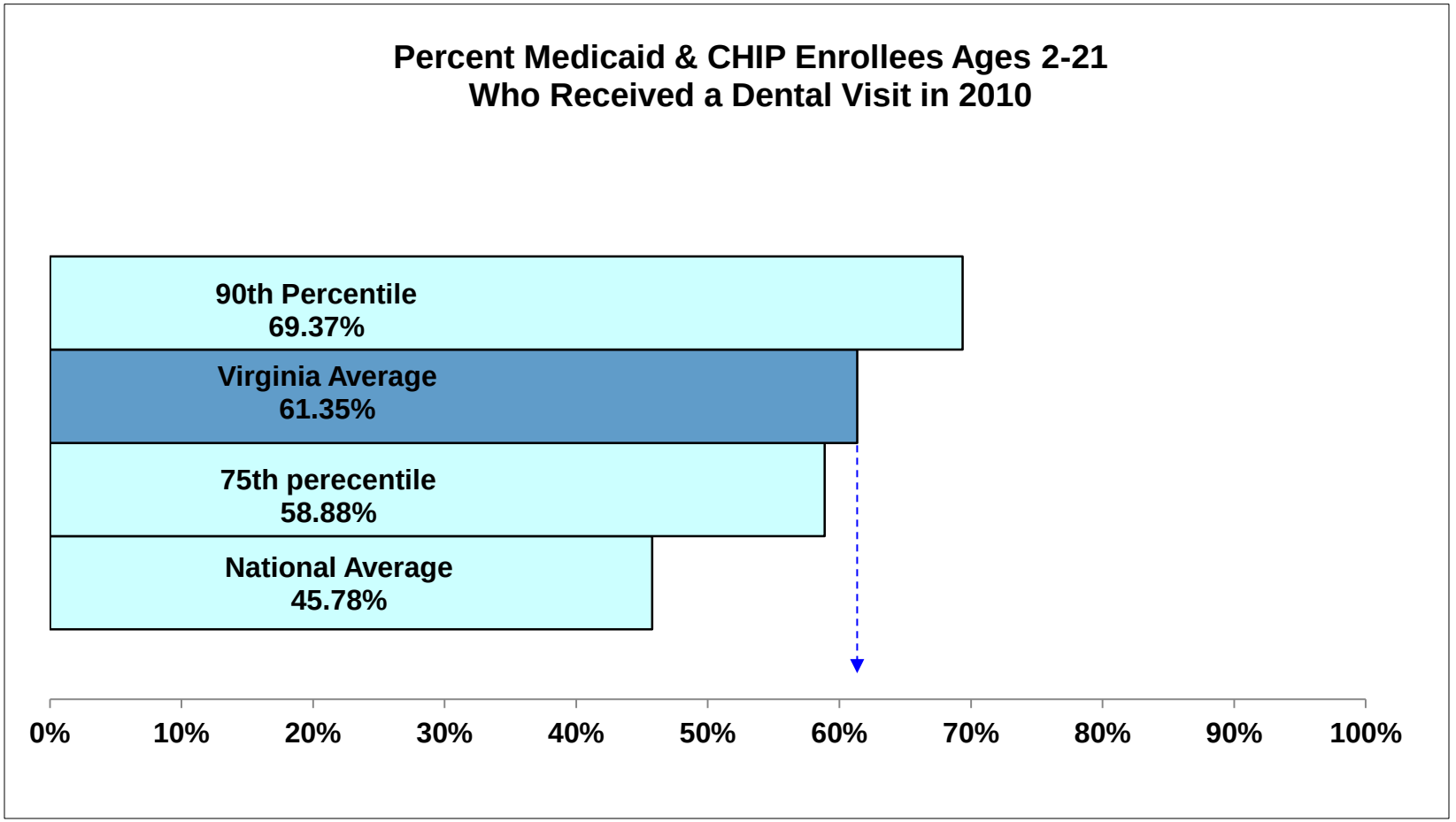
SFC Providers



Utilization



Annual Dental Visit Comparing SFC to HEDIS 2012

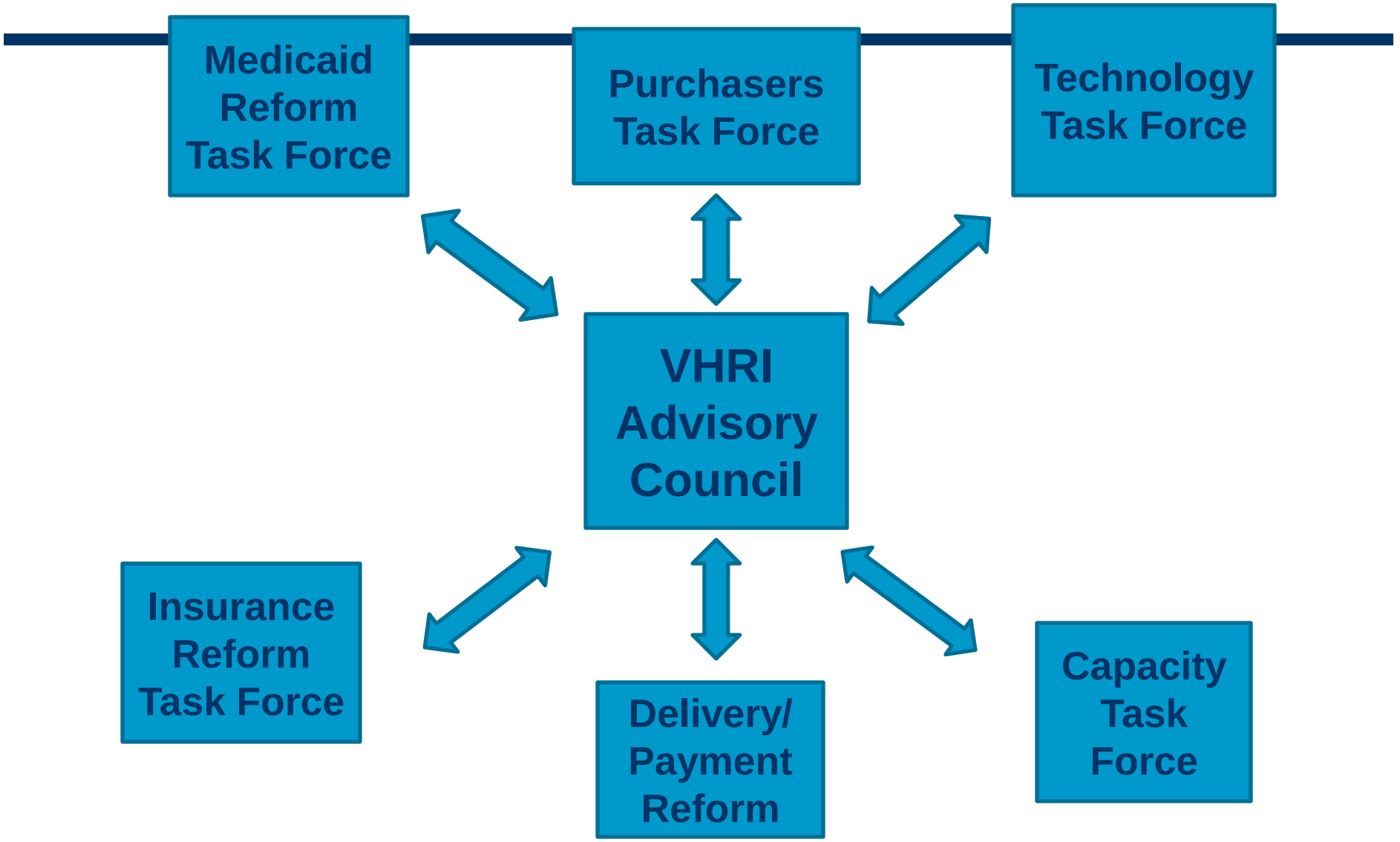


Opportunities

- Working to improve application of sealant rates
- Developing dental homes for children
- Targeting SFC network development in low access areas

Challenges

- Unchanged fee schedule reimbursement since 2005
- Health reform
- Increased enrollment due to economic downturn
- Fewer new dentists especially in underserved/rural areas
- Limited awareness of integral relationship between oral health and overall health


Medicaid Reform Task Force
Purchasers Task Force
Technology Task Force
VHRI Advisory Council
Insurance Reform Task Force
Delivery/ Payment Reform
Capacity Task Force

Notable Achievements in 2012

- **Creation of the Virginia Center for Health Innovation**

- **Expansion of the Capacity of Health Care Providers**
  - Nurse Practitioners: HB346 (O'Bannon)
  - Dental Hygienists/Licensure for Dental Faculty: SB146 (Puckett); HB344 (O'Bannon)/SB384 (McEachin)

- **Expansion Health Care Information and Technology**
  - All Payers Claims Database: HB343 (O'Bannon)/SB135 (Puller)

Notable Achievements in 2012

- **Implementation of Medicaid Reform**
  - Care Coordination Expansion
  - Program Integrity
  - Electronic Health Records
  - Eligibility System

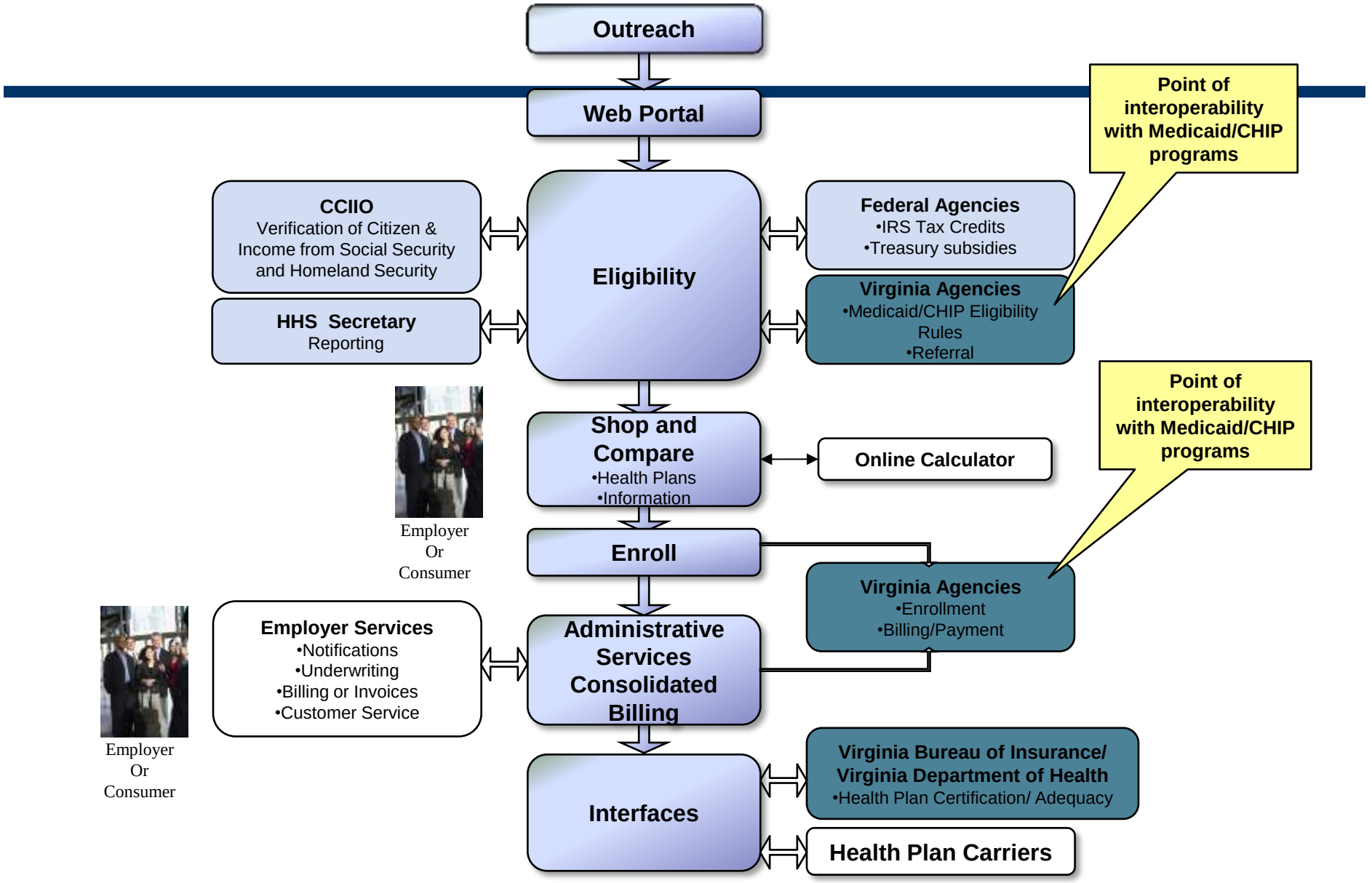
- **Implementation of Insurance Reform**
  - Continue Planning for Exchange

PAUSE

Health Benefit Exchange Five Core Functions

Eligibility	Accept applications from individuals and small businesses; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; determine employer and employee eligibility for SHOP enrollment; connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and conduct redeterminations and appeals.
Enrollment	Enrollment of consumers into qualified health plans; transactions with Qualified Health Plans and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions.
Consumer Assistance	Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.
Plan Management	Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer and QHP certification, monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.
Financial Management	Premium aggregation for SHOP (option to administer individual consumer premiums); user fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs.

Benefits Exchange Services Concept Diagram – Typical Solution



Note: Technology is based on a Service Oriented Architecture (distributed web services) including use of business rules engine

Exchange Timeline

June 2012
Supreme Court decision on healthcare reform

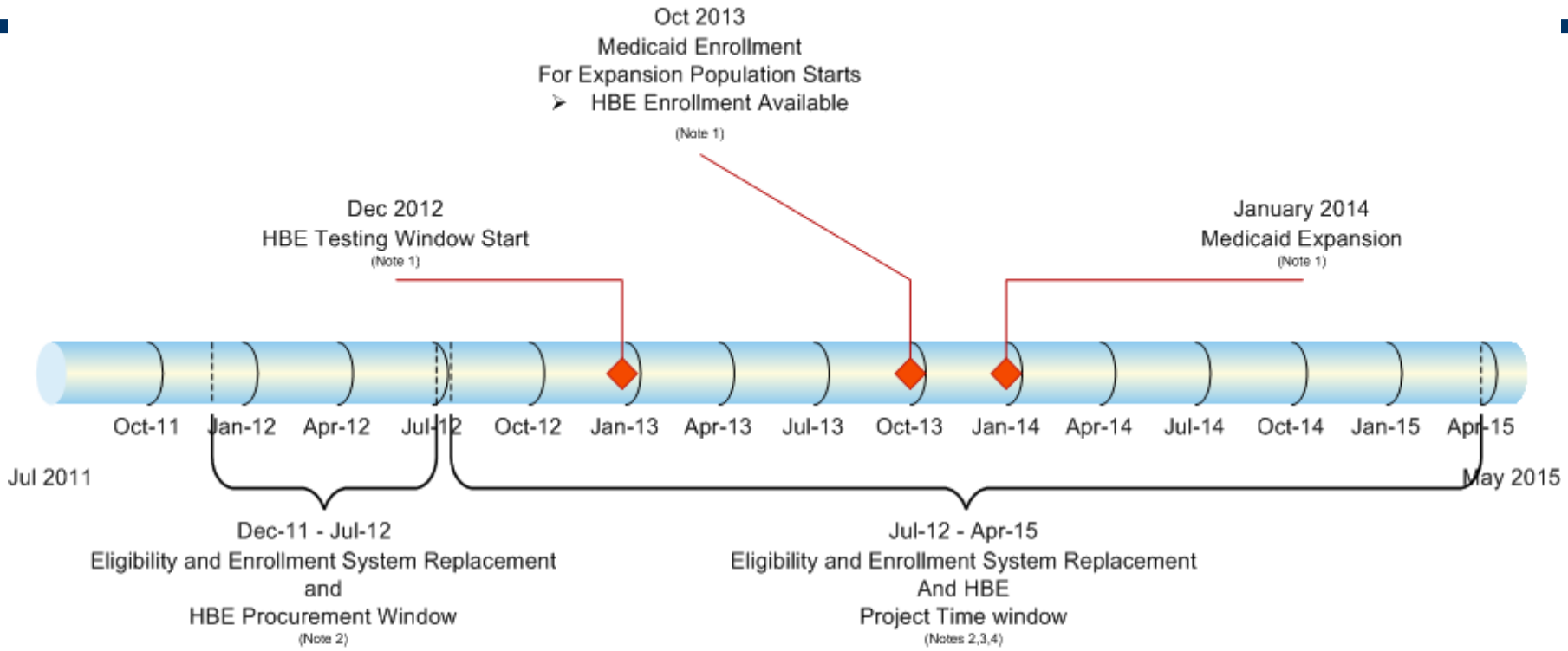
October 2013
Exchange opens for enrollment

December 31, 2014
Exchange must be self-sustaining

2012	2013	2014	2015

December 31, 2012
State must certify that it is ready to launch Exchange in 2014

Timeline

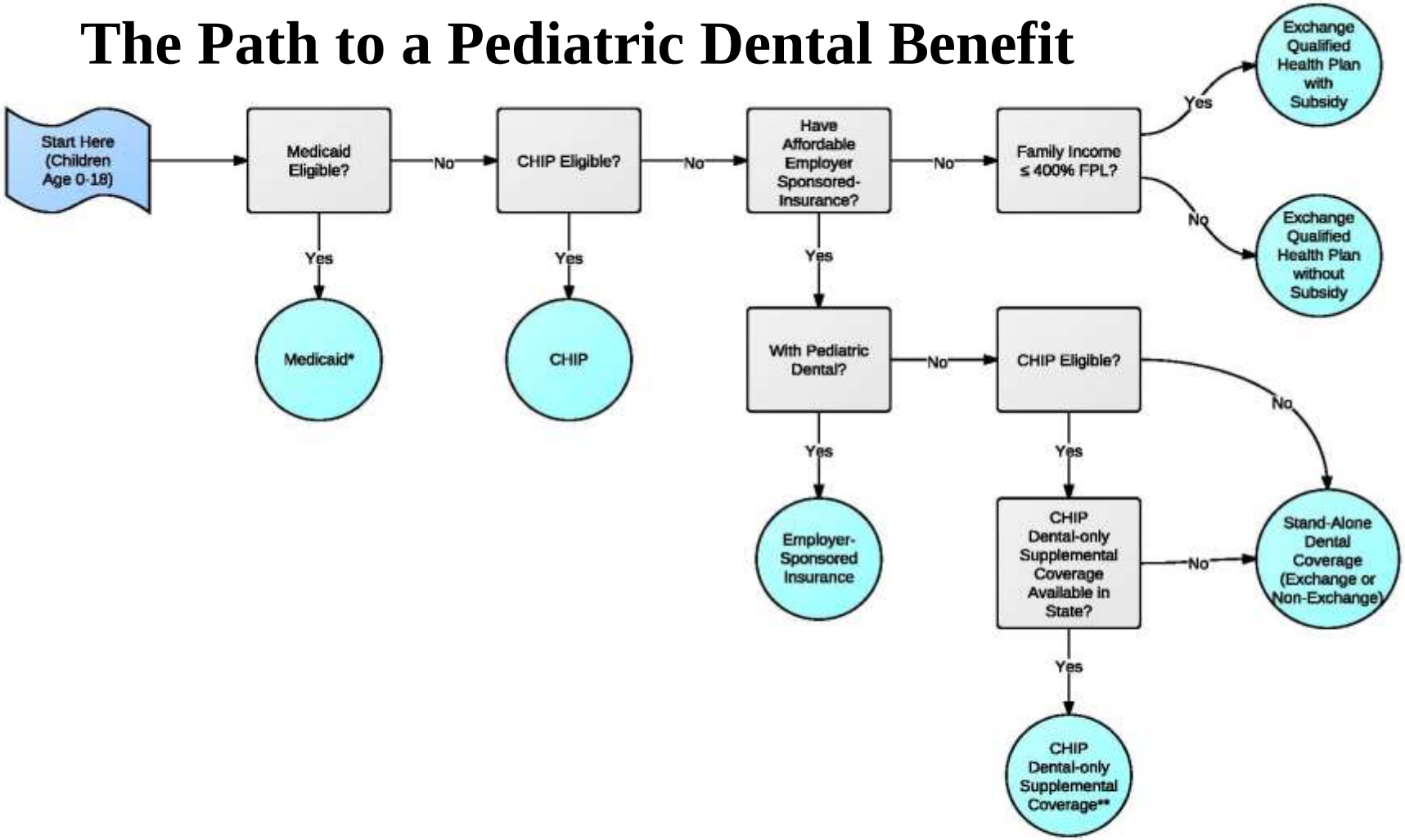


Notes:
1. Diamond milestones are federal mandated dates.
2. COV-HIE phases based on current projections.
3. Projects will be using VITA's SOA development, testing, and production environments currently under construction; including Enterprise Data Management.
4. HBE and Medicaid/CHIP programs are priorities. Full functionality may not initially be available for all social service programs.

The Challenge – Pediatric Benefit

- Ensuring adequate dental providers to care for increase in insured
- Ensuring the subsidies and cost-sharing is available to consumers purchasing pediatric dental coverage
- Ensuring consumers are aware of the pediatric dental benefit, which may be confusing
- VHRI recommended Smiles for Children benchmark for pediatric dental benefit

The Path to a Pediatric Dental Benefit



Overview of Pediatric Dental Benefits
Medicaid: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
CHIP: State determined benefits consistent with federal CHIP rules
Employer-Sponsored Insurance: Dental benefits often limited to a yearly cap (average is $1500)
Qualified Health Plan: Essential health benefits determined by the state consistent with federal rules

*Medicaid may "wrap around" any existing private coverage as the payer of last resort.

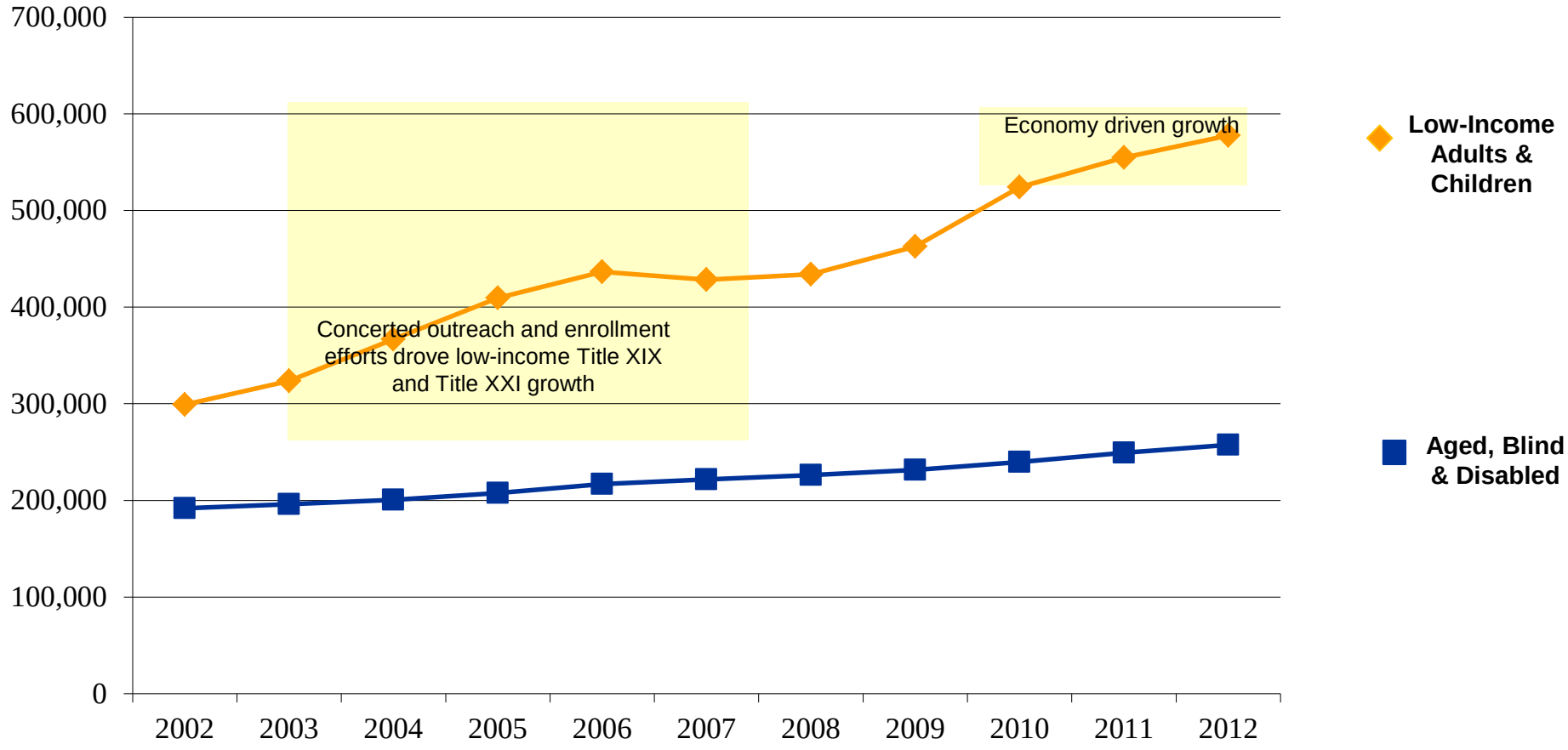
**States have the option under CHIPRA to provide supplemental or wrap around insurance to CHIP eligible children who have medical coverage through their parents but no dental insurance.

Slide courtesy of Children's Dental Health Project

Medicaid Reforms

Post SCOTUS

Virginia Medicaid Enrollment Trends FY02 - FY12



Notes:

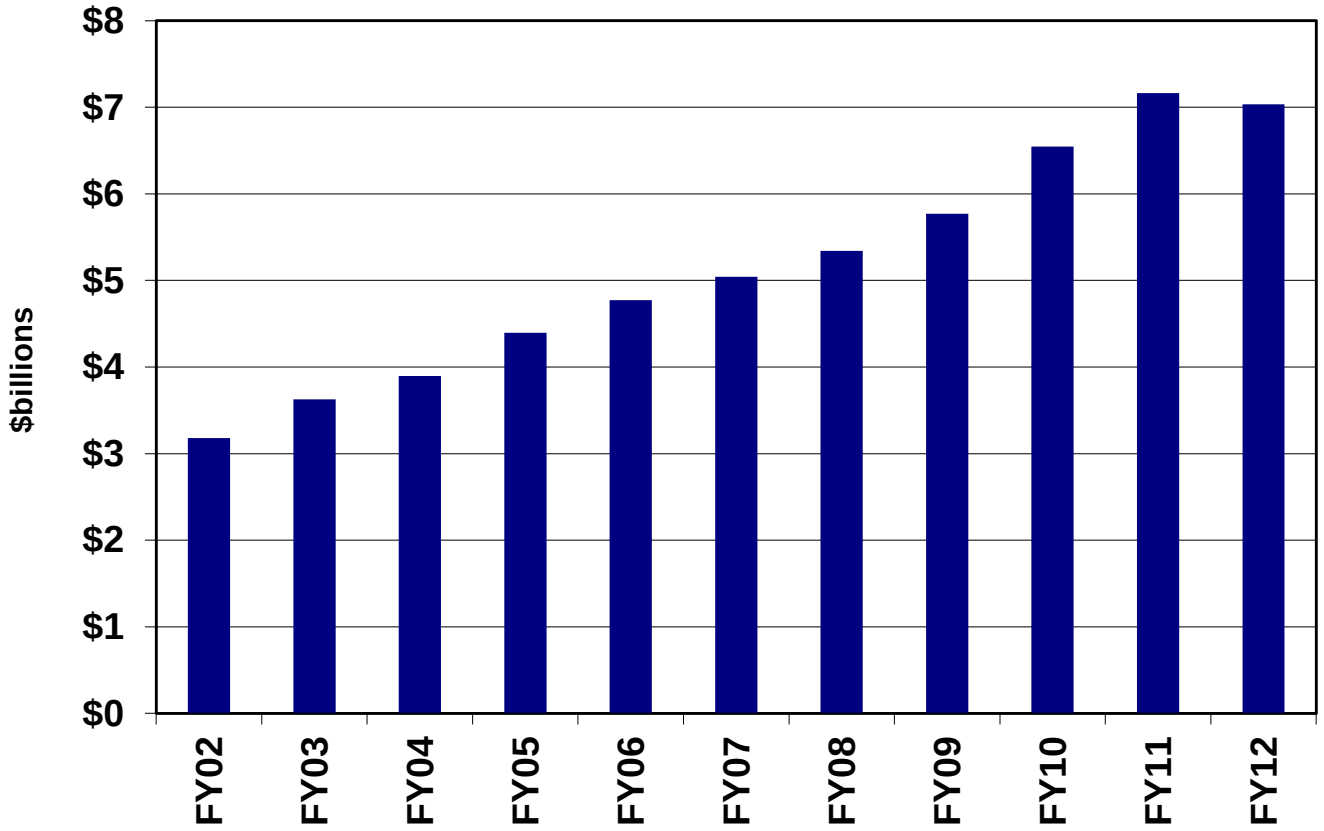
Average monthly enrollment in the Virginia Medicaid, as of the 1st of each month.

Medicaid: average annual growth 2002-2012 – 5%;

Low-income adults/children population - average annual growth rate – 7%;

ABD population – average annual growth rate – 3%; (increases in LTC waiver slots & enrollments)

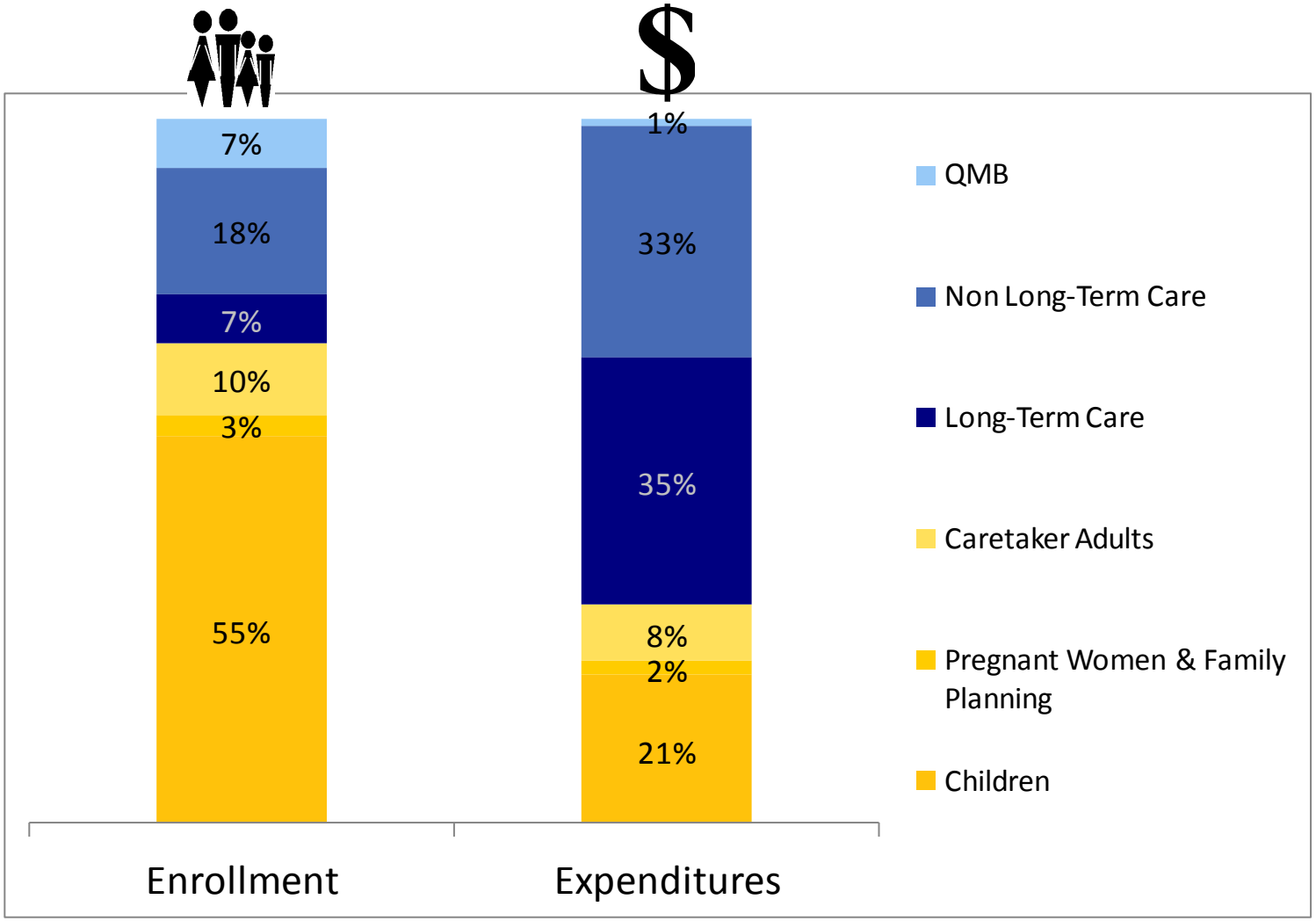
Virginia Medicaid Expenditures



Top Expenditure Drivers

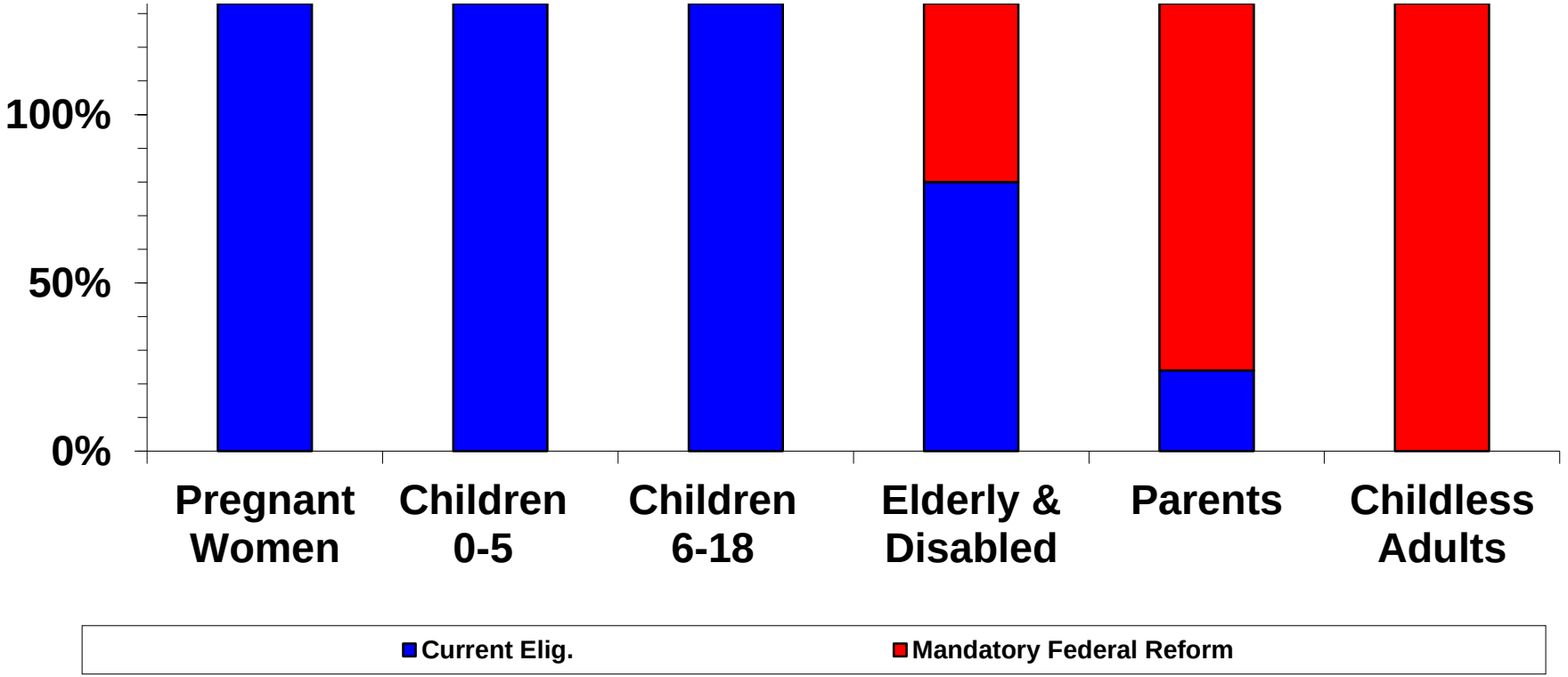
- **Enrollment Growth:** ***Now provide coverage to over 400,000 more members than 10 years ago (80% increase)***
- **Growth in the cost of health care**
- **Specific Services:** ***Significant growth in expenditures for Home & Community Based Long-Term Care services and Community Behavioral Health services***

Medicaid Enrollment v. Spending



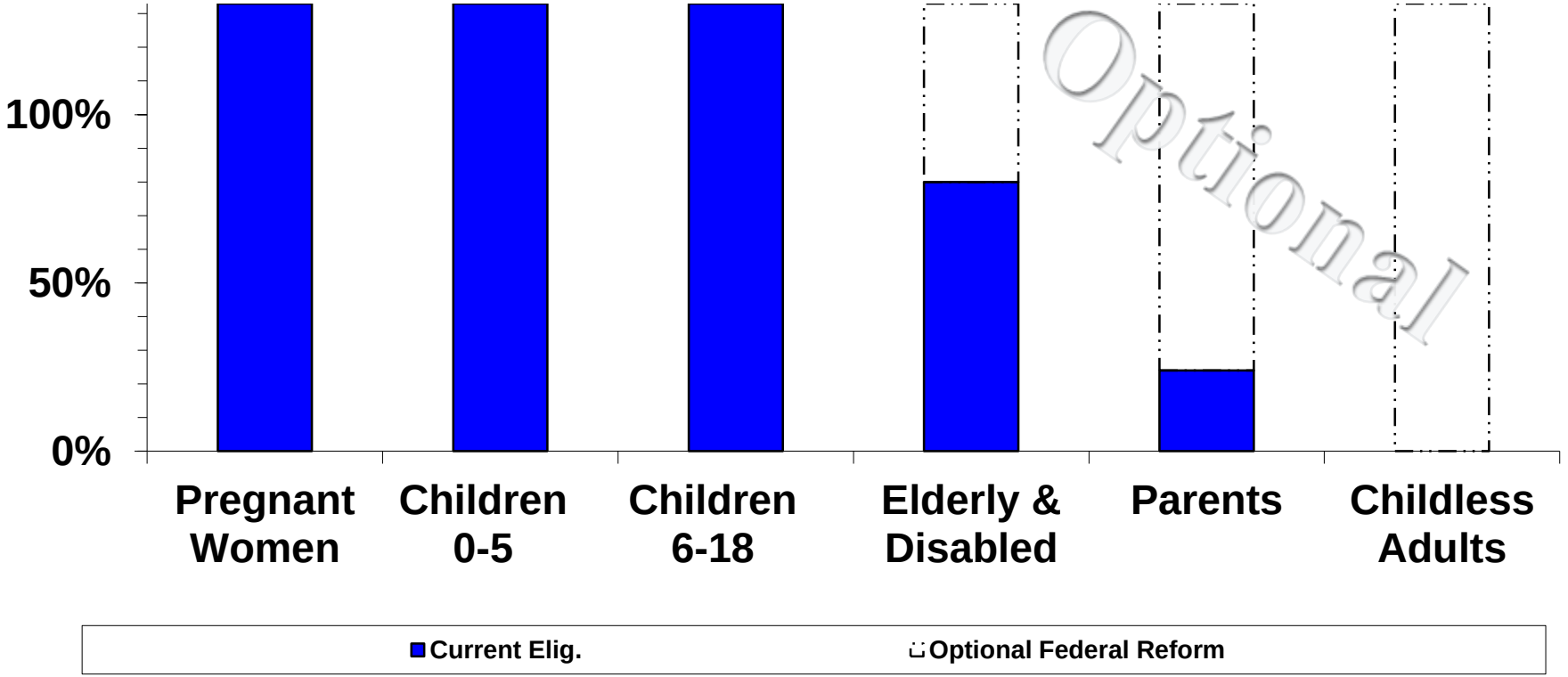
Eligibility Expansion: What We Thought Before June 28th

- Effective January 1, 2014: Mandatory Expansion of Medicaid Coverage of Adults to 133% of the Federal Poverty Level (FPL), plus a 5% income disregard



Eligibility Expansion: What We Know Now

- The Supreme Court effectively ruled that the Medicaid Expansion was optional for states
- This ruling causes the expansion to be a policy choice for Virginia, as opposed to a federal mandate



Eligibility Expansion: Potential Impacts

- When implemented, the mandatory expansion was estimated to:
  - add upwards of 425K* “new” + “woodwork” recipients to Virginia’s Medicaid roles
    - “new” population subject to an enhanced federal match rate
    - “woodwork” population under the existing match
  - require an additional State Medicaid expenditure of upwards of $2.15* billion through 2022
- But…
  - DMAS now has no authority to implement the expansion without explicit policy direction and appropriation from the Governor and the General Assembly
  - It is unclear if states will have any options for expanding in ways other than what was heretofore required under PPACA, while still securing the enhanced federal match

* Estimates from the 8-21-10 DMAS presentation to the Virginia Health Reform Initiative Advisory Committee; DMAS is currently re-estimating the impact of the now-optional expansion , but those estimates are not yet available

Beyond the Expansion, Eligibility Reforms Remain Mandatory

- Regardless of Virginia's decisions surrounding any potential Medicaid expansion, many eligibility "reforms" remain mandatory for Virginia
  - Modified Adjusted Gross Income (MAGI): As of January 1, 2014, PPACA modified the way states will calculate income for many existing coverage groups, primarily children, pregnant women, and low-income adults with children

- A new Eligibility and Enrollment (E&E) system and administrative structural changes are required to comply with MAGI and other provisions of PPACA for the existing population, regardless of the State's decision to expand coverage

- The Supreme Court decision did not remove the Maintenance of Eligibility (MOE) requirement under the PPACA

Payment/Provider "Reforms" with a Substantial Impact on Virginia

- The PPACA contains substantial payment/provider reforms that remain a significant concern to DMAS, including (among others):
  - Mandated reductions in federal Disproportionate Share Hospital (DSH) payment under Medicaid
  - Mandated increase (to Medicare levels) for Primary Care Physician Services in Medicaid
  - Significant federal changes and state administrative complexity in Medicaid provider screening, enrollment and termination requirements

Open Questions

- Will the ACA remain law?
- If not, what provisions will remain?
- If yes, should Virginia operate its own Exchange
- Will Medicaid Expand? And if so, to what level?
- How will the dental benefit be provided in the Exchange: standalone or within health plan?