

**REPORT OF THE
JOINT SUBCOMMITTEE STUDYING THE**

**Feasibility of Preserving a
Regional Health Planning
Mechanism in the
Commonwealth**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



House Document No. 37

**COMMONWEALTH OF VIRGINIA
RICHMOND
1984**

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**Report of the
Joint Subcommittee Studying the
Feasibility of Preserving a Regional
Health Planning Mechanism in the Commonwealth
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
February, 1984**

To: Honorable Charles S. Robb, Governor of Virginia
and
The General Assembly of Virginia

I. Origin of the Study

The Joint Subcommittee to Study the Feasibility of Preserving a Regional Health Planning Mechanism in the Commonwealth was established through House Joint Resolution No. 104 during the 1982 Session of the General Assembly. The Subcommittee was charged with studying the preservation of a regional health planning mechanism in anticipation of the reduction or termination of federal funding of the health systems agencies and the Statewide Health Coordinating Council. The Joint Subcommittee was continued by House Joint Resolution No. 45 during the 1983 Session (see Appendix A). The charge to the Subcommittee was broadened by this resolution and included the following goals:

1. To design a detailed system for health planning and regulation tailored to Virginia's unique needs; and
2. To develop a permanent funding mechanism for regional health planning in Virginia.

In accomplishing these goals, the Subcommittee was directed to analyze the systems of other states and evaluate the various proposals received during 1982.

Appointed to serve on the Joint Subcommittee were Delegates Warren G. Stambaugh of Arlington, Chairman; Mary A. Marshall of Arlington; C. Jefferson Stafford of Pearisburg; and Senators Elmon T. Gray of Waverly and Edward M. Holland of Arlington, Vice-Chairman. Citizen members appointed were Thomas R. Bernier, George E. Broman, M.D., Gillium M. Cobbs, James L. Gore, Carter T. Melton, Raymond O. Perry, E. Wayne Titmus, and Barbara S. Bolton, R.N.

II. Scope of the Joint Subcommittee's Work

The Joint Subcommittee met for the first time in April, 1983, to consider other states' health planning laws or proposals and to determine how to proceed with the study. The recently enacted health planning laws of Florida and Maryland and the proposals for revising the health planning laws of Washington State were reviewed for the Subcommittee by staff (see Appendix B for outlines). The Subcommittee was presented with several alternative methods for proceeding with the study (see Appendix C).

Following an extensive discussion, the Joint Subcommittee decided to attend the annual meeting of the American Health Planning Association and to conduct one informal and one formal meeting of the committee during this time. Staff was directed to draft a discussion outline for the formal meeting which addressed the following issues (see Appendix D for discussion outline):

1. State reimbursement system requirements, practicality, effects, etc. What do we have to do to go to a state reimbursement system? What are the alternatives to DRG's?
2. Alternatives to geographical boundaries for the local planning agencies. Can the health planning scheme be the same as the planning district commission scheme/process? Can we do this under federal law?
3. How can the regulatory functions be most effectively shifted to the state level, if the planning

activity is the basis for the regulatory functions?

4. What are the aspects of regulation that could be eliminated? What are we regulating that we should not be and what are we not regulating that we should?
5. What should be the content of local health planning, e.g., education, resource monitoring, etc.?

The Joint Subcommittee met on the first day of the annual meeting of the American Health Planning Association and members conferred on which discussion groups each would attend. Many issues related to health planning and capital construction regulation were included in these discussions, i.e., data collection systems, diagnosis related groups, certificate of need, capital construction caps or ceilings, all-payers rate setting systems and many others.

The members of the Joint Subcommittee felt that the exposure to these discussions was invaluable in providing insight into possible approaches to health planning. It became apparent that any health planning mechanism designed to meet the future needs of the state would have to be flexible and sensitive to change. The rapid changes taking place in the reimbursement systems had created a new climate in the health care industry which could not be ignored.

In March, 1983, the federal government passed amendments to the Social Security Act relating to Medicare reimbursements, which are considered by all constituencies of the health care industry to be far reaching. The federal amendments establish a prospective reimbursement system based on "diagnosis related groups" or DRG's which will be phased in over three years.

The country will be divided into nine regions and different rates for DRG's will be established for urban and rural hospitals. If a hospital can serve a patient within the "length of stay" established for his DRG, the hospital will gain or lose profit according to its costs. If the hospital's costs are greater than the DRG rate, then it will lose; however, if its costs are less than the DRG rate or the patient can be treated and released within a shorter period, then the hospital gets to keep the profits.

It can be readily understood that this system provides an incentive for hospitals to contain costs. Obviously, also, the physicians' role in this matter becomes crucial as they are the generators of the costs. As a group, physicians are resistant to change and, as a result, hospitals may have to educate actively their staff physicians in order to maintain their fiscal viability. In reference to the need to involve the physicians, DRG's create a strong, primary incentive for hospital administrators to contain costs, but only a weak, secondary incentive for physicians. Because physicians control the hospitals' costs, the need for their cooperation in containing costs and maintaining accurate, up-to-date records will have to be a primary focus for the hospital administrators.

Each hospital will have to evaluate its practices in relationship to the DRG rates. Each hospital will also have to impress upon its staff that the purpose of keeping medical records will be broadened by the DRG's. Medical records have always been treatment tools, e.g., the doctors' notes, which are used to refresh his memory and provide a record of the procedures used, medications given and findings on the patient. Medical records will be, under the DRG system, accounting tools, and this additional emphasis will require an adjustment in attitudes of physicians. Without accurate records, hospitals will lose money.

DRG's might be defined as "best estimates." They are computations of the average cost of treatment for specific illnesses. Obviously, the variety of circumstances under which hospitals operate cannot be taken into account. Therefore, the federal act establishes what are known as "outlier payments." These are payments for cases which for some valid reason exceed the limits of the "lengths of stay" established for the DRG's. The federal act also directs that a study of possible outlier payments for shorter stays be conducted.

The New Jersey prospective payment rate-setting system, which was the pioneer in the use of DRG's, was established by a 1978 law. The one effect of this system that appears to be accepted by the experts is that hospitals are being forced to change. One of the possible effects of DRG's, as the New Jersey experience reveals, may be that, initially, hospitals with financial problems appear to respond more readily to the pressure of the DRG's to contain costs than hospitals with sound profit margins. All hospitals eventually begin to feel the pressure. These

effects have been explained by the fact that the initial rates in New Jersey were deliberately generous. The New Jersey rates also included "working cash infusion" and, for the first time, "uncompensated care." The federal DRG rates will not include these factors; however, the initial rates will also be more generous because the first year's phase-in will be 75% cost-based and 25% DRG based. As the phase-in period progresses, the rates will be shifted away from cost-based factors.

Part of the reason for the concern for hospitals' viability expressed by many health care industry experts is that the federal law provides for a reduction in the capital costs which are eligible for reimbursement. Return on equity will be reduced by one and one-half times to an amount equal to the rate of interest paid on the assets of the Hospital Insurance Trust Fund. The conference report on the federal act explains that additional legislation can be expected to address the issue of capital costs before October 1, 1986 (the third year of the phase-in period). The Secretary of the Department of Health and Human Services has been directed in the Act to conduct a study on "the methods by which capital, including return on equity, can be incorporated into the prospective payments system."

The system in New Jersey is said to reward rapid turnover of patients. This will no doubt be true of the DRG payments for Medicare. It is important to know that 34% of Virginia hospitals' revenue in 1981 was paid by Medicare. Medicaid paid only 9% of the gross patient revenues; Blue Cross paid 22% of the gross patient revenues; the commercial carriers paid 18% and self-pay and others paid 17% (data provided by Laurens Sartoris of the Virginia Hospital Association to the Joint Subcommittee Studying Regional Health Planning at its April 18, 1983 meeting). Since Medicare accounts for the largest percentage of the gross patient revenues of the Virginia hospitals, the practices, which develop as DRG's are implemented, will probably have a ripple effect on the other payment systems.

Some of the possible effects that may result as the DRG's are implemented, as judged by the New Jersey experience, are:

1. Rates may not be updated and established in a timely way. However, it is important to keep in mind that in New Jersey rates are set for each hospital for each DRG, whereas the federal system will set rates for two categories of hospitals, rural and urban, in each of the nine regions;
2. Differences in operating circumstances and patient mixes will not be taken into consideration, and therefore some areas of the state will experience more changes than others;
3. Payments will be computed according to the discharge diagnosis, which will result in the hospitals using that diagnosis providing the most favorable rate and could result in what some experts are calling "DRG creep";
4. Quality of care may be affected by discharge of patients within the "length of stay" established for their DRG (in order to obtain the most favorable payment rate) regardless of whether they are entirely well;
5. Specialization may be developing with hospitals treating primarily those patients they are best equipped to handle most cost effectively;
6. Strain may be placed on public institutions, if the trend towards transferring costly patients to these institutions becomes more pronounced;
7. Patterns of patient care may experience substantial shifts; for example, out-patient treatment will most likely become more frequent and more comprehensive;
8. Rural and inner city hospitals may experience difficulties or fold;
9. The system is complicated and appears to evolve to be more so rather than less so, which may result in a heavy regulatory burden at least until hospital administrators revise their accounting procedures and educate their staff physicians;

10. Utilization review will probably become an in-house reality for each hospital;
11. Cost-shifting will probably become a thing of the past, because all major reimbursement systems will have moved to prospective payment methods;
12. Indigent care will increase and become a matter of concern to the state as a result of the inability to shift costs because of the various prospective payment systems (DRG's, Medicaid and Preferred Provider Organizations in Virginia) and hospitals will increasingly be unable to provide uncompensated care; and
13. Hospital administrators and other health care constituents may push for a lessening or a shift in the state's regulatory role as provided in the certificate of need program.

The Joint Subcommittee reviewed the discussion outline developed for the issues given above. The following tentative decisions were made:

1. The Joint Subcommittee did not adopt a position in favor of a state rate-setting or reimbursement system; however, such systems were considered intriguing by some of the members;
2. The present geographical boundaries or health service areas were considered the most viable for regional health planning at this time;
3. The Joint Subcommittee directed staff to develop several alternatives for shifting the regulatory functions to the state level or redesigning the regional health planning mechanism;
4. The Joint Subcommittee also directed staff to develop a generic list of projects which could be eliminated from COPN;
5. The staff outline section on the contents of local health plan was discussed at length and generally the Subcommittee concurred with these suggestions; and
6. Much discussion was conducted on the possible definition of the health care environment as it will or might exist in five years or more.

The Joint Subcommittee agreed that the market was changing more rapidly than anyone had anticipated and in directions that had not been expected. Staff's description of possible changes in the industry were felt to be as valid as anyone else's.

The Joint Subcommittee directed staff to develop or design some alternatives to satisfy the following:

1. A resolution on a data collection system for health care statistics. Because of the recent gaps created by elimination of federal data programs and the vital need over the next few years to monitor the developments in the health care market, this data collection system was considered by the Joint Subcommittee to be attractive. Several of the members of the Joint Subcommittee had attended presentations on data collection systems designed by AT & T and other companies. The Joint Subcommittee also requested staff to contact AT & T to ask for a presentation, similar to the ones being given to business round tables, on their system, which is considered exemplary;
2. A generic list of suggested exemptions from COPN. It appeared to the Joint Subcommittee that the usefulness of COPN was being lessened as the prospective payment systems forced the various elements of the market to compete and that, although still necessary, the scope of COPN should be constricted;
3. Proposed alternatives for simplification of the review process for COPN applications. The present process in which the review by the HSA could take weeks and require attendance by the applicant of up to six meetings and then the SCHH and Health Department review would be conducted appeared to the Subcommittee extremely time-consuming, costly and complicated;
4. A more detailed proposal for the design of usable local health plans. Consistent

methodology, useful information and a general refocusing of the HSA's on planning rather than regulation seemed appropriate to the Subcommittee.

5. Descriptions of some or all of the five state all-payers rate-setting systems. To some members of the Joint Subcommittee, these systems which cover Medicare as well as Medicaid and all other third party payors appeared to be the wave of the future. To other members of the Committee, these systems seemed the most egregious regulation and restriction on competition.

At the meeting in October, all of these materials were presented to the Subcommittee and Dr. Donald Johnson, Biostatistician for AT & T, described the company's data collection system. The Subcommittee discussed these issues and made certain changes and revisions. Staff was directed to incorporate these suggestions and include the requirements for establishing an all-payers rate-setting system in a set of proposals. These proposals were sent to the members of the Joint Subcommittee for comments, printed and distributed widely across the state to health care providers, associations and others prior to public hearing (see Appendix E for proposals). The Joint Subcommittee held its public hearing on November 28, 1983, and a work session on the next day.

III. Conclusions

Much testimony was heard at the public hearing concerning the need for eliminating home health services, hospices, "life care" facilities and health maintenance organizations from the certificate of need process. After considerable discussion among the members of the Joint Subcommittee, it was decided to recommend that only home health services be eliminated at this time. Home health services, it was felt, are subject to market pressures; it appears to be impossible to ascertain "need" for these facilities, such facilities do not require capital construction and are cost-effective alternatives to institutionalization. Hospices, it was felt, are not clearly defined at this time and the regulations had not been written to license such facilities. "Life care" facilities, those facilities having both a home for adults and a nursing home and requiring the signing of a "life care" contract, are frequently certified for payment under Medicare and Medicaid for nursing home beds. Therefore, allowing proliferation would, perhaps, mean creation of excess nursing home beds and increased costs for medical assistance.

It was pointed out that health maintenance organizations are not covered except when they build facilities or buy equipment which exceed the monetary ceilings. Allowing health maintenance organizations to build or buy at will would not be fair to hospitals and other facilities.

The Joint Subcommittee applauded the efforts of the Board and Department of Health in reducing through regulations the number of projects required to obtain COPN. The testimony received by the Subcommittee indicated that, in some cases, much time and effort was being required of applicants in the review process used by the HSA's. Some HSA's were holding many meetings on every application. This delay was considered unnecessary and expensive. Although the Joint Subcommittee had considered eliminating the role of the HSA's in review of applications for COPN, this idea was rejected in favor of limiting their role. Therefore, the Subcommittee felt the HSA's should be limited to two meetings on any application and the applicant should be given the opportunity to make a presentation before the HSA board, if desired. The presentations were considered important by providers as it would give them an opportunity to refute recommendations of HSA staff for denial.

The present law requires that appeals of COPN decisions must go through two levels - first the informal appeal and then the formal appeal. This is a very time consuming and costly process, which the Subcommittee felt could be simplified. Furthermore, if the application must be reviewed by the Statewide Health Coordinating Council prior to the initial determination by the Commissioner, more time and effort is required of the applicant. The Subcommittee also came to believe that the present due process procedure, which provides that the Commissioner make all of the decisions, could create the appearance of conflict of interests and lack of objectivity in the decision-making process. Therefore, the Subcommittee recommended removing the Statewide Health Coordinating Council from the review process altogether, eliminating the informal review and installing a panel to hear the formal review composed of two consumer members and one provider member of the SHCC. The applicant should also be provided the

opportunity to present his case to the Commissioner prior to the initial decision, the Subcommittee felt. This would, the Committee believes, provide a chance for a meeting of the minds before adverse determinations are made.

The Subcommittee felt that the efforts of the Health Systems Agencies and the Statewide Health Coordinating Council should be redirected to health planning activities and deflected from the regulatory process. The Health Systems Agencies are quasi-public agencies and not creatures of the state; as such the importance of their role in the regulatory process should not be increased, but softened. The planning agencies must redirect their efforts to planning. The administrators of these agencies must understand that regulation of the health care industry might well take a different form or disappear altogether in future years. The contents of the health plans, the Subcommittee feels, must be made more relevant to the changing climate of the health care industry. The Subcommittee, therefore, also feels that uniformity in methodology and consistency in contents of the plans should be required and that these elements should be designed at the state level in order to provide a viable basis for the State Health Plan. The Statewide Health Coordinating Council should be responsible for the State Medical Facilities Plan as well as the State Health Plan. The coordination of these plans should provide decision-makers with more accurate, credible data.

The Subcommittee felt the competitive initiatives in Virginia, which are extensive and include Medicare DRG's, prospective rates for Medicaid, Preferred Provider Organizations, Health Maintenance Organizations and self-insurers, should be allowed to operate freely. The health care industry in Virginia is having to adjust to more rapid changes than in most other states because of these competitive initiatives; and although five states have established rate-setting systems, there has not been time to evaluate the effects of these systems. Therefore, it was unanimously agreed not to recommend that Virginia move to an all-payers rate-setting system at this time.

Finally, in view of the reductions in the federal funding for health planning and the financial difficulties faced by some HSA's, the Subcommittee feels that a matching grants program administered by the State Department of Health should be established. This program would require the HSA's to obtain local funds, public or private, and might increase the public relations of the HSA's and strengthen their relationships with the local communities. The Joint Subcommittee wished to make it clear that no obligation was being placed on local government for these funds.

IV. Recommendations

The Subcommittee recommendations are as follows:

1. eliminate home health agencies from the certificate of public need process (all of such agencies, whether free-standing or institutional-based);
2. limit the number of meetings held on an application for certificate of public need by the health systems agencies to two meetings, one of which must be a public hearing;
3. allow the applicant for a CON the opportunity to make a presentation during the decision-making meeting of a health systems agency board;
4. simplify the review - due process procedure for applications for COPN by eliminating the informal review, establishing an advisory appeals panel to hear the formal review, which will be composed of three members of the Statewide Health Coordinating Council - two consumer members and one provider member. This appeals panel must consider the substantive and procedural legal aspects of all applications and make its recommendations to the Commissioner within thirty days. The Commissioner will continue to make the initial determination and the final determination. The final determination will be made fifteen days after he receives the recommendations of the appeals panel and must include the rationale and substantiating facts or statistics if in variance with the recommendations of the panel;
5. allow the applicant for a COPN the opportunity to make a presentation before the Commissioner prior to the initial determination;

6. eliminate the role of the Statewide Health Coordinating Council in the COPN review except for the members of the appeals panel;

7. place responsibility for the State Medical Facilities Plan under the Statewide Health Coordinating Council which already has the responsibility for developing the State Health Plan;

8. require certain components to be included in regional health plans including educational activities, needs assessments focused on gaps in services, overutilization and underutilization of services, data collection focused on facilities, services and utilization of services, recommendations for resource allocation, development of competitive initiatives, recommendations for services to provide a continuum of care and a medical facilities component.

The contents of these components and the methodology will be established by the State Health Department in cooperation with the Health Systems Agencies.

9. request funding for matching grants of up to 6 cents per capita for the health systems agencies; grants to be administered by the Department of Health; and

10. request a study of the feasibility of establishing a Virginia Medical Expense Plan Data Base, because of the decrease in statistics being provided to the states by the federal government and to provide a mechanism for the state to monitor the rapid changes in the health care industry caused by the recent changes in reimbursement systems.

The bills incorporating these recommendations are included in Appendix F of this report.

Respectfully submitted,

Warren G. Stambaugh, Chairman

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DISSENTING-IN-PART OPINION OF

DELEGATE C, JEFFERSON STAFFORD

I am not convinced that the expenditure in recommendation #9 is justified. Also, in recommendation #10, I am not sure that the State should get involved with funding of local health systems agencies if federal funds are not available.

APPENDIX A

HOUSE JOINT RESOLUTION NO. 45

Continuing the study of the Joint Subcommittee on the Feasibility of Preserving a Regional Health Planning Mechanism in the Commonwealth.

Agreed to by the Senate, February 23, 1983

Agreed to by the House of Delegates, February 25, 1983

WHEREAS, the status of the National Health Planning and Resources Development Act, P.L. 93-641, is uncertain at this time; and

WHEREAS, the federal funding of regional health planning has diminished to the extent that the survival of the Health Systems Agencies is in question; and

WHEREAS, the Joint Subcommittee has prepared tentative recommendations on regional health planning which have met with general approval and submitted a report to the Governor and the 1983 General Assembly; and

WHEREAS, the Joint Subcommittee has developed an interim funding mechanism to assure the survival of health planning in Virginia and recommended the adoption of this temporary funding system to the General Assembly; and

WHEREAS, the Joint Subcommittee wishes to stress that this proposed interim funding mechanism, if enacted by the General Assembly, would expire at the end of one year; and

WHEREAS, the Joint Subcommittee has received much conflicting testimony on the appropriate implementation and funding of a Virginia health planning system; and

WHEREAS, in order to develop the details of health planning to meet Virginia's needs, the Joint Subcommittee must analyze the systems of other states and evaluate the various proposals received this year; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the work of the Joint Subcommittee on the Feasibility of Preserving a Regional Health Planning Mechanism in the Commonwealth shall be continued to accomplish the following:

1. To design a detailed system for health planning and regulation tailored to Virginia's unique needs; and

2. To develop a permanent funding mechanism for regional health planning in Virginia.

The Subcommittee shall complete its work in time to submit its recommendations to the 1984 Session of the General Assembly. The membership of the Joint Subcommittee shall remain the same.

The cost of this study shall not exceed \$10,000.

APPENDIX B

OUTLINE OF SOME STATE REVISIONS

OR

PROPOSED REVISIONS OF HEALTH PLANNING

I. Maryland

A. Created a Health Resources Planning Commission in order to provide a decision-making process which is consistent and relatively free of political pressure.

1. Fourteen members - six providers, Secretary of Health, five consumer representatives of the HSA's, two at-large consumer members. All citizen members appointed by the governor.
2. The Commission will be under the administration of the Health Department for budgetary purposes only, has independent decision-making responsibility including the certificate of need program, assignment of the role and designation of the HSA's.
3. HSA's designated as local planning agencies and provided one-year funding mechanism through grants from the Commission.
4. HSA's comment on any proposed project within their area, but full review of each project by HSA's not required.
5. Funding provided through a user fee (tax) on each hospital and nursing home admission of approximately \$1.60 (state hospitals and kidney dialysis treatment units exempted from user fee). Fee slated to raise no more than \$1 million. The Commission develops the user fee through a ratio of actual admissions of each facility to the total admissions of all facilities. Minimum and maximum assessments will be established by the Commission.

B. Major changes in regulatory and planning process:

1. Requires a less detailed analysis of hospitals' operations with a one-level review of proposed projects for certificates of need.
2. Places primary responsibilities for health planning with the new Commission.
3. Consolidates the duties of the SHCC and the SHPDA under the Commission.
4. Maintains HSA's through October, 1983.
5. Provides for local CON hearings, but reduces the authority of HSA's and places the responsibility for hearings in the Commission.
6. Provides the governor with the authority to establish health service areas after one year, each of which would have a health planning agency (approved by the U.S. Secretary of Health and Human Resources, if necessary).
7. Establishes undefined role of local health planning agencies that will require them to prove their worth.
8. Provides the governor and the Commission with broad authority to respond to federal budgetary changes.
9. Establishes criteria for grandfathering HSA's for one year and for continuing them after one year if they measure up.

10. Permits local health planning agencies to comment on the Health Department's programs and budgets.
11. Eliminates administrative review.
12. Provides Commission with authority to set CON application fees, if facility is not assessed user's fees.
13. Allows CON hearings to be evidentiary or nonevidentiary as requested.
14. Continues CON program thresholds, regulations and procedures at federal levels for one year; thereafter, they may be adjusted by the Commission to reflect new developments in the health care industry.
15. Provides for a three-part transition to the new system with transfer of present staff and responsibilities from existing agencies to the new Commission:
 - a. A dual system consisting of all existing agencies and implementation of Commission until 1983;
 - b. Commission assumed authority in 1983; and
 - c. An evolving system based on experience and the input of the local governments, governor and the legislature.
16. Changes time lines for CON: 150 days after docket of application, if evidentiary hearing is requested; 120 days, if evidentiary hearing not requested.
17. Requires first level of appeal of denial to be a request for reconsideration by the Commission, then appeal within 30 days to court of competent jurisdiction.
18. Requires a study of the possibility of giving the new Commission the authority to withdraw approval for existing, unneeded facilities.
19. Makes Commission responsible for developing a State Health Plan which will clearly address priorities and resource availability.

II. State of Washington - Task Force Report and Recommendations

A. Board of Health and State Health Coordinating Council consolidated and intended to serve as a major advisory body to the Secretary of Social and Health Services and the Director of the Division of Health. This new body would have a membership larger than the Board of Health and smaller than the SHCC. Its responsibilities would encompass all of those of the SHCC and the legislative authority of the Board of Health. This proposed new group is referred to in the report as the State Health Board.

B. Certificate of need program continued, but name changed to "certificate of approval." Name of program changed because the task force felt that the term "need" was elusive and poorly defined. Relationship between the "certificate of approval" program and the state health plan strengthened.

C. Local role in health planning voluntary in the form of regional health councils. Proposes matching funds from localities for planning functions only; regulatory functions to be funded by the state. State share of the program to be provided through fees.

D. State Health Plan would be limited according to the wishes of the new State Health Board. Indicated the need to shift emphasis from medical issues to broad health issues. Topics would be limited during a given planning cycle, but almost any health issue could be considered appropriate. The plan would be focused on system-wide issues related to intent, direction and impact of programs rather than their managers. Plan would be concerned with the regulation of health facilities and services as covered in the new "certificate of approval" program. The plan would establish standards and criteria to guide reviewing agencies. These standards and criteria

would be provided to allow flexibility for regional councils and a trend toward one-level review. Certain types of projects would be exempt from this process, i.e., individual health practitioners' offices, non-clinical projects that do not increase patients' charges and rates, projects to correct code or accreditation deficiencies, debt refinancing and land acquisition. Decrease in services, elimination of services or replacements of existing movable equipment would require reports, but be exempt from reviews. Class or group exemptions could be established by the State Health Board. A single format for review would be developed.

III. Florida

A. Health planning law revised to establish "local health councils," which will replace the HSA's. These councils will consist of a variable number of members according to the number of counties included in the council (1 1/2 times the number of counties, but no more than 12). Each county must have at least one member. Members will be appointed by the local governing bodies. The new councils will cover the same areas as the "service districts" established by the state.

B. Certificate of Need Process revised as follows:

1. Public hearings at the local level on request. Such hearings will be evidentiary in form. Minor projects will not require public hearings, letters of intent or batching. The local health councils will not review applications. One review will be conducted by the Department of Health and Rehabilitative Services. The local councils may conduct public hearings, comment on various Department policies and are mandated to develop district plans "using uniform methodology as set forth by the Department..." Decisions on CON applications will be based on the local plans; however, regulatory functions will be the prime responsibility of the Department. The local health councils are also required to promote manpower allocation, competition and community awareness of preventive health activities and cost-effective health care selection.

2. CON application fees are assessed by the Department as follows:

a. minimum base fee of \$500

b. plus 0.4 of 1% of the proposed capital outlay, not to exceed \$4,000.

No fee will be assessed for CON applications for replacement of equipment. All fees will be deposited in the local health trust fund and will be used to fund the local health councils.

3. Application review process timeline cut from 90 days to 45 days.

4. The local health councils are funded through contracts with the Department, which will develop a formula for allocation of the funds. Federal planning funds provided to the state may be passed through as grants to the local health councils for planning, education and promotion of competition activities only. Local health councils' staffs will be paid according to the comparable salaries of the State Career Service.

APPENDIX C

House Joint Resolution NO. 45 as adopted by the General Assembly during the 1983 Session mandates this Subcommittee:

1. To design a detailed system for health planning and regulation tailored to Virginia's unique needs; and
2. To develop a permanent funding mechanism for regional health planning in Virginia.

In order to meet these goals, the following alternatives are suggested for the scheduling of the study. It should be noted that these are only suggestions. The Subcommittee may decide that some combination of these alternatives or some alternative not included is more appropriate.

Alternatives for the Study Schedule

1. Plan at least one working meeting for each of the next four months.
 - a. Each meeting could be structured around one or more of the tentative recommendations (see pages 6-8 of the Report) as they relate to the Virginia law.
 - b. A tentative plan could be adopted in order to complete a draft of a Virginia Health Planning Law by the end of the summer. This would allow time for receiving public commentary and refining the proposal.
2. Divide the Subcommittee into two or more subcommittees and assign each of these subcommittees issues to address. A deadline for tentative recommendations to be received by the full Subcommittee could be set to allow time to discuss and refine the recommendations.
 - a. Each subcommittee could be charged with developing suggestions to implement a certain number of the tentative recommendations. For example, subcommittee A could be assigned the task of developing proposals for the implementation of recommendations 1 through 4 and subcommittee B could be assigned the task of developing proposals for tentative recommendations 5 through 8.
3. Continue to receive recommendations and commentary from the providers, HSA's, third-party payors and other relevant groups until such time as the Subcommittee is ready to develop a proposal.
 - a. Additional information could be provided to the Subcommittee on the implementation and success of the revised health planning laws adopted by other states.
 - b. A plan could be developed for the Subcommittee to receive comments and suggestions for the implementation of the tentative recommendations in a sequence, which would provide the Subcommittee with a framework for arriving at a consensus.
4. Attend the annual meeting of the American Health Planning Association, "Health Planning of the Future: Challenge and Opportunity," June 15-17, Washington, DC, as a Subcommittee with established plans to meet regularly during these three days and work out ideas. The Subcommittee could spend three days emerged in the issues and receiving expert technical assistance. This would give the Subcommittee the opportunity to conduct their meetings along the lines of a "retreat." An objective could be set by the Subcommittee to complete its discussions and agree to an outline for the Virginia proposal during this meeting and staff could be directed to develop this outline for a later Richmond meeting. The initial material could be refined and revised over the following months during the Subcommittee's home meetings.

It should be noted that this alternative has the potential for being expensive. If all members expenses were charged to the Subcommittee's budget: \$6,101. This cost might be reduced if some members of the Subcommittee are already planning to attend this meeting for business reasons or could charge the expense of attending this meeting to their organizations.

In addition to the above suggestions, it is brought to your attention that the Alpha Center in Bethesda is charged with providing technical assistance to the SHPDA's in this area of the country. This Center monitors the developments in health planning across the country very carefully. The staff of this Center may be willing to provide the Subcommittee and others with a workshop on health planning, however, the request would have to come from the SHPDA. Mr. Raymond Perry has indicated his willingness to investigate this possibility for you, if the Subcommittee feels such a workshop would be helpful.

APPENDIX D

Discussion outline

1. State reimbursement system requirements, practicality, effects, etc. What do we have to do to go to a state reimbursement system? What are the alternatives to DRG's?

In order to develop an authorized "state cost control system," which covers all-payors (medicare, medicaid and health insurance), state legislation would first have to be enacted requiring such a system, then an application would have to be filed for the waiver substantiating that the following requirements would be met.

The state cost control system must:

1. apply to substantially all non-acute care hospitals in the state;
2. apply to at least 75% of all inpatient revenues or expenses in the state;
3. provide assurances that payors, hospital employers and patients are treated equitably;
4. provide assurances that the state's system will not result in greater medicare expenditures over a three-year period than would otherwise have been made;
5. not preclude an HMO or CMP from negotiating directly with hospitals with respect to payments for inpatient hospital services;
6. be operated directly by the state or an agency designated by state law;
7. be prospective;
8. provide for hospitals to make such reports as are required by the Secretary of HHS;
9. provide satisfactory assurances that admissions practices will not result which will reduce treatment to low income, high cost, or emergency patients;
10. not reduce payments without 60 days notice to the hospitals and the Secretary of HHS; and
11. provide satisfactory assurances that local officials have been consulted concerning the impact of the program on publicly owned hospitals during the development of the program.

The Secretary is required to approve any state program which meets the last six of these requirements within 60 days of the date the application is submitted. He is prohibited from denying approval of a state application because it is not based on DRG's or the medicare expenditures could be greater than the federal prospective payment system would be (please note, this prohibition is inconsistent with requirement number 4 above). In other words, state applications are almost assured approval.

The all-payor systems presently in place were approved as Section 1115 demonstration projects. West Virginia will be the first state to receive a waiver to develop a system under the new law.

The federal government has agreed to continue to provide the medicare cost reports for two years after the DRG system is implemented. Many state medicaid programs, including Virginia's, use the medicare cost reports as the basis for their rates. This means that in two years, Virginia will have to develop a cost reporting system or go to the DRG system.

Some experts are predicting that eventually the federal government will require the medicaid programs to implement the DRG system. In the event this prediction becomes reality and given the fact that the cost reports will cease in two years, implementation of a state cost control system based on DRG's now would have the advantage of providing experience in the DRG system before it might be required. However, the disadvantages appear to outweigh this

advantage in Virginia .

The Virginia Medicaid program already has a prospective rate system based on the regional average costs. This system has saved the Commonwealth considerable money over the last year. Implementation of the DRG system now would cost the Virginia Medicaid program more than the present prospective system at least for the first three years. For the first three years, the DRG system will be phased-in. During the first year, the reimbursements will be 75% cost-based and only 25% DRG-based. The following year, the rates will 50% cost-based and 50% DRG-based. One hundred percent implementation will not be achieved until the fourth year.

In Virginia, the Medicaid program has become a well-run, cost-effective operation and from all indications, will continue to improve. It does not appear wise to recommend that the federal DRG system be adopted at the present time. Perhaps in a few years, the state should consider going to the DRG system. This alternative might become particularly attractive after the system has been fully implemented, the issue of capital costs has been resolved and the system has gained enough experience to substantiate its claims of cost containment.

There are, of course, alternatives to the DRG rates, for example, the present Virginia prospective system for Medicaid. This system appears to satisfy the requirements of the federal law for application for a waiver. However, it should be noted again that in two years, Virginia will have to develop its own cost reporting system in order to continue this prospective system or will have to implement a DRG system, because the medicare cost reports will be discontinued. The question raised by this set of facts is: Will it be cheaper to develop a cost reporting system or to implement the DRG system in two years?

Developing a cost reporting system will require a lot of work, may require expertise not available at this time and additional resources, e.g., data processing capabilities. The cost could be substantial. However, it must be remembered that the federal DRG system will not be fully implemented in two years. The rates will still be 25% cost-based. It should also be noted that implementation of a DRG system, an all-payers system or a state rate-setting mechanism would cost money because of start-up. Further, the resistance to a mandatory state rate-setting system may still be strong. Virginia does not move into new procedures quickly. The present rate-review commission requires data submission, but compliance is voluntary. Any state reimbursement system, whether all-payers or limited in scope, would negate the need for the rate review commission and provide a mandatory rate-setting mechanism.

It may be wise to wait until the bugs are worked out of the DRG system and the results of some states' experience with all-payers systems have been compiled before trying such a system in Virginia. It might also be beneficial for Virginia to begin to develop a cost comparison of its options, i.e., development of a cost reporting system and continuation of the prospective reimbursement system adopted for Medicaid; application for the federal waiver for an all-payers system in two years; or implementation of the DRG system for the Medicaid program in two years.

2. Alternatives to geographical boundaries for the local planning agencies. Can the health planning scheme be the same as the planning district commission scheme/process? Can we do this under federal law?

There are 22 planning district commissions in the State of Virginia (see map). Participation in a commission is voluntary and requires each participating locality to provide funding. The State provides \$5,000/25,000 people with a minimum of \$10,000 for each planning district commission. These agencies are subject to profound political pressures, because of the membership requirements. Although membership of the commissions varies, each governing body is represented and there are other members, all of whom must be qualified voters and residents of the member districts. The effectiveness of some of the commissions has been questioned.

Arguments for using the planning district commission boundaries and scheme for local health planning agencies:

1. may prove to be more responsive to local concerns;
2. may provide vital local input into the state health plan;

3. structures are already in place.

Arguments against using the planning district commission boundaries and scheme for local health planning agencies:

1. lack of expertise in health planning on the local level;
2. too expensive to establish health planning agencies or expand the planning district commissions' duties in so many areas;
4. possibility that health planning would become more politicized;
5. would not provide the consistency the present regions have with the regional health department (health services areas).

The subcommittee may want to look at some of the other state service areas or district boundaries such as the labor law enforcement regions, Congressional Districts, etc. The Congressional Districts are based on population and community of interest. The labor law enforcement regions appear to be based on employment patterns and, perhaps, population.

Further, the Subcommittee should be aware that a study conducted by the Virginia Medicaid program indicated that the present health service areas were appropriate in terms of community of interest, income levels, employment patterns and general demographic characteristics. It is therefore suggested that the local health planning regions should continue to coincide with the health service areas of the Regional Health Departments for the sake of uniformity, consistency and community of interest. The Subcommittee may want to consider dividing the large health service areas, such as HSA's I, IV and III, and thereby, create additional health systems agencies or regional health planning units.

Under the present law, the status of any new state boundaries as designated HSA's and therefore eligible for federal funding is questionable. However, the proposal currently being considered by Congress would allow the states flexibility in this matter.

3. How can the regulatory functions be most effectively shifted to the state level, if the planning activity is the basis for the regulatory functions?

If the regulatory functions are shifted completely to the state level, then it would seem that the basis for the CON decisions must become even more firmly grounded on the state and local health plans. Further, the state health plan would have to be based firmly on the data contained in the local health plans and uniform formats and procedures for the developing of the local plans would have to be developed. Public hearings on the projects could be kept at the regional or local level with the applicant or other affected parties allowed to request the hearings. The hearings could be conducted by the local planning agencies or by State Department officials.

The Subcommittee may want to consider relieving the local agencies of the review of CON applications. Local agencies could be given the privilege of commenting on any project which would be considered to have significant implications (adverse or favorable) for the local health plan.

Clear, concise goals and definitive duties would have to be developed for the local health planning agencies. It might be beneficial to provide, as Florida did, that the salary scales for the local agencies' personnel would be comparable to the state's salary scale. Personnel levels would have to be defined precisely.

4. What are the aspects of regulation that could be eliminated? What are we regulating that we should not be and what are we not regulating that we should?

It would appear that we could deregulate, at least some aspects, of the home health care industry. This industry appears to be developing some competition. However, it should be noted that this care is still reimbursed on a cost-basis by the Medicaid program. Perhaps, it would be desirable to develop some prospective methodology. This may be a difficult task. A number of reasons can be given for deregulating this segment of health care, i.e., it is impossible to

determine "need" for these agencies, the deregulation would be consistent with Virginia's impetus for developing alternatives to institutionalization.

Virginia may be over regulating the development of free standing surgicenters and emergicenters. These facilities are lower cost alternatives to hospitalization and yet, they must satisfy the appropriateness requirement. Some people think we should let them develop and take their chances. However, if these centers are reimbursed on a fee-for-services basis and not on the basis of DRG's or prospective rates then the possibility remains that the cost of their services will increase.

On the other hand, we may be making a mistake in not looking more closely at hospital restructuring. The health care industry, particularly the hospital industry, began a push toward "restructuring" several years ago. The most obvious example of this would be the emergence of the multi-state corporations and the move to acquire non-profits being made by the for-profits. But there are many much more subtle aspects of this movement. In anticipation of the DRG system, some hospitals have begun to look at hospital group practices, for example. One example of this in Virginia, is the group being formed by National Orthopedic in Arlington.

The obvious benefit of a "restructuring" would appear to be tax. In corporate tax law, this maneuver would be referred to as a "reorganization." This term was apparently rejected by the health care industry as too blatant.

Balance sheet games would also appear to be possible even if the institution restructures itself without buying additional facilities or being bought. Some of the results of restructuring will be simple diversification - that is, segments of the industry attempting to protect its profits. Some segments appear to be restructuring to protect themselves from the effects of change (such as DRG's) through the availability of alternative sources of income. Some of this diversification may become a form of evasion in the future - evasion of the cost containment effects of the prospective payment systems. If technology moves away from the acute care facilities and into free standing satellites and if these "centers" remain outside the DRG system, then funding and cost problems could develop. The source of the problems would simply have shifted from the hospitals to another facility.

5. What should be the content of local health planning, e.g., education, resource monitoring, etc.?

The local planning agencies could provide any or all of the following functions:

1. Education of physicians and the public. A great deal has been said about the need and benefits of educating the general public about the health care industry and health care costs and personal health care. This education does indeed appear to be beneficial and cost effective. However, it appears that health care costs will not be contained unless physicians are educated about the problems, the causes of the problems and the possibilities of the death of the goose that continues to lay the golden egg. It is possible that the reasons for individuals becoming physicians are not compatible with cost containment objectives.

2. Needs assessments. Gaps in services, overutilization of services or resources, inappropriate use of services or resources, unavailability of services could be identified by the local planning agencies.

3. Performance assessments. Evaluations of the quality of care available in the local area could be conducted by the local planning agencies.

4. Data collection. Statistical data could be collected at the local level in order to provide credibility for the local health plans and the state health plan.

5. Recommendations for resource allocation. If these recommendations could become one element in the review of CON applications, then some incentive might be provided for even distribution of resources.

6. Development of competitive initiatives. Assistance, information and ideas for competitive initiatives, alternative practice schemes and perhaps even seed money could be provided by the local health planning agencies.

7. Development of valid local health plans, demonstrating credible use of background data and valid recommendations. These plans should provide the basis for the State Health Facilities and Services Plan and the data for assessment of CON applications.

6. A definition of the environment as it will exist in five years; the things that the market will address, those that planning should address and those that regulation should address.

In order to answer this, one would need to be either a psychic or crazy. However, based on the premise that the DRG's will stimulate some predictable changes in the hospital industry as well as in the nursing home industry (a sort of fall-out), that the hospital industry will no longer be immune to the effects of market trends or be guaranteed a handsome profit without working very hard for it, then the following schemes may constitute some possible elements of the health care environment as it will exist in five years.

1. Less expensive alternatives to institutionalization will become commonplace rather than the exception. Presently, only 70 people have been served by the Personal Care Services Program initiated by the Virginia Medicaid program last year. We are moving into this area very slowly, but carefully. The Medicaid personnel predict that there will be a substantial increase in the number of people served by this program in time. Adult foster care, home health care, personal care services, home maker, chore and companion services will become significant programs.

2. The nursing home industry is predicting that the nursing home of the future will be the center of care for the elderly and the disabled and will provide both institutional and noninstitutional care. Although no great activity in this direction has been detected in Virginia, most people seem to feel that this focus would be appropriate. Nursing homes provide activity programs for their residents which are very appropriate for adult foster care centers. Several nursing homes in Virginia are providing these services. There is some interest in providing personal care services which are provided on a contract basis to Medicaid recipients. Some nursing homes have also obtained CON's for Home Health Agencies.

3. A need may develop for increasing the number of skilled care beds in the nursing home industry in Virginia after the DRG system is implemented. Only 8% of the Virginia nursing home beds are skilled care beds as compared to many states in which 50% are skilled beds. The nursing home industry believes that the institutions are receiving sicker patients and as the DRG system is implemented, the number of those requiring skilled care will increase.

4. Some believe that implementation of a prospective payment system for medicare will provide more equitable payments for the medicare recipients in nursing homes and result in more medicare patients being certified for nursing home care. This could mean a shortage in nursing home beds in the next five years.

5. The insurance industry will revamp its payment systems by implementing prospective systems (like the PPO), perhaps providing preventive services or incentives for not using services such as increased copayments and deductibles or reimbursements for low utilization.

6. New patterns of practice will be stimulated as a result of the revision of payment systems, e.g., group practices, HMO's, CMP's, free standing centers.

7. Quality of care may decline as the profitable payment systems are revised.

8. Unprofitable services may become scarce or unavailable.

9. Specialization will develop among hospitals.

10. Hospitals will diversify and develop multifacility institutions.

11. Bankruptcy will occur frequently among at-risk institutions, probably rural and inner city hospitals.

12. Public institutions will have to take steps to protect their fiscal integrity because of the strain of treating high cost patients and the cost of medical education.

13. Doctors may find private practice in free standing centers more profitable than hospital practice. Hospitals presently compete for staff physicians who provide them with many patients. Hospitals will be scrutinizing staff practices carefully and may restrict practice to those physicians who provide cost-effective patients and may, also, be in a position to pick and chose among physicians and offer lower salaries.

14. Cost-shifting among programs will probably become a thing of the past, however, cost-shifting among multifacility institutions may become a reality.

15. Competition will become more of a reality than it is now.

PROPOSALS FOR HEALTH PLANNING

AND REGULATION IN THE COMMONWEALTH

The Joint Subcommittee to Study the Feasibility of Preserving a Regional Health Planning Mechanism in the Commonwealth was established through House Joint Resolution No. 104 during the 1982 Session of the General Assembly. The Subcommittee was charged with studying the preservation of a regional health planning mechanism in anticipation of the reduction or termination of federal funding of the health systems agencies and the Statewide Health Coordinating Council. The Joint Subcommittee was continued by House Joint Resolution No. 45 during the 1983 Session. The charge to the Subcommittee was broadened by this resolution and included the following goals:

1. To design a detailed system for health planning and regulation tailored to Virginia's unique needs; and
2. To develop a permanent funding mechanism for regional health planning in Virginia.

In accomplishing these goals, the Subcommittee was directed to analyze the systems of other states and evaluate the various proposals received during 1982.

The Joint Subcommittee has approved the attached proposals for the purpose of eliciting public comment. The Joint Subcommittee will hold a public hearing to receive these comments on September 28, 1983, at 10:00 a.m. in House Room C of the General Assembly Building. A working meeting will be held on September 29, 1983, at 10:00 a.m. Commentators are requested to prepare written statements and submit these statements in advance. Speakers are also requested to be explicit and detailed in their responses. Specific counterproposals are requested rather than mere negative reactions. The Subcommittee hopes to generate discussion on the attached items as they relate to: (a) the design of a viable mechanism for health planning and cost containment in Virginia regardless of the success or failure of the prospective payment systems; and (b) a mechanism for the long-range management of health planning, which can be adjusted to respond to issues quickly.

Speakers may submit written statements in advance or pre-register by contacting:

Ms. Norma E. Szakal
Staff Attorney
Division of Legislative Services
P. O. Box 3-AG
Richmond, VA 23208
(804) 786-3591

I. FEASIBILITY OF ESTABLISHING A VIRGINIA MEDICAL EXPENSE PLAN DATA BASE

Requesting the Departments of Health, Management Analysis and Systems Development, and Planning and Budget to study the feasibility of establishing a Virginia Medical Expense Plan Data Base.

WHEREAS, accurate data provide the fundamental basis for informed government and private decisions; and

WHEREAS, the health care industry is evolving rapidly at this time as the result of the revised reimbursement systems; and

WHEREAS, viable data on services and facilities are crucial to the understanding of these changes; and

WHEREAS, the federal efforts to collect and disseminate data have been and will apparently continue to be reduced; and

WHEREAS, the Medicare Costs Reports will be eliminated in 1985, thereby creating another gap in the data available to the Commonwealth; and

WHEREAS, although the cost containment efforts of the Virginia Medicaid Program will not be hampered initially by the elimination of the Medicare Cost Reports, future efforts to control the costs of Medicaid and other health care programs in Virginia may suffer because of lack of data; and

WHEREAS, the information surveys required of health care facilities by various government and private organizations are time consuming and expensive to complete; and

WHEREAS, a uniform data collection system would provide relief to Virginia's health care industry from the duplicative and fragmentary efforts presently required for cost review, licensure, certificate of need and certification for payment; and

WHEREAS, the implementation of a uniform billing form will take place in the near future; and

WHEREAS, the development of a uniform accounting system would provide insight into the accounting practices of various institutions; and

WHEREAS, collection and dissemination of critical aggregate health care data would benefit the Commonwealth and its business and industry community; and

WHEREAS, precise data on the cost and utilization of health care services are essential to maintain the quality of care available to Virginians and to prevent health care from becoming unaffordable; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Departments of Health, Management Analysis and Systems Development, and Planning and Budget are hereby requested to study the feasibility of establishing a Virginia Medical Expense Plan Data Base.

During the course of this study, the following issues shall be examined:

1. the feasibility of requiring a uniform accounting system or form;
2. the means to protect the privacy of the institutions and individuals;
3. the adequacy of the information contained on U.B. 82; and
4. the cost and efficiency of establishing such a data base.

The Secretary of Administration and Finance shall be responsible for coordinating this study. In conducting this study, the responsible agencies shall confer with the Virginia Health Services Cost Review Commission, insurance companies and other organizations with established medical data base systems and seek input from representatives of the health care industry. The work of this study shall be completed in time to report the findings to the Governor and the General Assembly by December of 1984.

II. CERTIFICATE OF NEED EXEMPTIONS

The following categories of projects are proposed to be exempted or eliminated from the regulatory process of certificate of need *unless* they will (i) require capital construction or (ii) increase the operating costs of the facility by an estimated 5% or more:

1. the addition of new services;
2. the acquisition of equipment;
3. the acquisition of facilities;
4. the relocation of beds; and
5. the increase in number of beds.

Applications for certificate of need would be required for projects proposed by all general or special hospitals and nursing homes which are government-owned or which are required to be licensed by the Board of Health or the Board of Mental Health and Mental Retardation when such projects:

1. will require capital expenditures exceeding the established amount for the construction of a new facility or the replacement of an existing facility; or
2. will require capital expenditures exceeding the established amount or 25% of the fair market value of the facility for the replacement, expansion or rehabilitation of part of an existing facility; or
3. will require capital expenditures below the established amount for any construction when the addition will increase the operating expenses of the facility by an estimated 5% or more; or
4. will not require capital expenditures for construction, but will increase the operating expenses of the facility by an estimated 5% or more.

The established amount for the 1984-85 year shall be \$600,000; thereafter this amount shall be raised by \$200,000 per year for the next two years until this amount equals \$1,000,000 on July 1, 1986. In reviewing applications for certificate of need, the Commissioner would be authorized to consider an increase in operating costs in his review. A new goal would be added to the CON law: to encourage the provision of a continuum of care.

III. PROPOSED ALTERNATIVES FOR SIMPLIFICATION OF THE REVIEW PROCESS FOR CON APPLICATIONS:

PROPOSAL A:

Review of only major expenditures involving patient care and clinically related projects and a three-tiered process consisting of one local review, review by the SHCC or its equivalent and a three-member panel consisting of the Commissioner, a SHCC representative and a local planning representative.

PROPOSAL B:

Elimination of the certificate of need review by the health system agencies and the Statewide Health Coordinating Council and creation of a one-level review by the State Department of Health; local public hearings to be conducted at the request of the applicant or the governing body having jurisdiction in the locality in which the facility is proposed; and the role of the HSA's and the SHCC would be confined to health planning.

IV. DESIGN FOR A USABLE LOCAL HEALTH PLAN

The components of the local health plans should be prescribed at the state level in order to provide consistency and uniformity. Uniform formats and data requirements should provide the State Health Plan with a credible information base and stimulate the development of local plans that would be important to the decision-making and regulatory process.

The SHCC should be given responsibility for the medical facilities plan (presently the responsibility of the Board of Health) and the HSA's should be required to include a facilities component in the local health plans. This would completely remove the HSA's and the SHCC from the regulatory process and provide them with responsibility for all of the elements of health planning. The State Health Plan may then become the State Health and Medical Facilities Plan. A separate state medical facilities document might not be necessary.

The following elements are proposed as appropriate content for the local health plans:

1. education activities for the public and the medical community;
2. needs assessments focused on gaps in services, overutilization and underutilization of services, inappropriate use of services or resources, accessibility of vital services (especially in light of the possible restriction of and reallocation of resources which are predicted to result from the DRG system);
3. data collection (as provided by a centralized system) focused on the facilities, services and utilization of particular services;
4. recommendations for resource allocation which could be used by facilities applying for CON as support and by state officials in making decisions; and

5. development of competitive initiatives (technical assistance, information and ideas for competitive initiatives, alternative practice schemes and, at some point in the future, perhaps, dissemination of seed money for competitive projects or maintenance of needed services).

Examples of background data which should be included in the local health plans are: numbers and types of facilities in the region, services available in the area, cost of services (in terms of range), population figures, utilization figures, figures illustrating patterns of patient care and changes in net patient revenues.

V. REQUIREMENTS FOR ESTABLISHING AN ALL-PAYORS RATE-SETTING MECHANISM (State Cost Control System):

In order to develop an authorized "state cost control system" which covers all-payors (Medicare, Medicaid and health insurance), state legislation would first have to be enacted requiring such a system, then an application would have to be filed for the waiver substantiating that the following requirements would be met.

The state cost control system must:

1. apply to substantially all nonacute care hospitals in the State;
2. apply to at least 75% of all inpatient revenues or expenses in the State;
3. provide assurances that payors, hospital employers and patients are treated equitably;
4. provide assurances that the State's system will not result in greater Medicare expenditures over a three-year period than would otherwise have been made;
5. not preclude an HMO or CMP from negotiating directly with hospitals with respect to payments for inpatient hospital services;
6. be operated directly by the State or an agency designated by state law;
7. be prospective;
8. provide for hospitals to make such reports as are required by the Secretary of HHS;
9. provide satisfactory assurances that resulting admissions practices will not reduce treatment to low income, high cost, or emergency patients;
10. not reduce payments without 60 days' notice to the hospitals and the Secretary of HHS; and
11. provide satisfactory assurances that local officials have been consulted concerning the impact of the program on publicly owned hospitals during the development of the program.

The Secretary is required to approve any state program which meets the last six of these requirements within 60 days of the date the application is submitted. He is prohibited from denying approval of a state application because it is not based on DRG's or because the Medicare expenditures could be greater than the federal prospective payment system would be (please note, this prohibition is inconsistent with requirement number 4 above). In other words, state applications are almost assured approval.

The all-payor systems presently in place were approved as Section 1115 demonstration projects. West Virginia will be the first state to receive a waiver to develop a system under the new law.

Summary of the Four All-Payors Rate-Setting Systems

1. *Maryland* - The Maryland Health Services Cost Review Commission is composed of seven members appointed by the Governor. This independent agency was created in 1973 and was the first rate-setting commission to move to an all-payors system in the late seventies. Maryland uses a public

utility approach to hospital rate-setting; therefore, the principal components of this system are rate review, inflation adjustment and guaranteed inpatient revenues (uncompensated care is factored into this element). Inflation, volume and pass-through costs are utilized in establishing the rates.

2. *New Jersey* - The New Jersey Prospective Case-Mix Based Reimbursement System was established by law in 1978 and was the pioneer in the use of diagnosis related groups. The Hospital Rate-Setting Commission, a sub-agency of the Department of Health, is composed of five members - the Commissioners of Health and Insurance, two consumers and one hospital administrator. The New Jersey rates include "working cash infusion" and "uncompensated care" and are said, for this reason, to have stimulated greater response from hospitals with financial problems than those with sound profit margins.

3. *Massachusetts* - Massachusetts has had its Rate-Setting Commission for a number of years. In 1982, Massachusetts adopted the Hospital Rates of Payment and Charges Law, which established the Rate-Setting Commission Hospital Policy Board. The purpose of this Board is to oversee the Rate-Setting Commission's regulation of hospitals. This new law established an all-payers system based on control of revenues (similar to New York). A productivity factor will be applied in ascending scale (2%, 4%, 6%) according to the fiscal year of the institution. This productivity factor is a required *reduction* in revenues, which will be phased in over the next six years. Each facility will be allowed to earn no more than its "approved gross patient service revenues." Hardship relief is allowed under certain circumstances.

APPENDIX F

SENATE BILL NO. HOUSE BILL NO.

A BILL to amend and reenact §§ 32.1-102.1, 32.1-102.3, 32.1-102.6 and 32.1-102.7 of the Code of Virginia, relating to certificate of public need.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-102.1, 32.1-102.3, 32.1-102.6 and 32.1-102.7 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-102.1. Definitions.—As used in this article, unless the context indicates otherwise:

1. "Certificate" means a certificate of public need for a project required by this article.
2. "Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.
3. "Health service area" means the area served by a health systems agency.
4. "Health systems agency" means an entity organized and operated as provided in Title XV of the United States Public Health Service Act and designated as a health systems agency pursuant to Title XV of the Public Health Service Act or, in the absence of such an agency, a local, district or regional health planning body established under the laws of the Commonwealth.
5. "Medical care facility" means any institution, place, building or agency, whether licensed or required to be licensed by the Board or the State Mental Health and Mental Retardation Board, whether operated for profit or nonprofit and whether privately-owned or privately-operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled, or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans. The term includes, but is not limited to:
 - a. General hospitals.
 - b. Sanatoriums.
 - c. Sanitariums.
 - d. Nursing homes.
 - e. Intermediate care facilities.
 - f. Extended care facilities.
 - g. Mental hospitals.
 - h. Mental retardation facilities.
 - i. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.
 - j. Specialized centers or clinics developed for the provision of outpatient or ambulatory surgery, renal dialysis therapy, radiation therapy, computerized tomography (CT) scanning or other medical or surgical treatments requiring the utilization of equipment not usually associated

with the provision of primary health services.

k. ~~Home health agencies required to be licensed pursuant to Article 6 (§ 32.1-157 et seq.) of Chapter 5 of this title.~~

1. Hospices.

The term "medical care facility" shall not include a physician's office except as provided in § 32.1-102.1 6e or a clinical laboratory if the clinical laboratory is independent of a physician's office or a hospital and has been determined to meet the requirements of paragraphs (10) and (11) of § 1861 (s) of Title XVIII of the Social Security Act.

6. "Project" means:

a. A capital expenditure by or on behalf of a medical care facility, including but not limited to any studies, surveys, designs, plans, working drawings and specifications, which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which:

(1) Exceeds \$600,000 or such higher amount as the Board may prescribe,

(2) Increases the total number of beds, or

(3) Relocates ten beds or ten percent of the beds, whichever is less, from one physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of ten percent of its beds as nursing home beds as provided in § 32.1-132;

b. The acquisition by a medical care facility, through donation or lease, of equipment or facilities which, if purchased by the medical care facility, would require an expenditure described in paragraph 6a of this section;

c. The acquisition by a medical care facility of equipment or facilities through a transfer at less than fair market value if the transfer at fair market value would require an expenditure described in paragraph 6a of this section;

d. The introduction by a medical care facility of a clinical health service , *except home health services*, which the facility has never provided or has not provided in the previous twelve months;

e. The acquisition, by purchase, lease, gift or bequest, by or on behalf of a medical care facility or, if the unit of equipment is generally and customarily associated with the provision of health services in an inpatient setting, by or on behalf of a physician's office, of equipment whose fair market value, including the value of any studies, surveys, designs, plans, working drawings, specifications and other activities essential to the acquisition of the equipment, exceeds \$400,000 or such higher amount as the Board may prescribe by regulation and which is used for the provision of medical and other health services.

7. "Statewide Health Coordinating Council" means the duly authorized statewide health advisory agency established pursuant to Article 4 (§ 32.1-117 et seq.) of Chapter 4 of this title.

8. "State Health Plan" means the plan provided for in Article 2 (§ 32.1-103 et seq.) of Chapter 4 of this title.

9. "State Medical Facilities Plan" means the plan provided for in Article 4 (§ 32.1-120 et seq.) of Chapter 4 of this title.

§ 32.1-102.3. Certificate required; criteria for determining need.—A. No person shall commence any project without first obtaining a certificate issued by the Commissioner. No certificate may be issued unless the Commissioner has determined that a public need for the project has been demonstrated. If it is determined that a public need exists for only a portion of a project, a certificate may be issued for that portion and any appeal may be limited to the part of the decision with which the appellant disagrees without affecting the remainder of the

decision. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Health Plan and the State Medical Facilities Plan.

B. In determining whether a public need for a project has been demonstrated, the Commissioner shall consider:

1. The recommendation and the reasons therefor of the appropriate health systems agency ~~and any recommendation and the reasons therefor of the Statewide Health Coordinating Council~~.

2. The relationship of the project to the applicable health plans of the Board, the health system agency, and the Statewide Health Coordinating Council.

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

4. The need that the population served or to be served by the project has for the project.

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health service area in which the project is proposed.

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

8. The immediate and long-term financial feasibility of the project.

9. The relationship of the project to the existing health care system of the area in which the project is proposed.

10. The availability of resources for the project.

11. The organizational relationship of the project to necessary ancillary and support services.

12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health service area in which the project is to be located.

14. The special needs and circumstances of health maintenance organizations.

15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

16. In the case of a construction project, the costs and benefits of the proposed construction.

17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those

proposed.

20. The need and the availability in the health service area for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

§ 32.1-102.6. Administrative procedures.—A. To obtain a certificate for a project, the applicant shall file a completed application for a certificate with the Department and the appropriate health systems agency. At least thirty days before any person is contractually obligated to acquire an existing medical care facility, the cost of which is \$600,000 or more, that person shall notify the Commissioner and the appropriate health systems agency of the intent, the services to be offered in the facility, the bed capacity in the facility and the projected impact that the cost of the acquisition will have upon the charges for services to be provided. If clinical services or beds are proposed to be added as a result of the acquisition, the Commissioner may require the proposed new owner to obtain a certificate prior to the acquisition.

B. The appropriate health systems agency shall begin to review each complete application for a certificate within such time as the Board may prescribe by regulation. The health systems agency shall hold a *one* public hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city. The health systems agency shall cause notice of the public hearing to be published in a newspaper of general circulation in the county or city where a project is proposed to be located at least nine days prior to the public hearing. *In no case shall a health systems agency hold more than two meetings on any application, one of which shall be a public hearing. The applicant shall be given the opportunity to make a presentation during any meeting at which a recommendation is finalized.* The health systems agency shall submit its recommendations on each application and its reasons therefor to the Department and the Statewide Health Coordinating Council within such time as may be prescribed by the Board by regulation.

C. After commencement of a public hearing and before a decision is made there shall be no ex parte contacts concerning the subject certificate or its application between (i) any person acting on behalf of the applicant or holder of a certificate or any person opposed to the issuance or in favor of revocation of a certificate of public need, and (ii) any person in the Department who has authority to make a determination respecting the issuance or revocation of a certificate of public need, unless the Department has provided advance notice to all parties referred to in (i) of the time and place of such proposed contact.

D. ~~A copy of each application may be referred by the Commissioner to the Statewide Health Coordinating Council for its recommendations. Upon referral, the Council shall consider the advice and recommendations of the health systems agency and shall submit its recommendations and reasons therefor to the Department within the time proposed by regulation of the Board.~~

E. A determination whether a public need exists for a project shall be made by the Commissioner within ninety days of the receipt of a completed application. *The applicant shall have the option of making a presentation to the Commissioner prior to any initial determination.*

F. 1. ~~Informal proceedings provided for in § 9-6.14:11 of the Code shall be held, in the case of an application for a certificate, upon request of the applicant, any person showing good cause, any third party payor providing health care insurance or prepaid coverage to five percent or more of the patients in the applicant's service area, or the health systems agency if the initial determination was contrary to its recommendation and, in the case of revocation of a certificate, upon request of the person whose certificate is being revoked. The request shall be filed with the Commissioner within thirty days after the initial determination. Such proceedings shall commence within thirty days of the receipt of such request. Formal proceedings A formal hearing provided for in § 9-6.14:12 of the Code shall be held upon request, filed with the Commissioner within fifteen days after the initial decision in the informal proceedings, of the applicant, of any third party payor providing health care insurance or prepaid coverage to five percent or more of the patients in the applicant's service area, or of the health systems agency if the Commissioner's decision following the informal proceedings was contrary to its recommendation or, in the case of revocation, by the person whose certificate is being revoked. Such proceedings shall commence within thirty days of the receipt of such request. Both the~~

~~informal and~~ The formal proceedings shall be public proceedings and shall be held before a three-member advisory appeals panel consisting of two consumer members and one provider member of the Statewide Health Coordinating Council, who shall not reside in the same health services area. One of the members of the panel shall be designated as chairman each year by the Statewide Health Coordinating Council. The Statewide Health Coordinating Council shall appoint the three members to serve on the advisory appeals panel and shall develop a procedure for substitution in any case when one of the appointed members cannot attend a hearing. Of the three members appointed to serve in 1984, one shall serve a term of one year, one shall serve a term of two years, and one shall serve a term of three years. All appointments thereafter shall be for terms of three years. No appointed members shall be eligible to serve more than two consecutive terms .

2. For purposes of this subsection, "good cause" shall mean that (i) there is significant, relevant information not previously considered; (ii) there have been significant changes in factors or circumstances relied upon in reaching the determination whether to issue a certificate, or (iii) material procedures have not been followed in reaching the determination whether to issue a certificate.

3. A ~~decision~~ The advisory appeals panel shall forward its written recommendation, including the reasons therefor ~~shall be issued~~ , to the Commissioner within thirty days ~~after completion of the informal proceedings pursuant to § 9-6.14:11 or~~ after any formal proceedings pursuant to § 9-6.14:12 ; ~~whichever is applicable~~ .

In reviewing a proposed project, the panel shall consider the substantive and procedural legal aspects of the application.

4. The Commissioner shall render a final decision on the application within fifteen days of receiving the recommendations of the Advisory Appeals Panel. The Commissioner's decision shall be in writing and shall contain the rationale for his determination. If the decision is contrary to the recommendations of the Advisory Appeals Panel, the Commissioner shall also provide factual or statistical support for his rationale.

5. No member of the Advisory Appeals Panel shall be held civilly liable for any communication, decision or recommendations resulting from the discharge of his duties. The Office of the Attorney General shall represent or appoint special counsel to represent the members of the Panel in any court proceeding related to the performance of their duties on the Panel or any recommendations of the Panel.

§ 32.1-102.7. Appeals.—A. Any applicant aggrieved by a final administrative decision on his application for a certificate, any third party payor providing health care insurance or prepaid coverage to five percent or more of the patients in the applicant's service area, a health systems agency operating in the applicant's service area or any person issued a certificate aggrieved by a final administrative decision to revoke his certificate, within thirty days after the decision, may obtain a review, as provided in § 9-6.14:17 of the Code, by the circuit court of the county or city where the project is intended to be or was constructed, located or undertaken. Notwithstanding the provisions of § 9-6.14:16 of the Administrative Process Act, no other person may obtain such review.

B. Within five days after the receipt of notice of appeal, the Department shall transmit to the appropriate court all of the original papers pertaining to the matter to be reviewed. The matter shall thereupon be reviewed by the court as promptly as circumstances will reasonably permit. The court review shall be upon the record so transmitted. The court may request and receive such additional evidence as it deems necessary in order to make a proper disposition of the appeal. The court shall take due account of the presumption of official regularity and the experience and specialized competence of the Commissioner and the Advisory Appeals Panel . The court may enter such orders pending the completion of the proceedings as are deemed necessary or proper. Upon conclusion of review, the court may affirm, vacate or modify the final administrative decision.

C. Any party to the proceeding may appeal the judgment of the court to the Virginia Supreme Court in the same manner as appeals are taken and as provided by law.

SENATE BILL NO. HOUSE BILL NO.

A BILL to amend and reenact §§ 32.1-120 and 32.1-121 of the Code of Virginia, to amend the Code of Virginia by adding sections numbered 32.1-120.1 and 32.1-120.2, and to repeal §§ 32.1-103 through 32.1-111 of the Code of Virginia, relating to health planning and the requirements for regional health plans.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-120 and 32.1-121 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 32.1-120.1 and 32.1-120.2 as follows:

§ 32.1-120. Duties of Council.—The Council is authorized and directed to:

1. Prepare, review and revise as necessary a State ~~health plan~~ *Health Plan and a State Medical Facilities Plan* which shall be ~~made up of~~ *based on* the health plans prepared by the health systems agencies, with due consideration and review of other plans relating to physical and mental health services provided by agencies of the Commonwealth.

2. Review annually the budgets and applications for designation and funding made by the health systems agencies to the Secretary and make recommendations to the Governor and the Secretary on its findings from these reviews.

3. Review annually and approve or disapprove any plan or application submitted by an agency of the Commonwealth for the receipt of any federal funds under the allotment made to the Commonwealth under the United States Public Health Services Act, the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act or the Drug Abuse Office and Treatment Act of 1972.

4. Inform the Board generally on the performance of the Council's responsibilities under the provisions of this article and the federal act.

5. Perform such other functions relating to the coordination of health planning as the Governor may request.

§ 32.1-120.1. *Requirements for regional health plans.—A. The components and methodologies for the regional health plans shall be established by the Department of Health in its capacity as the designated Health Planning and Development Agency to provide consistency and uniformity and stimulate the development of regional health plans that provide a credible base for the State Health Plan.*

B. All regional health plans shall contain at least the following activities: (i) education for the public and the medical community; (ii) needs assessments focused on gaps in services, over-utilization and under-utilization of services, inappropriate use of services or resources, and accessibility of vital services; (iii) data collection focused on the facilities, services and utilization of services; (iv) resource allocation recommendations; (v) a medical facilities component to be used in the development of the State Medical Facilities Plan; (vi) encouragement of services to provide a continuum of care; and (vii) development of competitive initiatives.

§ 32.1-120.2. *State Medical Care Facilities Plan.—The State Medical Care Facilities Plan shall be developed by the Statewide Health Coordinating Council and shall be a plan designed to provide the necessary physical facilities for comprehensive health care services throughout the Commonwealth so that medical care facilities and services are reasonably accessible to all of Virginia's citizens.*

The Plan shall set forth, in order of priority, the relative need for construction, modernization and conversion of medical care facilities.

The Statewide Health Coordinating Council shall review the Plan annually and make modifications to it as necessary.

§ 32.1-121. Department of Health to act as designated agency; duties of Commissioner.—The

Department is hereby designated as the Health Planning and Development Agency of the Commonwealth for the performance of such functions as are designated by this article and the federal act. The Commissioner shall:

1. Conduct the health planning activities of the Commonwealth and, subject to the approval of the Board, implement those parts of the State ~~health plan~~ *Health Plan* provided for in § 32.1-120 and the plans of the health systems agencies which relate to the government of the Commonwealth.

2. Prepare, review and revise as necessary a preliminary State ~~health plan~~ *Health Plan and a State Medical Facilities Plan* which shall be ~~made up of~~ *based on* the health plans prepared by the health systems agencies and submit such preliminary plan to the Council.

3. Provide staff and administrative services for the Council and assist the Council in the performance of its functions generally.

4. Administer § 1122 of the United States Social Security Act if the Commonwealth has made an agreement with the Secretary pursuant to such section.

5. After consideration and review of recommendations submitted by the health systems agencies regarding new institutional health services proposed to be offered within the Commonwealth, make findings as to the need for such services.

6. Review at least once every five years all institutional health services being offered in the Commonwealth and, after considering the recommendations submitted by the health systems agencies and the Council regarding such services and after review by the Board of Health, make public the findings.

7. Perform any other functions relating to health planning activities in the Commonwealth as may be requested by the Governor.

8. Establish, with the cooperation of the health systems agencies, the components and methodology for the regional health plans.

2. That §§ 32.1-103 through 32.1-111 of the Code of Virginia are repealed.

SENATE BILL NO. HOUSE BILL NO.

A BILL to amend the Code of Virginia by adding a section numbered 32.1-121.1, providing a fund for health planning.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 32.1-121.1 as follows:

§ 32.1-121.1. Fund for health planning.—In the interest of maintaining a regional health planning mechanism in the Commonwealth, there is hereby established a fund for health planning. From such moneys as may be appropriated, this fund shall provide supplemental support of no more than six cents per capita for each health systems agency or such other regional or local health planning agency as may be established. Each agency shall be required to match any such funds with equal sums of local funds received from private or public sources. Per capita population figures shall be obtained from the Tayloe Murphy Institute at the University of Virginia for the established health services area or other established regional or local health planning area.

Any local governing body may choose to appropriate funds for the purpose of providing matching grant funds for a health systems agency or other established regional or local health planning agency. However, nothing in this section shall place any obligation on any local governing body to appropriate funds to any health planning agency.

Each agency shall be required to apply for these funds, which shall be distributed as grant funds. This fund shall be administered by the Department of Health, and the Board of Health shall promulgate such regulations as are necessary and relevant to administer this fund in a manner consistent with federal and state law. All applications for such funds shall be accompanied by statements of commitment for the required matching funds and letters of assurance that the applicant shall comply with all state requirements.

HOUSE JOINT RESOLUTION NO.....

Requesting the Departments of Health, Management Analysis and Systems Development, and Planning and Budget to study the feasibility of establishing a Consolidated Health Care Data Base for Virginia.

WHEREAS, accurate data provide the fundamental basis for informed government and private decisions; and

WHEREAS, the health care industry is evolving rapidly at this time as the result of the revised reimbursement systems; and

WHEREAS, viable data on services and facilities are crucial to the understanding of these changes; and

WHEREAS, the federal efforts to collect and disseminate data have been and will apparently continue to be reduced; and

WHEREAS, the Medicare Costs Reports will be eliminated in 1985, thereby creating another gap in the data available to the Commonwealth; and

WHEREAS, although the cost containment efforts of the Virginia Medicaid Program will not be hampered initially by the elimination of the Medicare Cost Reports, future efforts to control the costs of Medicaid and other health care programs in Virginia may suffer because of lack of data; and

WHEREAS, the information surveys required of health care facilities by various government and private organizations are time consuming and expensive to complete; and

WHEREAS, a uniform data collection system would provide relief to Virginia's health care industry from the duplicative and fragmentary efforts presently required for cost review, licensure, certificate of need and certification for payment; and

WHEREAS, the implementation of a uniform billing form will take place in the near future; and

WHEREAS, the development of a uniform accounting system would provide insight into the accounting practices of various institutions; and

WHEREAS, collection and dissemination of critical aggregate health care data would benefit the Commonwealth and its business and industry community; and

WHEREAS, precise data on the cost and utilization of health care services are essential to maintain the quality of care available to Virginians and to prevent health care from becoming unaffordable; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Departments of Health, Management Analysis and Systems Development, and Planning and Budget are hereby requested to study the feasibility of establishing a Consolidated Health Care Data Base for Virginia.

During the course of this study, the following issues shall be examined:

1. The feasibility of requiring a uniform accounting system or form;
2. The means to protect the privacy of the institutions and individuals;
3. The adequacy of the information contained on U.B. 82; and
4. The cost and efficiency of establishing such a data base.

The Secretary of Administration and Finance shall be responsible for coordinating this study.

In conducting this study, the responsible agencies shall confer with the Virginia Health Services Cost Review Commission, insurance companies and other organizations with established medical data base systems and seek input from representatives of the health care industry. The work of this study shall be completed in time to report the findings to the Governor and the General Assembly by December of 1984.

