INTERIM REPORT
OF THE
JOINT SUBCOMMITTEE ON

Health Care For All Virginians

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Report of the
Joint Subcommittee on Health Care
For All Virginians
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1989

To: Honorable Gerald L. Baliles, Governor of Virginia
and
The General Assembly of Virginia

AUTHORITY FOR THE STUDY

The joint subcommittee was created by two joint resolutions which were combined during the 1988 General Assembly. Senate Joint Resolution 99, proposed by the Governor and introduced by Senator Stanley C. Walker, authorized a study of indigent health care, including acute hospital care, long term care, Medicaid cost containment, and the appropriate role of the Certificate of Public Need program. House Joint Resolution 78 was introduced by Delegate Ford C. Quillen. This resolution authorized a study of eliminating Virginia's 209(b) status under Medicaid, which involves certain restrictive eligibility criteria regarding elderly and disabled recipients of Supplemental Security Income. These two joint resolutions were combined and approved by the 1988 General Assembly.

INTRODUCTION

The General Assembly has been concerned with the rising cost of health care and the burden of uncompensated hospital care for many years. The most recent legislative report was issued in 1986 by the Joint Subcommittee Established to Study Alternatives for a Long Term State Indigent Health Care Policy (House Document 29 of 1986). This report included a recommendation to establish a Governor's Task Force on Indigent Health Care. This task force was then created by Senate Joint Resolution 32 of 1986 and continued by Senate Joint Resolution 151 of 1987. The Governor's Task Force on Indigent Health Care issued its final report as Senate Document 11 of 1988.

The task force report was issued at the same time as the report of the Governor's Commission on Medical Care Facilities Certificate of Public Need, in December, 1987. As a result of

these two reports, a number of proposals were considered but not introduced by the 1988 General Assembly. Instead, the Governor proposed legislation calling for a two-year moratorium on granting Certificates of Public Need along with a further legislative study of health care cost containment, indigent health care, and long term care.

The 1988 General Assembly adopted a one-year moratorium on Certificate of Public Need, as an amendment to the budget bill. The General Assembly also adopted Senate Joint Resolution 99 which created the Joint Subcommittee on Health Care For All Virginians. This resolution was combined with House Joint Resolution 78 which called for a study of eliminating Virginia's restrictive Medicaid eligibility criteria for Supplemental Security Income recipients.

The joint subcommittee met six times during 1988 and adopted this interim report on December, 28, 1988. During this period a large number of presentations were made by interested persons and groups. In addition, the joint subcommittee was assisted throughout the study period by consultants from Peat Marwick Main & Co. of Chicago.

The joint subcommittee wishes to express its sincere appreciation to the many interested persons and groups who contributed to this study. In particular, the subcommittee gratefully acknowledges the assistance of Catherine Sreckovich, Senior Manager of Peat Marwick Main & Co., and her staff; Maston T. Jacks, Deputy Secretary of Health and Human Resources; the Departments of Health, Medical Assistance Services, and Aging; the Health Services Cost Review Council; and, the Bureau of Insurance of the State Corporation Commission. The joint subcommittee also extends its appreciation to the Virginia Hospital Association and the Virginia Health Care Association for their efforts on behalf of this study.

EXECUTUVE SUMMARY

The rising cost of health care is one of the most intractable problems facing the Commonwealth. A significant part of this problem is the need to provide health care for the approximately 880,000 Virginians who do not have health insurance of any kind from any source -- public or private. Many of these persons are employed and have incomes in excess of the the poverty level. For most of these Virginians health insurance is simply not affordable. Many others have incomes below the poverty line, but above the eligibility levels which restrict Medicaid and other public programs. Hospital care for those without any health insurance (public or private) is an increasing financial burden on Virginia's hospitals.

At the same time the changing environment of hospital finance has raised new questions about the appropriate role of state government in regulating the supply of hospital beds, equipment and services. Virginia's Certificate of Public Need program was originally intended to control costs, but recent evidence suggests carefully designed reimbursement systems may be more effective in this regard.

A Public-Private Partnership

These and other problems associated with health care financing are in the final analysis societal problems which affect all Virginians, and not just one industry. Likewise, solutions to these problems will involve actions by the business community and by health care providers as well as additional public financing. A joint public and private partnership is needed to enable all parties to share in the responsibility for addressing the rising cost of health care.

A Trust Fund for Indigent Health Care. As a first step, the joint subcommittee proposes that this partnership take the form of a new trust fund for indigent health care, administered by the Department of Medical Assistance Services. As a measure of our good faith in trying to solve these problems, we suggest the General Fund contribute one half of the funds the first year ($7.5 million).

For fiscal year 1990, we expect the trust fund will provide about $15 million to be distributed to those hospitals which provide greater than a standard level of charity care. A portion of our General Fund contribution will be directed to those hospitals which provide an extraordinary level of charity care. Payments to the remaining hospitals will be supported equally by hospital contributions and the General Fund. The portion of the trust fund provided by hospitals will be in the

form of contributions from those hospitals which provide less than the standard level of charity care. We propose a sunset clause for the trust fund to expire after the first year, so that we may consider further steps and modifications, as needed, during the second phase of this study.

State-Local Hospitalization. We also propose steps, as recommended by JLARC in 1988, to strengthen the State-Local Hospitalization program (at a cost of $4 million in General Funds). This program, also to be administered by the Department of Medical Assistance Services, will become our payer of first resort for those Virginians who have no health insurance of any type, and whose incomes fall below the poverty level. When state and local allocations for this program are exhausted, then the trust fund will be available as a backstop.

Deregulation of Hospitals. We believe that this new partnership should proceed hand in hand with legislation to eliminate regulation of hospitals under the Certificate of Public Need program, with certain exceptions. We suggest that psychiatric and rehabilitation hospital beds continue to be under COPN pending further study and that no hospital beds be converted to nursing home beds during the moratorium.

We recommend that hospitals submit consolidated audits each year to the Virginia Health Services Cost Review Council. These audits should include hospital affiliates, so we can be assured that public monies are being distributed in a fair and equitable manner.

The joint subcommittee reiterates that this is only a first step. We recommend that during the second phase of our study we continue to review this situation to determine whether additional contributions will be needed.

Health Insurance

In addition to these steps to provide hospital care for those Virginians whose family incomes fall below the poverty level, we believe additional steps are needed to make health insurance more affordable. The joint subcommittee notes the disturbing estimate that 880,000 Virginians have no health insurance from any source, either public or private.

While hospital insurance is available to anyone who wishes to purchase a policy, it is simply not affordable for many working families. One factor which contributes to the rising cost of health insurance is the inclusion of mandated benefits and providers in state laws governing such insurance.

The joint subcommittee recommends a one year moratorium on the consideration of any further mandated benefits or providers so that further study may be conducted of the social and financial impact of these mandates. The Bureau of Insurance of the State Corporation Commission should assist in this effort. The second phase of our study should also include consideration of other cost containment initiatives and incentives to make health insurance more affordable.

Long Term Care

We recognize that in the future we will need more nursing home beds and other long term care services to meet the needs of our rapidly growing elderly population. For now, we recommend the moratorium on approval of new nursing home beds be continued until January 1, 1991 and that no applications be filed until the end of the moratorium. At the same time, we recommend that nursing homes come under the prospective budget review system of the Health Services Cost Review Council.

We also recommend further steps to improve the availability and coordination of home and community-based services to enable more of our elderly citizens to continue to live in their own homes.

Medicaid

The cost of Medicaid is rising quickly. In fiscal year 1988 Medicaid expenditures from all funds were $806 million. Our projections indicate that by 1994 the cost of Medicaid will exceed $1.5 billion. Medicaid will soon represent the largest single expenditure in the state budget.

As costs have risen, the role of Medicaid has been transformed since its creation in 1965. What was originally intended to be a medical care program for poor families and children who met traditional welfare-related definitions, has been transformed into a program which is now the single most important funding stream for long term care for the elderly and disabled, due to the tremendous impact of long term care costs on family resources.

Reimbursement Concerns. We recognize that Virginia's eligibility standards for Medicaid are low in comparison to many other states. However, before any options to expand eligibility are adopted, certain underlying weaknesses in our reimbursement policies must be addressed. These weaknesses relate primarily to hospitals, nursing homes, and physicians.

We recommend that Medicaid reimbursement for hospitals and nursing homes be enhanced by the inclusion of a new Virginia-specific forecast of inflation for fiscal 1990, to recognize the fact that nursing salaries are rising faster in Virginia than in the nation as a whole. This new inflation factor will cost $2.4 million (GF).

In recent years our physician reimbursement under Medicaid has fallen far behind. In fact, some of our fees are now as low as the fifth percentile. Even those fees we recently raised to the 25th percentile have now fallen behind. In order to correct this situation, we recommend that Medicaid physician fees be increased to the 25th percentile over the next three years, with the first step to the 15th percentile as of January 1, 1990, at a cost of $6.0 million (GF).

In addition to raising physician reimbursement, we must consider further strategies to make primary health care more available. The Board and Department of Health should continue to take the lead in this area, and prepare to make specific recommendations during the second phase of this study.

Conclusion

The estimated cost of this series of recommendations in fiscal year 1990 to the General Fund of the Commonwealth will be in the range of $20 million.

Finally, we recommend that a Joint Resolution be adopted to continue the Joint Subcommittee on Health Care For All Virginians, with a final report to the presented to the 1991 General Assembly.

CERTIFICATE OF PUBLIC NEED

A major impetus for this study was the desire to resolve the many issues surrounding Certificate of Public Need (COPN). The Commonwealth has a stake in controlling the cost of hospital and nursing home care, but the evidence is mixed as to the overall effectiveness of COPN in restraining health care cost increases. In view of the changing environment of health care finance we conclude the time has come to move towards deregulation of the hospital industry as part of an overall strategy to address the problem of indigent health care. Other issues with respect to COPN require further study.

Pending completion of this study, a moratorium on approval of any further certificates was included in the 1988 Appropriations Act (Item 374). However, the following exceptions were included:

- Projects for renovation or replacement of an existing facility or part thereof as required to comply with life safety codes, licensure, certification or accreditation standards;
- Projects required to comply with the conditions of research grants;
- Projects required to meet a clearly demonstrated emergency public health need, renovate or replace equipment due to equipment failure or obsolescence, provide innovate technologies of proven significance for which the citizens of the Commonwealth do not have reasonable access, or which have been substantially funded by charitable contributions, or which will reduce health care costs;
- Projects required by the General Assembly pursuant to the Appropriations Act; or,
- Projects of a non-clinical nature.

This section of the report considers the original justification for COPN, recent changes in health care finance which lead us to reexamine the need for COPN, the Governor's Commission on COPN, and the findings and recommendations of the joint subcommittee.

Original Justification for Regulation.

Government control of private investment in the health care industry evolved over the past four decades as a means to control the rising cost of health care. The federal Hill-Burton Act of 1946 provided federal funds for hospital construction, but required states and localities to initiate health planning.

Since the creation of Medicare and Medicaid in 1965, there has been growing awareness of the rising share of our national income devoted to health care. In fact, by the early 1970's the problem of hospital shortages had been reversed, and concerns of oversupply dominated federal policy discussions. Congress established two separate capital expenditure review programs to control the cost of health care by limiting the growth of facilities. These two programs were the Section 1122 program under the Social Security Act amendments of 1972 and the Certificate of Public Need (COPN) program under the 1974 National Health Planning and Resources Development Act.

Recent Changes in Health Care Finance

Since the 1970's the nature of health care finance has changed dramatically, raising fundamental questions as to the continued need for such regulatory controls. For example, since the early 1980's government and private sector insurance reimbursement systems have been restructured to emphasize prospective cost controls. Virginia adopted a prospective Medicaid reimbursement system in 1982, soon to be followed by the Diagnostic Related Group (DRG) payment system which was part of the Medicare reforms of 1983. Another dramatic change in the health care industry has been the emergence of new ways of delivering medical services, including outpatient and ambulatory care and alternative delivery systems such as Health Maintenance Organizations and Preferred Provider Organizations.

These changes have encouraged competition as well as intense scrutiny of costs by the major third party payers such as Blue Cross-Blue Shield plans, private insurers, and Medicare and Medicaid. As a result, hospitals have become less able to pass along unjustified costs to the major payers.

Constrained reimbursement has contributed to the declining use of hospital inpatient services, and Virginia's occupancy rate (about 67 percent) mirrors the national trend. This excess acute care capacity has reduced the incentive to add new beds. As a result, mandatory government review of hospital decisions seems less important. The alternative view has emerged that heightened competition in the marketplace is the best guide for private investment.

The Governor's Commission on COPN

The Governor's Commission on Medical Care Facilities Certificate of Public Need was established by executive order in December 1986 to study the effectiveness of the COPN program and to recommend changes, if needed. The Governor's concerns were related to the issues of health care cost control, availablility of services, and access to services.

The Johns Hopkins University School of Hygiene and Public Health was selected to conduct a study of the COPN program in Virginia. The Johns Hopkins report concluded that it was unable to find documented evidence of any significant impact on cost by COPN; that the process needed to be improved; and that there were sharp differences of opinions about COPN among health care industry leaders.

The Governor's commission report was released in tandem with the report of the Governor's Task Force on Indigent Health Care. In a letter transmitting the two reports, the Secretary of Health and Human Resources stated that the two 1987 reports were inextricably linked, in that the Governor's Task Force sought to ensure that decisions made with respect to COPN should be assessed in relation to their effect on the availability of health care to the indigent.

In turn, the Governor's commission recommended partial deregulation of hospitals, provided that adequate measures to address the indigent health care burden could be developed. Specifically, the Governor's commission recommended that COPN no longer be required for purchase of major medical equipment and establishment of associated new clinical services. However, the Commission felt COPN should be retained for the construction of new hospital beds, including the addition of beds to existing facilities and relocation of existing beds. The Commission also recommended that COPN be retained for nursing homes and that a number of administrative improvements be made in the COPN process and in the health planning capabilities of the Commonwealth.

Discussion

The Commonwealth has a stake in the cost of hospital care. While Medicaid accounted for only three percent of hospital revenues in 1987, hospital reimbursement will still account for 22 percent of Medicaid expenditures this year. However, there is insufficient evidence to support the claim that continuation of COPN is justified in order to restrain hospital cost increases. In view of today's highly competitive health care marketplace, COPN is no longer necessary for most types of hospital beds, equipment and services.

The experience of states which have deregulated hospitals suggests there has been no surge in the number of acute care beds. At the same time, we note that in several of these states there has been an increase in the number of psychiatric and rehabilitation beds. These services are frequently mandated in state law and there are fewer reimbursement controls on these services. Further study is needed before psychiatric or rehabilitation beds are removed from COPN. We also conclude that hospitals should not enjoy an unfair advantage over nursing homes during the moratorium by converting excess acute care beds to nursing home use.

The Commonwealth plays a dominant role in financing nursing home care through Medicaid, which is an entitlement program. In fact, Medicaid pays for about two-thirds of all private nursing home patient days in Virginia, and nursing home reimbursement will account for over 28 percent of Medicaid expenditures this year. While there is a need to control the potential cost to Medicaid of unlimited growth in the supply of nursing home beds, it is unclear as to whether that control should be exercised through COPN regulation or through other types of limits in the Medicaid program. This is an issue which should be addressed by the Joint Subcommittee next year.

In the context of a public private partnership in which competition will be encouraged, there are certain additional types of information which must be required by the Commonwealth and made available to the consumers of health care in order to insure fairness and equity in the allocation of public funds.

Recognizing that the environment of health care delivery and finance is changing so rapidly, it seems clear that the Commonwealth should take steps now to strengthen its ability to carry out statewide health planning in a more effective manner. This concern should be addressed in the second phase of the study.

Recommendations

We offer the following recommendations with respect to the Certificate of Public Need (COPN) program:

1. Hospitals. The time has come to deregulate the hospital industry from Certificate of Public Need, with certain exceptions. Psychiatric and rehabilitation hospitals should continue under COPN regulation, and no hospital beds should be converted to nursing home beds, pending completion of this study.

At the same time we believe this decision must be made in the context of a new public and private partnership to ensure the provision of hospital care to those Virginians who are unable to obtain any health insurance and whose incomes are below the poverty level.

2. Nursing Homes. The moratorium on approval of new certificates of public need for nursing home beds should be continued until January 1, 1991. During this period no new applications for nursing home beds should be received by the Commissioner of Health. The joint subcommittee should continue its study of the certificate of public need program during the next phase.

The next section of this report addresses the concerns of Virginians who are uninsured and have difficulty obtaining essential hospital and primary health care.

VIRGINIA'S UNINSURED POPULATION

One of our key findings concerns those of our fellow Virginians who have no health insurance of any kind or from any source -- including Medicare, Medicaid, or private insurance. As described above, actions to deregulate the hospital industry must proceed in tandem with steps to address this critical need.

Who Are The Uninsured?

A large number of Virginians do not have any health insurance at all. The Employee Benefit Research Institute has estimated 880,000 Virginians (or 16.6 percent of our residents under age 65) were uninsured in 1987. This compares to 17.4 percent for the nation as a whole (which represents 37 million Americans without health insurance). The State Corporation Commission reports 270,000 (or 31 percent) of the uninsured in Virginia are age 17 or under.

Most of the uninsured are connected to the workforce. National studies suggest 75 percent of the uninsured (or about 28 million persons) are in households in which at least one family member is employed. Comparable surveys for Virginia suggest 600,000 (68 percent of Virginia's uninsured population) live in households with at least one working family member. At least two thirds of the uninsured live in households with incomes above the poverty level.

Many of the uninsured are employed in construction, retail trade, and service companies, and in small businesses, which often do not offer health insurance. The Governor's Task Force on Indigent Health Care found that 35 percent of businesses with fewer than 51 employees do not offer health insurance protection for their workers. One factor which may contribute to the high cost of health insurance for employees of small businesses is the inclusion of mandated benefits under state law. Further study is needed of this issue during the second phase of this study.

Primary Care for the Indigent

Families without health insurance also have difficulties obtaining primary care as well as hospitalization. In fact, the lack of a primary care physician often leads the uninsured to seek medical care in an inappropriate setting such as a hospital emergency room. The State Board of Health has reported that many Virginians do not have a family physician and do not receive basic medical services in their own communities because there is no doctor close to their home.

Across Virginia, 52 of our 136 cities and counties are designated as medically underserved areas, based on the national standard of one primary care physician for every 3,500 people. The Department of Health assumed responsibility in 1985 for addressing the issues of access to primary health services. At the November 28, 1988, meeting of the Joint Subcommittee, the Board and the Department of Health suggested a plan for encouraging the education of primary care physicians and placing those physicians in medically underserved areas.

During the second phase of this study, we believe the Department of Health should continue to explore the options in this critical area. In addition, we believe the department should explore potential roles which could be assumed by local health departments in cooperation with other parts of the medical community to provide better primary care.

Recommendations

During the second phase of this study further study is needed of mandated health insurance benefits and providers as well as of other potential strategies to make health insurance more affordable for all Virginians. Further study is also needed to develop strategies to expand the availability of primary care for indigent Virginians. We offer the following recommendations to address these concerns:

1. Affordability of Health Insurance. The Joint Subcommittee should continue to review, in the second phase of this study, appropriate steps to make private health insurance more affordable for working Virginians. Such steps might include social and financial impact analysis of mandated insurance benefits and providers and other cost containment initiatives and incentives to make health insurance more affordable.

2. Moratorium on State Mandates. The 1989 General Assembly should adopt a one year moratorium on the approval of any new mandated health insurance benefits or providers under the Code of Virginia, pending completion of a study of the social and financial impact of such mandates by the Bureau of Insurance of the State Corporation Commission, with the assistance of the Department of Health, to be presented to the joint subcommittee by September 1, 1989.

3. Availability of Primary Care. The Department of Health should present a report to the Joint Subcommittee by July 1, 1989, on potential options to expand the availability of primary care services for uninsured Virginians, and in medically underserved areas, including steps to encourage local health departments, community hospitals, the teaching hospitals, the medical schools, and the medical community in general to work together to develop innovative local programs to expand primary care delivery.

The high cost of health insurance and the unavailability of primary care for many Virginians have contributed to the growing burden of uncompensated care on Virginia's hospitals, as described in the following section.

EQUALIZING THE BURDEN OF INDIGENT HOSPITAL CARE

Hospitals are providing a growing amount of care to persons who are unable to pay their hospital bills, and who are not covered by Medicaid, Medicare or other public programs. This "uncompensated" care is considered to be either charity care or is written off as bad debts.

This section of the report considers the extent of charity care and bad debt, programs in other states to address this problem, Virginia's existing State-Local Hospitalization program, and recommendations of the joint subcommittee.

Charity Care and Bad Debt

A more precise definition of charity care was adopted by the Virginia Health Services Cost Review Council as of July 1, 1988. Under this new definition, charity care is defined as uncompensated care provided by hospitals to persons whose family income falls below the federal poverty level. As of February, 1988, the federal poverty level for a family of four was $11,650 per year (or $970 per month). Uncompensated care provided to persons with incomes above this level is now defined as a bad debt.

From fiscal 1982 to 1987 the level of uncompensated care (excluding state teaching hospitals) increased 94 percent -- from $119 to $230 million. However, due to pressures by third party payers to hold down costs, hospitals have become less able to shift this burden to their paying patients.

In order to analyze this burden we converted charges to costs, and considered only the cost of charity care, which is that part of uncompensated care which is provided to persons whose incomes are below the poverty level. We found that in 1987 total charity care by all hospitals was $125.5 million, of which $90 million (or 80 percent) was provided by the two state teaching hospitals (the University of Virginia Hospitals and the Medical College of Virginia). The remaining amount of charity care provided by private hospitals was $35.5 million.

The burden of of charity care is not evenly distributed among public and private hospitals in Virginia. For example, the Eastern Virginia Health Service Area bears an unusually high percentage of the total charity care burden. Certain hospitals also bear a disproportionate burden in relation to their gross patient revenue.

Review of Other States' Programs

We reviewed very carefully the experience of several other states which have devised various plans to address this problem. Several states have established minimum standards for the amount of indigent care hospitals should provide. Some states have built these standards into their Certificate of Public Need requirements, while others have established funding pools. The concept of a funding pool involves contributions from hospitals which provide less than the standard so the dollars can then be redistributed to the hospital providing more than the standard. Typically a formula is developed to distribute the dollars.

States with funding pools include: Arkansas, Colorado, Florida, Massachusetts, Nevada, New York, Ohio, and South Carolina.

- Florida. In Florida, all hospitals are assessed 1.5 percent of net operating revenues, and these revenues are matched with state general funds and deposited into a trust fund. Hospitals which provide at least 2.5 percent of their total inpatient days to Medicaid patients (or at least five percent of patient days to either Medicaid or charity patients) receive payments from the trust fund.

- New York. In New York, on the other hand, no state general funds are provided. Hospitals are assessed 1.9 percent of their total inpatient revenues, and receive payments from one of eight regional indigent care pools based on the type of hospital and the level of bad debt and charity care.

- Massachusetts. A 13 percent surcharge on all hospital bills is added in Massachusetts through the rate setting process. State general funds are also added to the funding pool, which reimburses hospitals which have uncompensated care costs greater than 13 percent of patient revenues. The surcharge is expected to be reduced under the new universal care program.

In each of these three states hospitals are assessed so that funds maybe made available to those hospitals which bear an extraordinary share of the indigent care burden. A more detailed analysis of all such programs in other states was provided to the joint subcommittee by Peat Marwick Main & Co.

State-Local Hospitalization

The SLH program was established in 1946. The state contributes 75 percent of the cost of the program, with localities contributing the other 25 percent. Each participating locality (through its local department of welfare or social services) develops its own eligibility criteria, service plans, and reimbursement methods.

SLH funds are allocated to all localities on the basis of population. Funds allocated to localities which do not participate in the program are redistributed to other cities and counties when their SLH expenditures exceed their original allocations. The program also has a reserve fund.

SLH has been criticized over the years. In 1987 JLARC made a series of recommendations designed to strengthen the program. JLARC recommended that all localities be required to participate in the program, that eligibility criteria and covered services be made uniform across the state, and that local shares be adjusted by the JLARC revenue capacity model, with or without an adjustment for local personal income.

Our review of these programs suggests that a plan to strengthen the SLH program in tandem with the creation of an indigent care funding pool has the greatest likelihood of success in Virginia.

Recommendations

We recommend a plan to involve state and local government and the hospital industry in a new partnership for hospital care for all Virginians whose incomes fall beneath the poverty level, and who are not already covered by Medicare or Medicaid. In brief, this plan has four parts:

1. Virginia's 94 acute care hospitals should participate in a new Indigent Health Care Trust Fund, to be managed by the Department of Medical Assistance Services (DMAS). The Commonwealth would contribute about one half of the trust fund with an appropriation of $7.5 million from the General Fund the first year. The remaining one half of the fund would be financed by those hospitals which do not provide a minimum level of charity care.

   - All acute care hospitals would be ranked from highest to lowest according to the percentage of charity care they provide in relation to their gross patient revenues.

- The median percentage of charity care in relation to gross patient revenues would be defined as the standard level of charity care.

- Contributions would be based on the amount of funds needed to pay hospitals which provide charity care in excess of the standard. Hospitals which pay into the fund would receive credit for the amount of charity care they provide.

- Hospitals with fewer than 100 beds would not have to make a contribution, but could receive payments for charity care in excess of the standard.

- Hospitals which provide more than the standard level of charity care would be paid 60 percent of their costs to ensure the trust fund is used only as a payer of last resort.

- The trust fund would be created for one year beginning July 1, 1989, with the initial contributions and payments made as of June 30, 1990. The trust fund would then expire unless reauthorized by the 1990 General Assembly.

2. <u>The State-Local Hospitalization (SLH) program should be strengthened.</u> A series of steps is recommended, based on the 1988 JLARC report.

   - First, SLH should be moved from the Department of Social Services to the Department of Medical Assistance Services.

   - Second, a number of changes should be made in SLH such as mandatory local participation, standard eligibility criteria and services, and a new formula (based on local revenue capacity adjusted by per capita income) to determine the local shares of the program. The cost of this step would be $4 million from the General Fund plus a net increase of about $300,000 in local funds.

3. <u>The plan should incorporate the deregulation of acute care hospitals from the Certificate of Public Need (COPN) process.</u> However, psychiatric and rehabilitation hospitals should still be included under the COPN moratorium pending further study, and no hospital should be

permitted to convert hospital beds to nursing home beds during the moratorium.

4. Hospitals should be required to submit consolidated annual audits (including their affiliates) for review and comment by the Health Services Cost Review Council, on forms approved by the council.

The strengthening of State-Local Hospitalization and the creation of a new Indigent Health Care Trust Fund to serve as a back-up funding stream for hospitals would signify a commitment by the Commonwealth to participate in providing for the health care of all Virginians who do not have any health insurance and whose incomes fall below the poverty level.

The deregulation of hospitals from the Certificate of Public Need program represents a determination that there are more effective ways for state government to promote efficiency and economy in the hospital industry than through the review and approval of private investment decisions which affect the supply of capital facilities, equipment and services.

This plan will require that the hospitals themselves agree to a new contribution from those hospitals which provide less than a standard level of uncompensated care. In addition, all hospitals will have to provide annual consolidated audits of their operations and the operations of their affiliates, so the Commonwealth can be assured that costs and benefits under this new plan are apportioned fairly and equitably.

We believe this plan represents a critical first step to finance hospital care for lower income Virginians. However, we emphasize that this is only an interim step. During the second phase of this study we also suggest continued review of these steps so that modifications, if appropriate, can be considered.

Another area of growing concern to the Commonwealth is the rising cost of long term care, including nursing homes for elderly Virginians and the need for home and community based alternatives. These issues are addressed in the next section.

NURSING HOMES AND LONG TERM CARE

A key area of concern for the second phase of the study will be the need to address Virginia's growing elderly population and the need to provide nursing home care and other types of long term care. Important objectives to be considered include the need to encourage cost effective alternatives to nursing home care and the need to improve coordination of all long term care services.

The Aging of Virginia's Population

Virginians over age 85 are the fastest growing segment of our population. From 1980 to the year 2000 this group will have increased 71 percent, as compared to an increase of 25 percent for the state population as a whole. By 1990 Virginia's population over age 65 will exceed the college age population.

The aging of Virginia's population requires that the Commonwealth take steps now to plan for and expand the supply of long term care services. Nursing homes represent one important component of long term care, but not the only component. Other services are needed to help older Virginians to remain in their own homes if possible.

Additional nursing home beds will be needed after the moratorium on Certificate of Public Need (COPN) is lifted. As of June 30, 1988 Virginia had 24,694 licensed nursing home beds and another 6,119 beds approved under COPN. However, even with these additional beds Virginia will have about 48 beds per 1,000 elderly population, compared to a national average of 54 beds per 1,000. For this reason it seems clear that more nursing homes will be needed in the future.

Coordinating Long Term Care

However, before the moratorium on approval of new beds is lifted, steps are needed to enable the Commonwealth to play a more active role in determining the appropriate number of nursing home beds which are actually needed and in forecasting the fiscal impact of the decisions to approve new beds. Further study is needed to determine whether Certificate of Public Need should be retained for nursing homes or whether other types of expenditure controls should be developed within the Medicaid program to limit future cost increases.

At the same time the rate of growth in the number of nursing home beds needed in the future can be moderated by a shift in emphasis towards home and community based care. This will require increased coordination of long term care services which are provided by several different public agencies.

Recommendations

Recognizing the significant implications of Virginia's aging population and the need to strengthen our coordination of long term care, we recommend the following actions:

1. Legislation should be adopted continuing the moratorium on new nursing home beds (under Certificate of Public Need) through January 1, 1991. This should include a provision that no applications may be filed until the end of the moratorium.

2. Legislation should be adopted to require nursing homes to come under the prospective budget review system of the Virginia Health Services Cost Review Council. The council should work with the nursing home industry to insure this requirement is implemented in such a manner as to minimize duplicate reporting.

3. Legislation should be considered during the second phase of this study to strengthen the Certificate of Public Need process as it relates to long term care. The legislation should provide for the development of a new methodology for determining how many new beds are needed, as well as other administrative improvements.

4. Legislation should be considered during the second phase of this study directing the Commissioner of Health to report each year to the General Assembly on the number of new nursing home beds needed, as well as the projected fiscal impact of the proposed beds, before they are approved.

5. Legislation should be considered during the second phase of this study to strengthen the Long Term Care Council so that it might serve as a more effective coordinating body for those public agencies which are involved in the provision and funding of long term care.

6. The Department of Medical Assistance Services should be encouraged to move forward with a strategy to expand waivers and optional services for home and community based care as recommended in its report to the Joint Subcommittee on October 24, 1988.

7. The Department for the Aging should develop a statewide information system for long term care services for the elderly, including a uniform assessment instrument for clients and a common data base available to all participating state and local agencies ($100,000 GF).

These recommendations are intended to address the critical needs facing Virginia in the areas of uncompensated hospital care and long term care. The next section of the report addresses the role of Medicaid in financing a variety of health services for eligible low income Virginians.

ASSESSING THE MEDICAID BUDGET

The Joint Subcommittee was created in large part because of concerns by the Governor and the General Assembly about the rapid growth of the cost of Medicaid and the effect of that growth on our ability to pay for other essential services. Medicaid already represents about eight percent of our General Fund budget, and this share could increase to ten percent by 1994. New federal mandates, new nursing home beds, and the reduction in the federal share of the program account for much of the increased cost of Medicaid to the General Fund.

Despite the growth in the size of the budget, Virginia has a relatively modest Medicaid program in comparison to most other states, particularly with respect to eligibility. For example, in 1986 Virginia ranked 39th among the 50 states in total Medicaid expenditures per capita, and 36th in the percentage of the poverty population covered by Medicaid.

The fundamental change which has occurred in Medicaid since its inception in 1965 has been the transformation of a program which was originally intended to serve categorically eligible families who met traditional welfare-related definitions, into a program which is now the most important funding stream for long term care for the elderly and disabled. A related change since 1985 has been the expansion of eligibility for certain high-risk groups such as pregnant women and children, far beyond traditional welfare definitions.

As we assess Virginia's Medicaid program, one of our major concerns has been the projected fiscal impact of recent federal changes in Medicare, as outlined in the next section.

The Medicare Catastrophic Coverage Act

The 1988 Medicare Catastrophic Coverage Act represents a significant new federal mandate on the Commonwealth to expand Medicaid eligibility. The act requires that by 1992 Virginia must have phased in Medicaid coverage of all elderly and disabled persons under the poverty level. (In 1986 the poverty level for a family of two was $7,372.) Medicare premiums and deductibles for this new group will be paid by Medicaid. This mandate will increase Medicaid enrollment by an estimated 26,000 elderly and 9,700 disabled recipients by 1993.

In addition, the Catastrophic Coverage Act eliminates Virginia's transfer of assets rules, which will enable more applicants to transfer their assets to other family members in order to qualify for nursing home care under Medicaid.

Our consultants from Peat Marwick Main & Co. have estimated the cost of the Catastrophic Coverage Act to be about $19 million (General Funds) in fiscal 1990. This cost is expected to rise to at least $108 million by 1994.

Options for Expanding Eligibility

Beyond the new federal mandates, Virginia has a number of options by which eligibility for Medicaid coverage could be expanded. These include elimination of the so-called 209(b) option as well as other steps to expand coverage of pregnant women and children. We believe further study is needed of these options during the second phase of the study, particularly in light of the potential for further changes at the federal level.

One of the key restrictions in eligibility is the 209(b) option. When the Supplemental Security Income (SSI) program was adopted in 1971, section 209(b) was passed by Congress to allow Virginia to maintain certain more restrictive eligibility criteria under Medicaid than would otherwise have been permitted for elderly and disabled SSI recipients. These more restrictive criteria include Virginia's $5,000 limit on contiguous property and the exemption of the first $2,500 of prepaid burial plans from countable assets. If these current restrictions were to be lifted, an additional 9,295 SSI recipients would become eligible for Medicaid at an annual cost of $14.4 million in General Funds.

Other potential options for expanded Medicaid eligibility include coverage of pregnant women and children (up to age 18) in families with incomes up to 185 percent of the poverty level. The Department of Medical Assistance Services has estimated the additional cost of covering children up to age five in families with incomes below 185 percent of poverty would be about $51.6 million (General Funds) in fiscal 1990.

Options For Improving Reimbursement

Our reimbursement of providers has lagged behind the rising cost of health care services. Two particular concerns which we have addressed are the inflation factor built into our hospital and nursing home prospective reimbursement systems and the overall level of physician reimbursement.

- Virginia Specific Inflation Forecasts. A new industry-specific measure of inflation published by Data Resources, Incorporated (DRI) was adopted as of July 1, 1988 as a cost containment

measure. However, nursing homes are concerned that this national forecast of inflation does not adequately reflect the rising cost of nursing salaries in Virginia -- a factor due in large part to the current nursing shortage. Nursing salaries appear to be rising faster in Virginia than in the nation as a whole. In order to address this problem the industry has suggested that Medicaid adopt the DRI Virginia specific inflation forecast, which would better represent salary cost increases in Virginia.

- Physicians' Reimbursement. Since Virginia began its Medicaid program in 1969, payments to physicians have been increased across the board only once (by five percent in 1981). As a result, physicians fees are now a major concern.

  The Department of Medical Assistance Services reported to us that current payments for physician services are generally less than the fifth percentile of all charges. Obstetricians' fees were raised in 1986 to the 25th percentile but have now fallen to the tenth percentile. Primary care physicians' fees were raised to the 25th percentile in 1987, but have since fallen behind again. Potential negative consequences of such low reimbursement may include steps by physicians to limit their Medicaid practices, the inability of Medicaid to cover even overhead charges for physicians' services, and possible federal lawsuits over restricted access to care.

We believe these underlying weaknesses in reimbursement policies should be addressed before any further optional steps are taken to expand eligibility.

Projected Medicaid Costs for 1994

Like most other states Virginia is concerned about rapidly increasing cost of the Medicaid. Total Medicaid costs in Virginia increased by 84 percent from $382 million (from all funds) in 1980 to $701 million in 1987. Our consultants project the cost of Medicaid will increase another 118 percent to $1,531 million in 1994.

This projection assumes that almost $260 million of the projected $1.5 billion cost of Medicaid in 1994 would be accounted for by three major factors:

- First, it assumes Virginia would eliminate the 209(b) option which restricts eligibility for elderly and disabled persons who also receive SSI, and that this step would cost $48 million annually (from all funds) by 1994.

- Second, it assumes the cost of the 1988 Medicare Catastrophic Coverage Act will be $103 million annually by 1994.

- Third, it assumes the cost of nursing home beds already approved and additional beds which would be approved after the moratorium on COPN expires would be $108 million per year by 1994 (from all funds). This assumes the current bed need methodology remains unchanged.

In view of these rapidly escalating costs, continued review of the Medicaid program is needed. We also recognize that a greater proportion of these costs will be borne by the Commonwealth in the future, as described in the next section.

Federal Participation in Medicaid

The federal share of Virginia's Medicaid program will have declined from 65 percent in 1971 to 50 percent by 1990. The federal share is determined by a formula which compares Virginia's per capita income with the national average. Since 1980 Virginia's per capita income has risen from 24th to 10th highest in the nation, so our federal match rate for Medicaid has dropped accordingly. There is a floor of 50 percent federal funding currently, but we are aware that this minimum federal share could be reduced in the future.

Of the $1.5 billion projected total cost of Medicaid in fiscal 1994, we can assume the Commonwealth's share of this total cost is $230 million higher ($995 million instead of $765 million from the General Fund) simply because of the reduction in the federal matching rate from 65 to 50 percent.

Recognizing the attention focused at the national level on reducing the federal deficit and the interest of the new Administration in Washington in the role of states in health care, we believe continued review of the Medicaid program by the Joint Subcommittee is essential.

Recommendations

We make the following recommendations with respect to the budget for Medicaid in fiscal 1990:

1. The budget for the Department of Medical Assistance Services should be adjusted to include a Virginia-specific inflation forecast (as published by Data Resources, Inc.) to adjust per diem rates paid to hospitals and nursing homes, effective July 1, 1989. This should cost $2.4 million (GF) in fiscal 1990.

2. The budget for the Department of Medical Assistance Services should be adjusted to increase physician reimbursement to the 25th percentile over a three year period, with the first step raising reimbursement to the 15th percentile on January 1, 1990. This should cost $6.0 million (GF) in fiscal 1990.

3. The Department of Medical Assistance Services should be encouraged to apply for additional federal waivers to expand the availability of home and community based care for the elderly, as alternatives to nursing homes. The Department should make a follow-up report to the Joint Subcommittee during 1989.

4. The joint subcommittee recognizes the cost of pharmacy services under Medicaid has increased by 71 percent over the past four years, and that the cost containment initiative of the 1988 General Assembly was appropriate. This initiative will result in a savings to the General Fund of $5.5 million in fiscal 1990.

CONCLUSION

The Joint Subcommittee on Health Care For All Virginians was created by the 1988 General Assembly pursuant to Senate Joint Resolution 99. The study also incorporated House Joint Resolution 78 which called for a study of eliminating Virginia's restrictive eligibility criteria for Supplemental Security Income recipients who apply for Medicaid.

The joint subcommittee was directed to study several issues including the Certificate of Public Need (COPN) law, the extent to which Virginians are not covered by health insurance, the growing burden of uncompensated hospital care, the growing need for long term care in an aging society, and the rapidly increasing cost of Medicaid and the need to contain costs wherever possible.

Findings and Recommendations

On December 28, 1988, the joint subcommittee adopted an interim report. In brief, the following conclusions and recommendations were included:

- The rising cost of health care is one of the most intractable problems facing the Commonwealth. A major part of the problem is to provide care for those whose family incomes fall below the poverty level. Hospitals are absorbing an increasing amount of charity care for persons in this category.

- This is a societal problem, and all parts of society should contribute to the solution. As a first step to address this problem, a trust fund is needed to finance hospital charity care. This trust fund should represent a joint partnership of the Commonwealth and the hospital industry. The fund should be managed by the Department of Medical Assistance Services (DMAS).

- The State-Local Hospitalization (SLH) program should be transferred from the Department of Social Services to DMAS. All localities should be required to

participate, eligibility and services should be uniform across the state, and local shares should be determined by a formula based on local revenue capacity with a per capita income adjustment, as recommended by JLARC. When funds for SLH are exhausted the trust fund should be available as a backstop.

- This new partnership between the Commonwealth and the hospital industry should proceed hand in hand with steps to eliminate regulation of hospitals under Certificate of Public Need (COPN), with certain exceptions. Psychiatric and rehabilitation hospitals should remain under COPN and no hospital beds should be converted to nursing home beds during the moratorium.

- The moratorium on Certificate of Publc Need for nursing home beds should be continued until January 1, 1991.

- Hospitals should submit consolidated annual audits and nursing homes should be brought under the prospective budget review system of the Health Services Cost Review Council.

- Medicaid has been transformed from a program which was originally intended to serve the welfare-related needy, into a program which is also the largest funding stream for long term care for the elderly and disabled. However, before any further expansions of eligibility are approved, several provider reimbursement issues should be addressed.

- Medicaid reimbursement for hospitals and nursing homes should be improved by adopting a Virginia-specific measure of inflation.

- Physicians' fees should be increased to the fifteenth percentile as of January 1, 1990, as the first step towards increasing fees to the 25th percentile.

- The Department of Health should prepare recommendations to the joint subcommittee to expand the availability of primary care services.

- Virginia will need more nursing home beds and other long term care services. However, greater coordination is needed between decisions to approve new nursing home beds and the budget process for funding those beds. Steps are also needed to improve the availability and coordination of home and community based services which enable the elderly to remain in their own homes as an alternative to nursing homes.

- An estimated 880,000 Virginians have no health insurance of any kind from any source. However, two-thirds of these persons live in households in which at least one family member is working.

- The joint subcommittee should study possible steps to make private health insurance more affordable. There should be a one-year moratorium on further mandated health insurance benefits and providers and this issue should be studied by the joint subcommittee. The Bureau of Insurance should provide a report on this topic by September 1, 1989.

- These recommendations are estimated to cost $20 million from the General Fund in fiscal year 1990.

- The joint subcommittee should be continued.

Respectfully submitted,

Stanley C. Walker, Chairman

Ford C. Quillen, Vice Chairman

Hunter B. Andrews

C. A. Holland

Robert B. Ball, Sr.

George H. Heilig, Jr.

S. Wallace Stieffen

Samuel B. Hunter, M.D.

Robert G. Jackson II

Bette O. Kramer

Charles B. Walker

Gerald L. Good

Eva S. Teig

Stuart W. Connock

Dissenting

Elliot S. Schewel

J. Samuel Glasscock

J. Bland Burkhardt, Jr.

Minority Reports Attached

J. Samuel Glasscock

J. Bland Burkhardt, Jr.

INDIVIDUAL DISSENTING STATEMENTS

DISSENT OF J. SAMUEL GLASSCOCK TO REPORT OF

JOINT SUBCOMMITTEE STUDYING HEALTH CARE FOR ALL VIRGINIANS

SJR 99/HJR 78

While I commend the work of the Subcommittee in its effort to help the Commonwealth deal with the difficult issue of health care for all Virginians, I do have two concerns about the report. They are (1) the certificate of public need law should not be completely eliminated for hospitals at this time and (2) there should be some stated agreement regarding the purpose of the contributions by hospitals to the proposed Trust Fund.

The certificate of public need law was established initially in order to contain health care costs. Many of the reimbursement rules which existed at that time have been changed and there are new forces at work. There is greater emphasis on competition among hospitals and perhaps less need to have certificate of public need legislation in order to contain costs in the short run. The effort of HMO's, PPO's and other organizations to enter into contracts with hospitals providing the lowest charges has made it necessary to see that we not only have competition, but that we have fair competition. The hospital which provides significant uncompensated care is at a distinct disadvantage when attempting to compete with the hospital that provides very little uncompensated care. We must

then be concerned about access to health care by the indigent. If hospitals providing large amounts of uncompensated care are allowed to fail, then we must be concerned about the long run costs as well as access. The Trust Fund proposed in the report is an attempt to help equalize the competition, but it deals with only a relatively small fraction of the uncompensated care. Until a more complete solution to that problem is developed, it seems wise to retain certificate of public need for the addition of hospital beds, the construction of new hospitals and the relocation of hospitals. It does appear advisable at this time to remove certificate of public need for new services and new equipment in an effort to encourage reasonable competition among hospitals.

I believe that we should state the purpose of the hospital contribution to the Trust Fund. It would seem that the legitimate purpose for this contribution is to equalize the competition among hospitals. If hospitals are asked to contribute to the Trust Fund beyond that point, then we would be asking the paying hospital patients to carry the burden of uncompensated care. It seems that the major portion of the uncompensated health care burden should be carried by the public at large.

MARYVIEW HOSPITAL
A Bon Secours Health Care Facilit

December 29, 1988

The Honorable Stanley C. Walker
100 West Plum Street
Suite 332
Norfolk, Virginia 23510

Dear Senator Walker:

It has been my honor to serve on the Joint Subcommittee on Health Care for All Virginians (SJR 99/HJR 78) with such a distinguished group of individuals. Many important issues have been addressed in the committee's recommendations, however, there are several points that cause me continued concern.

I have taken the liberty of outlining these concerns in the attached Minority Report. It is my hope that the committee will take these reservations into consideration and attach this report to the full report presented to the General Assembly in January.

Thank you and may you have a healthy New Year.

Respectfully,

J. Bland Burkhardt, Jr.
Executive Vice President/CEO

jab

cc: Dick Hickman
Jane Kusiak

3636 High Street, Portsmouth, Virginia 23707 804/398-22(

MINORITY REPORT OF J. BLAND BURKHARDT, JR.
MEMBER
JOINT SUBCOMMITTEE ON HEALTH CARE FOR ALL VIRGINIANS

The report approved by the Joint Subcommittee on Health Care for All Virginians (SJR 99/HJR 78) is a major step in recognizing the problems of assuring access to quality health care for all citizens in the Commonwealth. While I voted against the acceptance of the recommendations as written, I would like to applaud the committee's intent to resolve the problem of financing the care for the medically indigent in our state. The report stipulated many important findings and recognized that the problems of financing health care in Virginia are largely attributable to the lack or inadequacy of health insurance benefits for a substantial number of Virginians, and that these are societal problems in which all segments of society have stakes and responsibilities.

However, there are several points the recommendations do not address that cause me great concern. Because the Joint Subcommittee approved a report in "concept" rather than in "detail", I understand that some or all of these concerns may be resolved when implementing legislation is drafted. I mentioned several of these concerns in the discussion on December 28, 1988 and have outlined them below:

- The proposal calls for the creation of the Trust Fund to be administered by the Department of Medical Assistance Services (DMAS). While the performance of needed ministerial functions by DMAS is seemingly appropriate, I believe that for the fund to develop the sense of clear mission that allows it to be distinct from other programs and makes it a true partnership, its operation should be governed by an independent Trust Fund Board. The Board's job should be to promulgate necessary regulations, develop appropriate methodologies for contribution and distribution of funds and serve as the representative of "the partners". Initially, the partners represented on the Board should be from the government of the Commonwealth and from the hospitals of Virginia since these would be the initial parties contributing to the Fund. As the scope of the Trust Fund's contributors is expanded to the business community, health insurance organizations, administrators or self-insurance pools, and others, representatives of each such contributing group would be granted representation on the Board.

- The proposal seems to set forth a one-year commitment from the initial partners. Statutory language to create the Trust should make clear that the commitment for funds from the Commonwealth should always be in amounts at least equal to amounts to be assessed from hospitals and/or enactment of the Trust should provide for a sunset to be concurrent with the Trust's collection and disbursement of funds in 1990. At that point, all parties will have a better understanding of the workability of the concept, and it will certainly be time to broaden the base of financial support for the Trust.

- The Subcommittee's staff has worked long and hard in developing approaches which would govern collection and disbursement of monies.

Much good work has been done, but development of a methodology for collection and disbursement is difficult and clearly an essential feature of a viable Trust.

Recognizing that under the Subcommittee's proposal, the actual first exchange of monies proposed would not be until June or July of 1990, I recommend that the 1989 session statutorily create the Trust Fund Board and charge it with responsibility for developing carefully and fully the methodology that best suits the needs for the Commonwealth and those institutions to which the Commonwealth wishes to render assistance together with the other statutory features that will be required for the Trust Fund to operate.

Things seen in the abstract are always different from what is found in operation. Designing the program to be that which serves best the interests for all the partners can best be done by those who will have continuing responsibility to ensure that the true legislative intent of the General Assembly is carried out.

Upon receiving recommendations from the Trust Fund Board, the 1990 General Assembly will have before it a well conceived piece of legislation outlining the methodologies for contributions and disbursements and whose particulars have been examined and discussed thoroughly by the partners. The 1990 session of the General Assembly will also have before it proposals that are scheduled to arise from DMAS regarding Medicaid reimbursement modification. In effect, the 1990 session will be able to act on a comprehensive program.

- Much controversy has surrounded the Certificate of Need (CON) Program for many years. There may still be some dispute regarding whether or not the entire Program should be eliminated or merely portions of it. A good middle ground regarding hospital and acute care services would be to adopt recommendations as developed last year by a special Governors' Commission which would eliminate CON except for new beds, relocation of existing facilities and new facilities.

  Regarding a moratorium on nursing home beds, I understand the important motives of the Commonwealth in continuing this measure, however, would remind all that skilled nursing beds are those in the shortest supply. I feel that the CON moratorium proposed on the conversion of hospital beds for skilled nursing use should be lifted and hospitals allowed to convert existing beds to skilled nursing beds. Minimal capital expenditures are involved and specialty patient populations, such as ventilator dependent, AIDs, and other heavy care patients are in desperate need of skilled care services rather than acute care.

- One item absent from the Subcommittee's recommendations relates to proposed cuts in capital an outpatient reimbursement already scheduled to be implemented on July 1, 1989. The thrust of the recommendation is

to provide a more rational and adequate financing of health care to ensure health care access . It is ironic that the net new money about to be contributed by the Commonwealth to the Indigent Care Trust Fund is an amount substantially the same as the reductions in Medicaid reimbursement that hospitals will endure beginning in the Commonwealth's 1990 fiscal year. Failure to address the issue jeopardizes the purpose of the Trust Fund approach, i.e. to provide net new dollars to help improve a deteriorating situation.

It is my hope that we can work toward modifying the proposal into legislation that will better support the continued provision of quality health care for all residents of the Commonwealth.

Respectfully submitted,

J. Bland Burkhardt, Jr.
Executive Vice President/CEO
Maryview Medical Center

PUBLIC COMMENTS RECEIVED ON DRAFT REPORT

SUMMARY OF RESPONSES TO INTERIM REPORT

Joint Subcommittee on Health Care For All Virginians
(December 28, 1988)

Virginia Hospital Association

Trust Fund

- VHA supports the Indigent Health Care Trust Fund as a partnership between the Commonwealth and other parties. However, in order to be a true partnership the trust fund should be governed by an independent board (separate from the Board of Medical Assistance Services). The independent board should consist of representatives of state government and the hospital industry, and other stakeholders if sources of revenue were to be expanded in the future.

- Much good work has been done, but development of the methodology for collecting and disbursing funds is difficult and clearly an essential feature of a viable trust fund. More work needs to be done on the methodology for collecting funds. VHA recommends the 1989 General Assembly create the trust fund board and charge it with responsibility for developing the methodology for presentation to the 1990 General Assembly. Under this proposal the first contributions would be assessed and the first payments made as of June 30, 1990, just as suggested in the interim report.

- The commitment to a 50/50 financing partnership should be made explicit for the first and subsequent years (or the trust fund should sunset after the first year).

Other Comments

- VHA recommends that two specific reductions in Medicaid reimbursement (which were adopted by the 1988 General Assembly but made effective on July 1, 1989) now be rescinded. These two reductions pertain to 80 percent reimbursement for capital and outpatient costs.

- The 1990 General Assembly should also consider as part of a comprehensive package the proposals scheduled to come forward from the Department of Medical Assistance Services regarding Medicaid hospital reimbursement.

- VHA supports actions to strengthen State-Local Hospitalization.

- VHA supports partial deregulation from Certificate of Public Need (COPN) as recommended last year by the Governor's Commission; that is, to maintain COPN review for hospital beds and relocations but to deregulate equipment and services.

- VHA proposes an exemption from the COPN nursing home moratorium to permit conversion of hospital beds for skilled nursing use, on the grounds that skilled nursing beds are needed for speciality populations such as as AIDS patients and ventilator-dependent persons.

Humana, Inc.

- Humana suggests the trust fund is not an adequate substitute for a new, broad based source of revenue to fund indigent care. For this reason, Humana suggests action to adopt the trust fund be deferred until the 1990 General Assembly, and that hospitals participate as part of a broad based, uniformly applied solution. However, if the 1989 General Assembly adopts any methodology, it should include at minimum a credit for taxes paid.

- Humana addresses the differences between tax paying and tax exempt hospitals, suggesting that tax paying hospitals are already supporting public purposes by paying federal, state and local taxes. On the other hand, Humana believes that tax exempt hospitals are relieved of this burden because they are devoted to charitable purposes. Humana suggests that if tax exempt hospitals have no more obligation to provide indigent care than do tax paying hospitals, then the rationale for tax exemption of non-profit hospitals is called into question.

- Humana also suggests constitutional questions are raised by the trust fund methodology. The Commonwealth may impose uniformly applied taxes based on reasonable classifications. However, Humana suggest the proposed assessment is not uniform with respect to similarly situated hospitals and may amount to an unconstitutional taking of private property for public purposes without just compensation.

Hospital Corporation of America

- HCA states that the two percent credit for taxes paid does not provide a level playing field and should not serve as the basis for placing taxpaying hospitals and charitable hospitals in the same class in order to mandate a certain level of charity care. The concept of equal protection would be violated, according to HCA, unless for-profit hospitals were given full credit for taxes paid.

- Hospitals should be given credit for the hidden tax they already pay -- the difference between government reimbursement for Medicaid, Medicare and other public programs and the cost of providing that care.

- Hospitals with very low (or negative) operating margins should not be treated the same as the wealthiest hospitals.

- HCA hospitals are not audited individually. The only audit each year is for the entire corporation. Individual audits would cost an additional $300,000. HCA would like to minimize this added expense.

- HCA also suggests a safeguard be adopted to assure access for patients who need silled nursing care.

- HCA is neutral on the elimination of COPN. However, if COPN is eliminated for hospitals, there should still be a review process for new hospitals and bed relocations.

Blue Cross and Blue Shield of Virginia

- Blue Cross and Blue Shield opposes deregulation of hospitals from COPN.

- Health insurance programs are available to all Virginians; affordability is the issue. Blue Cross and Blue Shield already offers coverage to many small business and individuals; however, the cost may be very high.

- Blue Cross and Blue Shield proposes a one year moratorium on any further mandated benefits. The imposition of mandated health care benefits is a major factor contributing to higher insurance costs, according to Blue Cross and Blue Shield. While some mandates may be justified, each mandate should be analyzed in terms of the social benefits compared to the costs imposed. Language is suggested for the joint subcommittee to study this issue during the next year.

Health Insurance Association of America

- HIAA opposes deregulation of hospitals from COPN because competition alone cannot be relied upon to restrain costs, maintain access to care, fund medical education, and achieve other public objectives for the health care system.

- HIAA supports creation of a trust fund supported by hospitals and the state general fund.

- HIAA believes the public sector should be responsible for the poor and therefore supports expanded Medicaid eligibility.

- HIAA supports efforts next year to make health insurance more affordable, including elimination of mandated benefits.

Health Systems Agencies

- The Virginia Association of Health Systems Agencies (HSA's) opposes deregulation of hospitals under COPN. Other than development of specialized facilities (such as psychiatric and rehabilitation hospitals) and relocation of facilities from inner cities to suburban areas, the association expects comparatively little new bed capacity in the next five years -- with or without COPN. However, changes in the health

care marketplace result in strong incentives for hospitals to acquire an even wider array of clinical services and advanced medical technology to improve market share and profitability.

- The Association of HSA's also cites evidence that competition raises costs and that deregulation can have a negative effect on quality of care. The Association raises the concern that regulation is needed to guarantee the high volume of services (such as cardiac catherization and radiation therapy) necessary to promote high quality of care.

- The Association suggests that if the Joint Subcommittee decides to recommend deregulation, some mechanism other than licensure be set in place to address these quality and cost concerns.

- HSA of Central Virginia also opposes deregulation for construction or relocation of hospitals. Evidence is available, according to this HSA, to demonstrate the need for a high volume of practice, especially in cardiac and obstetrical services, to ensure successful outcomes. Higher volumes also tend to require lower costs for these services. Finally, advanced technology should be restricted to teaching hospitals until its effectiveness is shown and the cost is reasonable.

Free-Standing Renal Dialysis Centers

- ProCorp, Inc. of Harrisonburg points out that it would be unfair and discriminatory to continue to regulate free-standing or non- hospital providers under COPN at the same time hospitals are permitted to expand such services without COPN regulation.

- Dialysis Services Division of NMC National Medical Care, Inc. expresses the same concern and points out the majority of outpatient renal dialysis care is provided by non-hospital providers.

Virginia Health Care Association

- VHCA supports inclusion of Virginia-specific DRI to recognize the observation that nursing salaries are rising faster in Virginia than in the nation as a whole.

- VHCA supports continuation of the moratorium on nursing home beds. In addition, VHCA supports the recommendations to improve the COPN system, including better methodologies and batching of applications.

- VHCA will cooperate with the Virginia Health Services Cost Review Council to implement the prospective budget review requirements so as to minimize duplicate reporting. However, the industry does have some concern with this proposal (particularly the fees) and does not see a clear benefit from the additional reporting.

- For next year, VHCA suggests studying ways to expand the availability and affordability of long term care insurance so our reliance on Medicaid can be reduced. Without private insurance the elderly will continue to "spend down" in order to become Medicaid eligible.

Medical Society of Virginia

- The Medical Society supports raising physician fees to the 25th percentile, but points out that unless an annual inflation factor is built in these new fees will soon fall behind again.

- The Medical Society expressed its concern about the administrative and paperwork demands imposed by Medicaid. The Medical Society would like to address this concern during the coming year.

- The Medical Society also expressed its concern about potential liability exposure when physicians accept charity care or Medicaid patients. This concern takes two forms: first, the legitimate fear of lawsuits; and second, the potential for increased insurance costs. The Medical Society suggests the joint subcommittee address this concern next year.

APPENDICES

1 D 1/21/89 Szakal C 1/21/89 ens

2 SENATE JOINT RESOLUTION NO.....

3 Continuing the joint subcommittee on health care for all Virginians.

4

5 WHEREAS, the Joint Subcommittee on Health Care For All Virginians
6 was created by Senate Joint Resolution No. 99 and House Joint
7 Resolution No. 78 of the 1988 General Assembly; and
8 WHEREAS, the joint subcommittee met six times during the 1988
9 interim and conducted a detailed review of the major issues facing the
10 Commonwealth in the field of health care finance, including the
11 projected increase in the Medicaid budget, new federal mandates
12 contained in the Medicare Catastrophic Coverage Act of 1988, the
13 extent to which Virginians are not covered by health insurance,
14 indigent hospital care, primary care, long-term care for the aging,
15 the Certificate of Public Need program, and other issues which will
16 have significant fiscal impact over the next several years; and
17 WHEREAS, the joint subcommittee has submitted an interim report
18 to the 1989 General Assembly outlining a series of steps to begin to
19 address these concerns; and
20 WHEREAS, the joint subcommittee recognizes that these issues are
21 of such magnitude and complexity that further study and
22 recommendations are required; now, therefore, be it
23 RESOLVED by the Senate, the House of Delegates concurring, That
24 the Joint Subcommittee on Health Care For All Virginians is continued.
25 The current membership of the joint subcommittee shall continue to

1 serve and vacancies shall be filled in the manner in which the
2 original appointments were made.
3 The joint subcommittee's deliberations shall include the
4 following:
5 1. The appropriate role of the Certificate of Public Need
6 program and the need for procedural and administrative changes in this
7 program as well as other improvements to the statewide health planning
8 process, including, but not limited to:
9 a. Determination of the appropriate role for the Certificate of
10 Public Need program in the regulation of both psychiatric and
11 rehabilitation hospitals, and in the regulation of the conversion of
12 hospital beds to nursing home beds; and
13 b. Determination of an effective methodology for projecting
14 future needs for long-term care services, including nursing home beds,
15 and steps to ensure executive and legislative review of the fiscal and
16 programmatic impact of proposed nursing home beds before they are
17 approved, and consideration of cost-effective alternative programs
18 such as home and community based care;
19 2. Appropriate steps to strengthen the statewide planning,
20 coordination and management of long-term care services in the
21 Commonwealth;
22 3. Appropriate methods to make private health insurance more
23 affordable for working Virginians including a social and financial
24 impact analysis of mandated health care benefits, and other
25 cost-containment initiatives and incentives;
26 4. Appropriate ways to expand primary care services for the
27 uninsured population and in medically underserved areas, including
28 potential roles and responsibilities for local health departments in

1 cooperation with other public and private entities in the health care
2 industry and in the medical community;
3 5. Monitoring, evaluation, and refinement as needed of the
4 interim steps as recommended to the 1989 General Assembly, and
5 determination of further initiatives as needed to finance
6 uncompensated hospital care;
7 6. Assessment of the need for further enhancements and the
8 potential for further cost-containment steps in the Medicaid program;
9 and
10 7. Such other related matters as the joint subcommittee may deem
11 appropriate.
12 Staff support for the joint subcommittee shall be provided by the
13 staff members of the Senate Committee on Finance and the House
14 Committee on Appropriations.
15 All agencies of the Commonwealth shall provide assistance upon
16 request as the joint subcommittee may deem appropriate.
17 The joint subcommittee shall complete its work in time to submit
18 its findings and recommendations to the Governor and the 1991 General
19 Assembly as provided in the procedures of the Division of Legislative
20 Automated Systems for processing legislative documents.
21 The indirect costs of this study are estimated to be $15,860; the
22 direct costs of this study shall not exceed $18,360.
23 #

1 D 1/20/89 Szakal C 1/22/89 tmg

2 SENATE JOINT RESOLUTION NO.....

3 Requesting the Bureau of Insurance of the State Corporation
4 Commission, with the assistance of the Department of Health, to
5 study mandated benefits and providers, and recommending a
6 one-year moratorium on the adoption of any additional mandated
7 health insurance benefits and providers.

8

9 WHEREAS, the joint subcommittee on Health Care For All Virginians
10 was created by Senate Joint Resolution No. 99 and House Joint
11 Resolution No. 78 of the 1988 General Assembly; and
12 WHEREAS, the joint subcommittee has requested that it be extended
13 for further study of several issues, including the disturbing fact
14 that 880,000 Virginians, more than two-thirds of whom live in
15 households in which at least one family member is currently employed,
16 are not covered by any health insurance of any kind, either public or
17 private; and
18 WHEREAS, the joint subcommittee has determined that further study
19 is needed to address this situation through determination of
20 appropriate steps to make private health insurance more affordable for
21 working Virginians; and
22 WHEREAS, the joint subcommittee recognizes that a growing number
23 of mandated health insurance benefits and health care providers are
24 required under Title 38.2, Chapters 34 and 42, of the Code of
25 Virginia, to be included in both commercial and Blue Cross/Blue Shield
26 health insurance plans; and
27 WHEREAS, the joint subcommittee is concerned that additions to

1 such mandated benefits and providers may have the effect of
2 significantly increasing the cost of health insurance to the consumer;
3 and
4 WHEREAS, many large employers, including the Commonwealth of
5 Virginia, have chosen in recent years to move towards self-insurance,
6 and are therefore not governed by the mandates contained in state law,
7 and as a result the additional costs imposed by such mandates may fall
8 disproportionately on small businesses and their employees; and
9 WHEREAS, the joint subcommittee anticipates that legislation may
10 be proposed during the 1989 General Assembly to mandate additional
11 benefits and providers, which would further increase the cost of
12 private health insurance for working Virginians; now, therefore, be it
13 RESOLVED by the Senate, the House of Delegates concurring, That
14 the Bureau of Insurance of the State Corporation Commission, with the
15 assistance of the Department of Health, is requested to study the
16 social and financial impact of all current and proposed mandated
17 benefits and providers, including recommendations to make private
18 health insurance more affordable for working Virginians. In addition,
19 the Joint Subcommittee on Health Care for All Virginians recommends
20 the adoption of a one-year moratorium on the approval of any
21 additional mandated benefits and direct reimbursement to providers
22 pending completion of the study by the Bureau of Insurance. The joint
23 subcommittee recommends that all such legislation proposed during the
24 1989 General Assembly Session should be held in abeyance for further
25 evaluation.
26 The Bureau of Insurance shall complete its work in time to submit
27 its findings and recommendations to the Governor and the General
28 Assembly by September 1, 1989, as provided in the procedures of the

1 Division of Legislative Automated Systems for processing legislative

2 documents.

3 #

1 D 1/23/89 Szakal T 1/23/89 smw

2 SENATE BILL NO. .... HOUSE BILL NO. ....

3 A BILL to amend the Code of Virginia by adding in Title 32.1 a chapter
4 numbered 11, consisting of sections numbered 32.1-332 through
5 32.1-342, relating to the Virginia Indigent Health Care Trust
6 Fund; penalties.

7

8 Be it enacted by the General Assembly of Virginia:

9 1. That the Code of Virginia is amended by adding in Title 32.1 a
10 chapter numbered 11, consisting of sections numbered 32.1-332 through
11 32.1-342, as follows:

12 CHAPTER 11.

13 VIRGINIA INDIGENT HEALTH CARE TRUST FUND.

14 § 32.1-332. Definitions.--As used in this chapter unless the
15 context requires a different meaning:

16 "Board" means the Board of Medical Assistance Services.

17 "Charity care" means hospital care for which no payment is
18 received and which is provided to any person whose gross annual family
19 income is equal to or less than 100 percent of the federal nonfarm
20 poverty level as published for the then current year in the Code of
21 Federal Regulations.

22 "The Fund" means the Virginia Indigent Health Care Trust Fund
23 created by this chapter.

24 "Hospital" means any acute care hospital which is required to be
25 licensed as a hospital pursuant to Chapter 5 of Title 32.1.

26 "Panel" means the Technical Advisory Panel appointed pursuant to

1 the provisions of this chapter.

2 § 32.1-333. Creation of Fund; administration--A. There is hereby
3 created the Virginia Indigent Health Care Trust Fund, whose purpose is
4 to receive moneys appropriated by the Commonwealth and contributions
5 from certain hospitals and others for the purpose of distributing
6 these moneys to certain hospitals subject to restrictions as provided
7 in this chapter.

8 B. The Fund shall be the responsibility of the Board and
9 Department of Medical Assistance Services. However, the Fund shall be
10 maintained and administered separately from any other program or fund
11 of the Board and Department.

12 C. The Board may promulgate rules and regulations pursuant to
13 the Administrative Process Act (§ 9-6.14:1 et seq.) for the
14 administration of the Fund consistent with this act, including but not
15 limited to:

16 1. Uniform eligibility criteria to define those medically
17 indigent persons whose care shall qualify a hospital for reimbursement
18 from the Fund. Such criteria shall define medically indigent persons
19 as only those individuals whose gross family income is equal to or
20 less than 100 percent of the federal nonfarm poverty level as
21 published for the then current year in the Code of Federal
22 Regulations.

23 2. Hospital inpatient and outpatient medical services qualifying
24 for reimbursement from the Fund. Such medical services shall be
25 limited to those categories of inpatient and outpatient hospital
26 services covered under the Medical Assistance Program, but shall
27 exclude any durational or newborn infant service limitations.

28 3. A mechanism to ensure that hospitals are compensated from the

1 Fund only for charity care as defined in this chapter.
2 4. Terms, conditions and reporting requirements for hospitals
3 participating in the Fund.
4 § 32.1-334. Fund contributions.--The Fund shall be comprised of
5 such moneys as may be appropriated by the General Assembly for the
6 purposes of the Fund and by contributions from hospitals made in
7 accordance with the provisions of this chapter. The Fund may also
8 receive contributions from other entities as specified by law.
9 § 32.1-335. Technical Advisory Panel.--The Board shall annually
10 appoint a Technical Advisory Panel, whose duties shall include
11 recommending to the Board (i) policy and procedures for administration
12 of the Fund, (ii) methodology relating to creation of charity care
13 standards, eligibility and service verification, and (iii)
14 contribution rates and distribution of payments. The Panel shall also
15 advise the Board on any matters relating to the governance or
16 administration of the Fund as may from time to time be appropriate.
17 The Panel shall consist of seven members as follows: the
18 Chairman of the Board, the Director of the Department of Medical
19 Assistance Services, the Executive Director of the Virginia Health
20 Services Cost Review Council, two additional members of the Board, one
21 of whom shall be the representative of the hospital industry, and two
22 chief executive officers of hospitals as nominated by the Virginia
23 Hospital Association.
24 § 32.1-336. Annual charity care data submission.--No later than
25 ninety days following the end of each of its fiscal years, each
26 hospital shall file with the Department a statement of charity care
27 and such other data as may be required by the Department. Data
28 required for carrying out the purposes of this chapter may be supplied

1 to the Department by the Virginia Health Services Cost Review Council.
2 The Board shall prescribe a procedure for alternative data gathering
3 in cases of extreme hardship or impossibility of compliance by a
4 hospital.
5 § 32.1-337. Hospital contributions, calculations.--Hospitals
6 shall make contributions to the Fund in accordance with the following:
7 A. A charity care standard shall be established annually as
8 follows: For each hospital, a percentage shall be calculated of which
9 the numerator shall be the charity care charges and the denominator
10 shall be the gross patient revenues as reported by that hospital.
11 This percentage shall be the charity care percent. The median of the
12 percentages of all such hospitals shall be the standard.
13 B. Based upon the general fund appropriation to the Fund and the
14 contribution, a disproportionate share level shall be established as a
15 percentage above the standard not to exceed three percent above the
16 standard.
17 C. The cost of charity care shall be each hospital's charity
18 care charges multiplied by each hospital's cost to charge ratio as
19 determined from the Medicare allowable cost to charge ratio where
20 available. For those hospitals whose mean Medicare patient days are
21 greater than two standard deviations below the Medicare statewide
22 mean, the hospital's individual cost-to-charge ratio shall be used.
23 D. An annual contribution shall be established which shall be
24 equal to the total sum required to support charity care costs of
25 hospitals between the standard and the disproportionate share level.
26 This sum shall be equally funded by hospital contributions and general
27 fund appropriations
28 E. An annual hospital contribution rate shall be calculated, the

1 numerator of which shall be the sum of one-half the contribution plus
2 the sum of state corporate taxes paid by the hospital and the
3 denominator of which shall be the sum of the hospital's positive
4 operating margin plus the sum of state corporate taxes paid by the
5 hospital. The rate shall not exceed 6.25 percent.
6 F. A charity care and corporate tax credit shall be calculated,
7 the numerator of which shall be each hospital's cost of charity care
8 plus state corporate taxes and the denominator of which shall be total
9 patient revenues as defined by the Virginia Health Services Cost
10 Review Council.
11 G. For each hospital, the contribution dollar amount shall be
12 calculated as the difference between the rate and the credit
13 multiplied by each hospital's operating margin.
14 § 32.1-338. Distribution of Fund moneys.--The Fund shall
15 distribute moneys to hospitals in accordance with the following:
16 A. The payment to each hospital shall be determined as the
17 standard subtracted from each hospital's charity care percent,
18 multiplied by each hospital's gross patient revenues, multiplied by
19 each hospital's cost-to-charge ratio and multiplied by a percentage
20 not to exceed sixty percent.
21 B. Each hospital whose charity care percent is above the
22 standard but below the disproportionate share level shall be paid from
23 the total amount of the contribution.
24 C. That portion of a hospital's charity care percent which is
25 above the disproportionate share level shall be paid solely from
26 appropriations by the General Assembly to the Fund.
27 § 32.1-339. Frequency of calculations, contributions and
28 distributions.--Contributions to the Fund by hospitals shall be made

1 once annually in December of each calendar year beginning in December
2 1990 using financial data for the hospitals' most recent fiscal years
3 ending on or before June 30 of that calendar year. Calculations for
4 distributions shall be made under the same terms. The policy and
5 details relating to receipt of contributions and distribution of the
6 Fund moneys shall be prescribed by the Board.
7 § 32.1-340. Annual report.--The Board and Director shall report
8 to the Governor and the General Assembly prior to the 1990 Session of
9 the General Assembly on any statutory modifications identified by the
10 Board which are required to carry out the purposes of this chapter
11 effectively. In January of 1991, the Board and the Director shall
12 report to the Governor and the General Assembly on all moneys received
13 and distributed and shall make any recommendations for changes with
14 respect to the Fund and its administration.
15 § 32.1-341. Failure to comply; fraudulently obtaining
16 participation or reimbursement; criminal penalty.--A. Any person who
17 engages in the following activities, on behalf of himself or another,
18 shall be guilty of a Class 1 misdemeanor in addition to any other
19 penalties provided by law:
20 1. Knowingly and willfully making or causing to be made any false
21 statement or misrepresentation of a material fact in order to
22 participate in or receive reimbursement from the Fund;
23 2. Knowingly and willfully failing to provide reports to the
24 Department as required in this chapter; or
25 3. Knowingly and willfully failing to pay in a timely manner the
26 contribution to the Fund by a hospital as calculated by the Department
27 as described in § 32.1-333.
28 B. Conviction of any provider or any employee or officer of such

1 provider of any offense under this section shall also result in
2 forfeiture of any payments due.
3 § 32.1-342. Rights and responsibilities under this
4 chapter.--This chapter shall not be construed as (i) creating any
5 legally enforceable right or entitlement to payment for medical
6 services on the part of any medically indigent person or any right or
7 entitlement to participation or payment of any particular rate by any
8 hospital or other participant or (ii) relieving any hospital of its
9 obligations under the Hill-Burton Act or any other similar federal or
10 state law or agreement to provide unreimbursed care to indigent
11 persons.
12 2. That this act shall expire on June 30, 1991.
13 #

1 D 01/23/89 Szakal T 01/23/89 jds

2 SENATE BILL NO. .... HOUSE BILL NO. ....

3 A BILL to amend the Code of Virginia by adding in Title 32.1 a chapter
4 numbered 11, consisting of sections numbered 32.1-332 through
5 32.1-339 and to repeal Chapter 7, consisting of §§ 63.1-134
6 through 63.1-140, of Title 63.1 of the Code of Virginia, all
7 relating to the State/Local Hospitalization Program for indigent
8 persons; penalties.

9

10 Be it enacted by the General Assembly of Virginia:

11 1. That the Code of Virginia is amended by adding in Title 32.1 a
12 chapter numbered 11, consisting of sections numbered 32.1-332 through
13 32.1-339 as follows:

14 CHAPTER 11.

15 STATE/LOCAL HOSPITALIZATION PROGRAM.

16 § 32.1-332. Definitions.--As used in this chapter unless the
17 context requires a different meaning:

18 "Board" means the Board of Medical Assistance Services.

19 "Director" means the director of the Department of Medical
20 Assistance Services.

21 "Indigent person" means a person who is a bona fide resident of
22 the county or city, whether gainfully employed or not and who, either
23 by himself or by those upon whom he is dependent, is unable to pay for
24 required hospitalization or treatment. Residence shall not be
25 established for the purpose of obtaining the benefits of this chapter.
26 Migrant workers and aliens living in the United States illegally shall
27 not be considered bona fide residents of the county or city for

1 purposes of the State/Local Hospitalization Program.
2 § 32.1-333. State/Local Hospitalization Program.--There is
3 hereby established within the Department of Medical Assistance
4 Services the State/Local Hospitalization Program for indigent persons.
5 With such funds as are appropriated for this purpose, the Director of
6 the Department of Medical Assistance Services is authorized to
7 administer this program and to expend state and local funds in
8 accordance with the provisions of this chapter.
9 § 32.1-334. Counties and cities required to participate;
10 allocation and payment of funds to and payments by counties and
11 cities.--A. The governing bodies of every city and county in the
12 Commonwealth shall participate in the State/Local Hospitalization
13 Program for indigent persons established in this chapter.
14 B. The Director shall allocate annually to the counties and
15 cities of the Commonwealth such funds as may be appropriated by the
16 General Assembly for this program. The allocation of state funds
17 shall be based on the estimated total cost of required services in
18 each county and city less the funds which shall be provided by the
19 counties and cities. The Director shall estimate the costs of the
20 program based on the prevailing statewide per capita demand for
21 required services or actual local per capita demand, whichever is
22 greater, multiplied by the local average daily cost for required
23 services in each county and city, the product of which shall be
24 multiplied by the current population as shown by the last preceding
25 United States census or as estimated by the Tayloe Murphy Institute of
26 the University of Virginia.
27 C. Each county and city shall provide funds for a share of the
28 estimated total costs as determined by the Director. The share for

1 each county and city shall be calculated by dividing its per capita
2 revenue capacity by the statewide total per capita revenue capacity,
3 as determined by the Commission on Local Government, and by
4 multiplying the resulting ratio by an aggregate local share of
5 twenty-five percent. Each local share shall be adjusted according to
6 local income, as determined by dividing the median adjusted gross
7 income for all state income tax returns in each county and city by the
8 median adjusted gross income for all income tax returns statewide.
9 However, no county or city shall contribute more than twenty-five
10 percent to the total cost for providing required hospitalization and
11 treatment for indigent persons.
12 D. Upon allocation of funds appropriated pursuant to subsection
13 B of this section, each city and county shall remit within thirty days
14 to the Department the amount determined to be the local share pursuant
15 to subsection C of this section.
16 § 32.1-335. Director to establish standards; reimbursement of
17 services.--A. The Director shall prescribe regulations setting forth
18 the amount, duration and scope of medical services covered by the
19 Program which shall be uniform in all localities. Such services shall
20 consist only of inpatient and outpatient hospital services, services
21 rendered in free-standing ambulatory surgical centers and local public
22 health clinics by providers who have signed agreements to participate
23 in the State/Local Hospitalization Program and are enrolled providers
24 in the Medical Assistance Program. Services covered under the Program
25 shall not exceed in amount, duration or scope those available to
26 recipients of Medical Assistance Services as provided in the State
27 Plan for Medical Assistance pursuant to Chapter 10 of Title 32.1.
28 Subject to the above, the Board may modify such coverage so long as

1 uniformity of coverage is maintained throughout the Commonwealth.

B. Reimbursement for services under this Program shall be equal
3 to that of the Medical Assistance Program pursuant to Chapter 10 of
4 Title 32.1 as follows:

5 1. The reimbursement rate per visit for outpatient hospital
6 services shall be the same as that established by the Department of
7 Medical Assistance Services for an intermediate office visit for an
8 established patient;

9 2. The daily inpatient hospital reimbursement rate shall be the
10 same as that per diem rate established and in effect on June 30 of
11 each year by the Department of Medical Assistance Services for the
12 specific hospital;

13 3. Inpatient hospital stays for adults shall be limited to
14 twenty-one days of covered hospitalization within sixty days for the
15 same or similar diagnosis. The sixty day period shall begin with the
16 initial hospital admission. Only twenty-one total medically necessary
17 days shall be covered whether incurred for one or more hospital stays,
18 in the same or multiple hospitals, during the sixty day period.
19 Inpatient hospital admissions on Friday and Saturday shall not be
20 covered except in cases of medical emergencies. Reimbursement of
21 inpatient hospital days on behalf of individuals up to the age of
22 twenty-one shall be for medically necessary stays in excess of
23 twenty-one days as provided in the State Plan for Medical Assistance
24 Services;

25 4. The hospital emergency room reimbursement rate per visit
26 shall be the same as that rate established by the Department of
27 Medical Assistance Services for an intermediate level, established
28 patient emergency department visit;

1 5. The outpatient surgical rate for hospitals and ambulatory
2 surgical centers shall be the same as the rates established by the
3 Department of Medical Assistance Services for the facility component
4 for ambulatory surgical centers; and
5 G. Procedures identified by the Department of Medical Assistance
6 Services as outpatient surgical procedures shall be performed in an
7 outpatient setting unless the inpatient care was medically necessary
8 and outpatient surgery could not be safely performed, the surgical
9 procedure was performed with other surgical procedures requiring
10 inpatient admission or adequate outpatient facilities were not
11 available.
12 C. Acceptance of payment for services by a provider under this
13 Program shall constitute payment in full.
14 § 32.1-336. Eligibility for Program; duty of the Department of
15 Social Services and local welfare or social services agencies; data
16 required.--A. The Board of Medical Assistance Services shall
17 promulgate regulations to establish uniform eligibility criteria by
18 defining those persons who will qualify for payment for medical care
19 under the Program. Such criteria shall include, but not be limited
20 to, the following:
21 1. To be eligible, a person shall have net countable income,
22 using the current budget methodology of the Virginia Aid to Dependent
23 Children Program, equal to or less than 100 percent of the federal
24 nonfarm poverty level as published for the then current year in the
25 Code of Federal Regulations, except that localities which in fiscal
26 year 1989 used an income level higher than 100 percent of the federal
27 nonfarm poverty level may continue to use the same income level; and
28 2. To be eligible, a person shall have net countable resources,

1 using the current budget methodology of the Virginia Aid to Dependent
2 Children Program, equal to or less than the then current resource
3 standards of the federal Supplemental Security Income Program.
4 B. Eligibility under this Program shall be determined by the
5 Department of Social Services through the local boards of welfare or
6 social services upon application for assistance under this program
7 from residents of such localities. The eligibility criteria
8 established by the Board pursuant to this section shall be used in
9 processing all such applications. The local departments of welfare or
10 social services shall certify to the applicant and Department of
11 Medical Assistance Services within thirty days of receipt of each
12 application whether the person applying meets such criteria.
13 C. Administrative appeal of adverse eligibility decisions shall
14 be conducted by the Department using the procedures applicable to
15 applicants for Medicaid benefits under the State Plan for Medical
16 Assistance pursuant to Chapter 10 of Title 32.1.
17 D. The local governing body of every county or city shall report
18 annually data on rejected applications for hospitalization and
19 treatment of indigent persons which shall include, but not be limited
20 to, the number of days requested for reimbursement, and the services
21 received. The Director shall utilize this data as well as data on
22 accepted applications to estimate the costs of hospitalization for
23 indigent persons.
24 E. The State/Local Hospitalization Program shall be established
25 in the books of the Comptroller so as to segregate the amounts
26 appropriated and the amounts contributed thereto by the localities.
27 No portion of the State/Local Hospitalization Program shall be used
28 for a purpose other than that described in this chapter. Any state

1 funds remaining at the end of the fiscal year shall revert to the
2 general fund. Any local share money remaining at the end of the
3 fiscal year or the biennium shall remain in the locality's account
4 under the State/Local Hospitalization Program to be used by the
5 Department as an offset to the calculated local share for the
6 following year.
7 § 32.1-337. Nothing in this Act shall be construed as relieving
8 any hospital of its obligations under the Hill-Burton Act or any other
9 similar federal or state law or agreement to provide unreimbursed care
10 to indigent persons.
11 § 32.1-338. Liability for excess payments.--Any person who
12 obtains benefits under this program to which he is not entitled shall
13 be liable for any excess benefits received. If the recipient knew or
14 reasonably should have known that he was not entitled to the excess
15 benefits, he may also be liable for interest on the amount of the
16 excess benefits at the judgment rate as defined in § 6.1-330.10 from
17 the date upon which he knew or reasonably should have known that he
18 had received excess benefits to the date on which repayment is made to
19 the Commonwealth. No person shall be liable for payment of interest,
20 however, when excess benefits were obtained as a result of errors made
21 solely by the Department of Medical Assistance Services or any local
22 welfare or social services agency.
23 Any payment erroneously made on behalf of a recipient or former
24 recipient of this program may be recovered by the Department of
25 Medical Assistance Services from the recipient or the recipient's
26 income, assets or estate unless such property is otherwise exempted by
27 state or federal law or regulation.
28 Any person who, on behalf of himself or another, obtains or

1 attempts to obtain the benefits of this program by means of (i)
2 willful false statement, (ii) willful misrepresentation or concealment
3 of a material fact, or (iii) any other fraudulent scheme or device
4 shall be liable for repayment of any excess benefits received, plus
5 interest on the amount of the excess benefits at the rate of 1.5
6 percent per month for the period from the date upon which payment was
7 made for such benefits to the date on which repayment is made to the
8 Commonwealth.
9 All civil penalties collected pursuant to this section shall be
10 deposited with the Comptroller for the State/Local Hospitalization
11 Program in the same manner as the state and local shares.
12 § 32.1-339. Fraudulently obtaining benefits; criminal
13 penalty.--A. Any person who engages in the following activities, on
14 behalf of himself or another, shall be guilty of a Class 1 misdemeanor
15 in addition to any other penalties provided by law:
16 1. Knowingly and willfully making or causing to be made any
17 false statement or misrepresentation of a material fact in an
18 application for eligibility under this program or in order to
19 participate in or receive reimbursement from the program;
20 2. Knowingly and willfully concealing or failing to disclose any
21 event affecting the initial or continued right of any individual to
22 any benefits with an intent to secure fraudulently such benefits in a
23 greater amount or quantity than is authorized or when no such benefit
24 is authorized;
25 3. Knowingly and willfully failing to notify the local
26 department of welfare or social services, through whom the benefits of
27 this program were obtained, of changes in the circumstances of any
28 recipient or applicant which could result in reduction or termination

1 of the benefits;

2 4. Knowingly and willfully failing to provide any reports or

3 data to the Department as required in this chapter.

4 B. Conviction of any provider or any employee or officer of such

5 provider of any offense under this section shall also result in

6 forfeiture of any payments due.

7 2. That Chapter 7, consisting of §§ 63.1-134 through 63.1-140, of

8 Title 63.1 of the Code of Virginia is repealed.

9 #

1 D 1/21/89 Szakal C 1/22/89 JL

2 SENATE BILL NO. .... HOUSE BILL NO. ....

3 A BILL to amend and reenact §§ 9-156, 9-157, 9-158, 9-160 and 9-163 of
4 the Code of Virginia and to amend the Code of Virginia by adding
5 a section numbered 9-157.1, relating to the Virginia Health
6 Services Cost Review Council.

7

8 Be it enacted by the General Assembly of Virginia:

9 1. That §§ 9-156, 9-157, 9-158, 9-160 and 9-163 of the Code of
10 Virginia are amended and reenacted and that the Code of Virginia is
11 amended by adding a section numbered 9-157.1 as follows:

12 § 9-156. Definitions.--As used in this chapter:

13 "Consumer" means any person (i) whose occupation is other than
14 the administration of health activities or the provision of health
15 services, (ii) who has no fiduciary obligation to a health care
16 institution or other health agency or to any organization, public or
17 private, whose principal activity is an adjunct to the provision of
18 health services, or (iii) who has no material financial interest in
19 the rendering of health services;

20 "Council" means the Virginia Health Services Cost Review Council;

21 "Health care institution" means (i) a general hospital, ordinary
22 hospital, ~~or~~ outpatient surgical hospital , nursing home or certified
23 nursing facility licensed or certified pursuant to Chapter 5, Article
24 1 (§ 32.1-123 et seq.) of Title 32.1, (ii) a mental or psychiatric
25 hospital licensed pursuant to Chapter 8 of Title 37.1 (§ 37.1-179 et
26 seq.) and (iii) a hospital operated by the University of Virginia or

1 Virginia Commonwealth University. In no event shall such term be
2 construed to include any physician's office ~~, nursing home,~~
3 ~~intermediate care facility, extended nursing care facility,~~ or
4 nursing care facility of a religious body which depends upon prayer
5 alone for healing, independent laboratory or outpatient clinic;

6 "Voluntary cost review organization" means a nonprofit
7 association or other nonprofit entity which has as its function the
8 review of health care institution costs and charges but which does not
9 provide reimbursement to any health care institution or participate in
10 the administration of any review process under Chapter 4, Article 1.1
11 (§ 32.1-102.1 et seq.) of Title 32.1;

12 "Aggregate cost" means the total financial requirements of an
13 institution which shall be equal to the sum of:

14 a. The institution's reasonable current operating costs,
15 including reasonable expenses for operation and maintenance of
16 approved services and facilities, reasonable direct and indirect
17 expenses for patient care services, working capital needs and taxes,
18 if any;

19 b. Financial requirements for allowable capital purposes,
20 including price-level depreciation for depreciable assets and
21 reasonable accumulation of funds for approved capital projects;

22 c. For investor-owned institutions, after tax return on equity at
23 the percentage equal to two times the average of the rates of interest
24 on special issues of public debt obligations issued to the Federal
25 Hospital Insurance Trust Fund for the months in a provider's reporting
26 period, but not less, after taxes, than the rate, or weighted average
27 of rates, of interest borne by the individual institution's
28 outstanding capital indebtedness. The base to which the rate of return

determined shall be applied is the total net assets, adjusted by paragraph b of this definition, without deduction of outstanding capital indebtedness of the individual institution for assets required in providing institutional health care services.

§ 9-157. Commission continued as Council; members; terms; reimbursement; etc.--A. The Virginia Health Services Cost Review Commission is continued and shall hereafter be known as the Virginia Health Services Cost Review Council. The Council shall be composed of ~~eleven~~ fifteen members as follows: ~~ten~~ thirteen members shall be appointed by the Governor, five of whom shall be consumers, ~~three~~ six of whom shall be persons responsible for the administration of nongovernmental health care institutions, one of whom shall be an employee of a prepaid hospital service plan conducted under Chapter 23 (§ 38.1-810 et seq.) of Title 38.1 and one of whom shall be an employee of a commercial insurer which underwrites accident and sickness insurance; ~~and~~ one member shall be the Commissioner of Health or his designated representative and one member shall be the Director of the Department of medical assistance services or his designated representative . Two of the consumer members appointed by the Governor shall be experienced in financial management or accounting. The nongovernmental health care institution members shall consist of three employees of hospitals and three employees of nursing homes. Each member of the Council appointed by the Governor shall be appointed for a term of three years except that ~~one of~~ the ~~two~~ three members representing nursing homes initially appointed on July 1, ~~1980~~ 1989 , to increase the Council to ~~eleven~~ fifteen members shall be appointed for ~~a term of two years~~ terms of from one to three years to provide for staggered terms .

1 B. Appointive members of the Council shall not be eligible to
2 serve as such for more than two consecutive full terms. Two or more
3 years shall be deemed a full term.
4 C. Members of the Council shall receive fifty dollars per meeting
5 of the Council and committees appointed by the chairman, not to exceed
6 fifty dollars for any one day, for their service on the Council and
7 shall also be reimbursed for necessary and proper expenses that are
8 incurred in the performance of their duties on behalf of the Council.
9 D. A consumer member shall be elected by the Council to serve as
10 chairman. The Council may elect from among its members a vice
11 chairman. Meetings of the Council shall be held as frequently as its
12 duties require.
13 E. ~~Seven~~ Nine members shall constitute a quorum.
14 § 9-157.1. Executive Director; powers and duties.--A. The
15 Governor shall appoint an Executive Director of the Council, subject
16 to confirmation by the General Assembly. The Executive Director shall
17 hold his position at the pleasure of the Governor.
18 B. The Executive Director shall have the following powers:
19 1. To supervise the administration of work of the Council;
20 2. To prepare, approve, and submit any requests for
21 appropriations and be responsible for all expenditures pursuant to
22 appropriations;
23 3. To employ such staff as is necessary to carry out the powers
24 and duties of this chapter, within the limits of available
25 appropriations;
26 4. To do all acts necessary or convenient to carry out the
27 purpose of this chapter and to assist the Council in carrying out its
28 responsibilities and duties;

5. To make and enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers under this chapter, including, but not limited to, contracts with the United States, other states, and agencies and governmental subdivisions of the Commonwealth.

§ 9-158. Uniform reporting regulations.--A. The Council shall establish by regulation a uniform system of financial reporting by which health care institutions shall report their revenues, expenses, other income, other outlays, assets and liabilities, units of service and related statistics. In determining the effective date for reporting requirements, the Council shall be mindful both of the immediate need for uniform health care institutions' reporting information to effectuate the purposes of this chapter and the administrative and economic difficulties which health care institutions may encounter in complying, but in no event shall such effective date be later than ~~2 1/2~~ two and one-half years from the date of the formation of the Council. In the case of nursing homes, the effective date shall be no later than July 1, 1990. During the year of July 1, 1989, through June 30, 1990, each nursing home provider shall comply with subdivisions A1 and A2 of § 9-159 and assist in developing requirements for reporting such other costs incurred in rendering services as the Council may prescribe.

B. In establishing such uniform reporting procedures the Council shall take into consideration:

1. Existing systems of accounting and reporting presently utilized by health care institutions;

2. Differences among health care institutions according to size, age, financial structure, methods of payment for services, and scope,

1 type and method of providing services; ~~and~~

2 3. Other pertinent distinguishing factors ~~,~~ ;

3 4. Data and forms presently used by other state agencies

4 receiving similar information from hospitals and nursing homes, in

5 order to eliminate duplicate reporting of data and reduce the

6 administrative burden of compliance to the minimum; and

7 5. Methods to minimize the financial impact and administrative

8 burdens on all providers.

9 C. The Council, where appropriate, shall provide for modification

10 consistent with the purposes of this chapter, of reporting

11 requirements to reflect correctly these differences among health care

12 institutions and to avoid otherwise unduly burdensome costs in meeting

13 the requirements of the uniform system of financial reporting.

14 § 9-160. Continuing analysis, publication, etc.--A. The Council

15 shall:

16 1. Undertake financial analysis and studies relating to health

17 care institutions ~~,~~ .

18 2. Publish and disseminate information relating to health care

19 institutions' costs and charges including the publication of changes

20 in charges other than those having a minimal impact prior to any

21 changes taking effect ~~,~~ .

22 3. Survey all hospitals that report to the Council or any

23 corporation that controls a hospital to determine the extent of

24 commercial diversification by such hospitals in the Commonwealth. The

25 survey shall be in a form and manner prescribed by the Council and

26 shall request the information specified in subdivisions a, f, g, h and

27 i below on each hospital or such corporation and, with respect to any

28 tax-exempt hospital or controlling corporation thereof, the

information specified in subdivisions a through i below for each affiliate of such hospital or corporation, if any:

a. The name and principal activity;

b. The date of the affiliation;

c. The nature of the affiliation;

d. The method by which each affiliate was acquired or created;

e. The tax status of each affiliate and, if tax-exempt, its Internal Revenue tax exemption code number;

f. The total assets;

g. The total revenues;

h. The net profit after taxes, or if not-for-profit, its excess revenues; and

i. The net equity, or if not-for-profit, its fund balance.

As a part of this survey, each hospital that reports to the Council or any corporation which controls a hospital that reports to the Council shall submit an audited consolidated financial statement to the Council detailing the total assets, liabilities and net worth, as well as a statement of income and expenses, including of all its affiliates.

The Council shall report the results of this survey by December 1 of each year to the General Assembly. This report shall be open to public inspection. Information filed pursuant to this subdivision shall not be subject to the provisions of § 2.1-342.

4. Provide information concerning costs and charges to the public in a form which consumers can use to compare costs and services in order to increase competition within the health care industry and contain health care costs.

B. The Council shall prepare and may make public summaries and

1 compilations or other supplementary reports based on the information
2 filed with or made available to the Council.
3 C. The Council, in carrying out its responsibilities under this
4 section and § 9-161, shall be cognizant of other programs which bear
5 upon the operation of health care institutions including programs
6 relating to health planning, licensing and utilization review.
7 § 9-163. Administration.-- ~~A.~~ The Council (i) shall maintain
8 records of its activities; (ii) shall collect and account for all fees
9 prescribed to be paid into the Council and account for and deposit the
10 moneys so collected into a special fund from which the expenses of the
11 Council ~~including the salary of any personnel as may be employed by~~
12 ~~the Council~~ shall be paid; (iii) ~~may employ such personnel and~~
13 ~~assistance as may be required for the operation of the Council; (iv)~~
14 shall enforce all regulations promulgated by it; and ~~(v)~~ (iv) shall
15 contract with any voluntary cost review organization for services
16 necessary to carry out the Council's activities where this will
17 promote economy, efficiency, avoid duplication of effort and make best
18 use of available expertise.
19 #

1 D 1/21/89 Szakal C 1/22/89 jds

2 SENATE BILL NO. .... HOUSE BILL NO. ....

3 A BILL to amend and reenact § 32.1-102.1 of the Code of Virginia and
4 to amend the Code of Virginia by adding a section numbered
5 32.1-102.3:2, relating to certificate of public need.

6

7 Be it enacted by the General Assembly of Virginia:

8 1. That § 32.1-102.1 of the Code of Virginia is amended and reenacted

9 and the Code of Virginia is amended by adding a section numbered

10 32.1-102.3:2 as follows:

11 § 32.1-102.1. Definitions.--As used in this article, unless the

12 context indicates otherwise:

13 "Certificate" means a certificate of public need for a project

14 required by this article.

15 "Clinical health service" means a single diagnostic, therapeutic,

16 rehabilitative, preventive or palliative procedure or a series of such

17 procedures that may be separately identified for billing and

18 accounting purposes.

19 "Health service area" means the area served by a health systems

20 agency.

21 "Health systems agency" means an entity organized and operated as

22 provided in Title XV of the United States Public Health Service Act

23 and designated as a health systems agency pursuant to Title XV of the

24 Public Health Service Act or, in the absence of such an agency, a

25 local, district or regional health planning body established under the

26 laws of the Commonwealth.

1 "Medical care facility" , as used in this title, means any
2 institution, place, building or agency, whether licensed or required
3 to be licensed by the Board or the State Mental Health ~~and~~ , Mental
4 Retardation and Substance Abuse Services Board, whether operated for
5 profit or nonprofit and whether privately-owned or privately-operated
6 or owned or operated by a local governmental unit, (i) by or in which
7 health services are furnished, conducted, operated or offered for the
8 prevention, diagnosis or treatment of human disease, pain, injury,
9 deformity or physical condition, whether medical or surgical, of two
10 or more nonrelated mentally or physically sick or injured persons, or
11 for the care of two or more nonrelated persons requiring or receiving
12 medical, surgical or nursing attention or services as acute, chronic,
13 convalescent, aged, physically disabled or crippled, or (ii) which is
14 the recipient of reimbursements from third-party health insurance
15 programs or prepaid medical service plans. ~~The term includes, but is~~
16 ~~not limited to~~ For purposes of this article, only the following
17 medical care facilities shall be subject to review :
18 ~~1. General hospitals.~~
19 ~~2. Sanatoriums.~~
20 ~~3.~~ Sanitariums.
21 ~~4.~~ Nursing homes.
22 ~~5.~~ Intermediate care facilities.
23 ~~6.~~ Extended care facilities.
24 ~~7.~~ Mental hospitals.
25 ~~8.~~ Mental retardation facilities.
26 ~~9.~~ Psychiatric hospitals and intermediate care facilities
27 established primarily for the medical, psychiatric or psychological
28 treatment and rehabilitation of alcoholics or drug addicts.

1 ~~10. Specialized centers or clinics developed for the provision of~~
2 ~~outpatient or ambulatory surgery, renal dialysis therapy, radiation~~
3 ~~therapy, computerized tomography (CT) scanning or other medical or~~
4 ~~surgical treatments requiring the utilization of equipment not usually~~
5 ~~associated with the provision of primary health services.~~
6 ~~11.~~ ~~[Repealed.]~~
7 ~~12. Hospices.~~ Rehabilitation hospitals.
8 The term "medical care facility" shall not include a ~~physician's~~
9 ~~office except as defined in paragraph 5 under the definition of~~
10 ~~"Project" or a clinical laboratory if the clinical laboratory is~~
11 ~~independent of a physician's office or a hospital and has been~~
12 ~~determined to meet the requirements of paragraphs (10) and (11) of §~~
13 ~~1861 (s) of Title XVIII of the Social Security Act~~ facility of the
14 Department of Mental Health, Mental Retardation and Substance Abuse
15 Services or any community services board authorized by law .
16 "Project" means:
17 1. A capital expenditure by or on behalf of a medical care
18 facility, including but not limited to any studies, surveys, designs,
19 plans, working drawings and specifications, which, under generally
20 accepted accounting principles, is not properly chargeable as an
21 expense of operation and maintenance and which:
22 a. Exceeds $600,000 or such higher amount as the Board may
23 prescribe,
24 b. Increases the total number of beds, or
25 c. Relocates ten beds or ten percent of the beds, whichever is
26 less, from one physical facility to another in any two-year period;
27 however, a hospital shall not be required to obtain a certificate for
28 the temporary use of ten percent of its licensed beds as skilled

nursing ~~home~~ care beds for a maximum of thirty days per patient per bed as provided in § 32.1-132;

2. The acquisition by a reviewable 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 1 under the definition of "Project";

3. The acquisition by a reviewable 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 1 under the definition of "Project";

4. The introduction by a reviewable 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;

5. The acquisition, by purchase, lease, gift or bequest, by or on behalf of a reviewable 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.

"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.

"State Health Plan" means the plan provided for in Article 2 (§

1 32.1-103 et seq.) of Chapter 4 of this title.

2 "State Medical Facilities Plan" means the plan provided for in
3 Article 4 (§ 32.1-117 et seq.) of Chapter 4 of this title.

4 § 32.1-102.3:2. Certificates of public need; moratorium.--The
5 Commissioner of Health shall not approve, authorize or accept
6 applications for the issuance of any certificate of public need
7 pursuant to this article for a nursing home, intermediate care
8 facility or extended care facility from the effective date of this act
9 through January 1, 1991. However, the Commissioner may approve or
10 authorize the issuance of a certificate of public need for a project
11 for the renovation or replacement on site of an existing facility or
12 any part thereof, in accordance with the law, when a capital
13 expenditure is required to comply with life safety codes, licensure,
14 certification or accreditation standards.

15 #

LD4282305

1 **SENATE JOINT RESOLUTION NO. 99**
2 AMENDMENT IN THE NATURE OF A SUBSTITUTE
3 (Proposed by the House Committee on Rules
4 on March 4,1988)
5 (Patron Prior to Substitute--Senator Walker)
6 *Establishing a joint subcommittee to study health care for all Virginians.*
7 WHEREAS, access to professional health care is a necessity for life and happiness and
8 in recent years, the steadily increasing costs of health care have limited access to such
9 care for middle-class, poor and elderly citizens alike; and
10 WHEREAS, the cost of health care programs has become a staggering burden to both
11 businesses and government; and
12 WHEREAS, failure to confront now the issue of rising health-care costs will create
13 profound financial hardships for the Commonwealth and its citizens in the future; and
14 WHEREAS, federal health care cost control measures appear to be failing, thereby
15 creating new pressures on government-supported programs such as Medicare and Medicaid;
16 and
17 WHEREAS, the federal-state funded Medicaid program is the principal instrument for
18 ensuring adequate care for Virginia's poor and elderly citizens; and
19 WHEREAS, the total cost of the Virginia Medicaid program has risen more than 331
20 percent in less than a dozen years, and the Commonwealth has assumed an increasingly
21 large proportion of the total program cost; and
22 WHEREAS, the burden of uncompensated care for indigent persons is not equally
23 distributed among Virginia's hospitals, thereby jeopardizing the financial survival of some
24 hospitals in an environment in which health care is becoming an increasingly competitive
25 business; and
26 WHEREAS, it is essential that Virginians eligible to participate in the Medicaid program
27 be assured access to necessary acute and long-term health care; and
28 WHEREAS, the work of the Governor's Task Force on Indigent Health Care and the
29 Governor's Commission on the Medical Care Facilities Certificate of Public Need Law has
30 demonstrated that the problem of access to essential health care will become even more
31 acute in the near future; and
32 WHEREAS, any viable and lasting solution to the critical problem of financing indigent
33 and long-term health care must entail shared responsibility by the public and private
34 sectors, including the hospital and nursing home industries; and
35 WHEREAS, the federal Social Security Act's commonly known "209(b)" option allows
36 states to impose restrictive eligibility criteria on aged, blind and disabled people who seek
37 health insurance through the Medicaid program; and
38 WHEREAS, Virginia imposes several restrictive eligibility criteria which prevent more
39 than 10,000 recipients of Supplemental Security Income (SSI) benefits from receiving
40 Medicaid coverage; and
41 WHEREAS, the cost of health care programs has become a staggering burden to both
42 businesses and government as thousands of Virginians either do not have health insurance
43 or are under-insured for health costs, and can be classified as the working poor or the
44 medically indigent; and
45 WHEREAS, many of these individuals are not eligible for medical assistance services,
46 and the State and Local Hospitalization Program within the Department of Social Services
47 only provides a small percentage of hospital coverage for indigents; and
48 WHEREAS, in some areas of the state, the working poor obtain care from the state
49 medical schools but most of these persons do not live in close enough proximity to the
50 state medical schools to obtain such care, and frequently, such individuals do not have
51 access to private health care except, perhaps, in an emergency; and
52 WHEREAS, the number of persons eighty years of age and over will nearly double by
53 the year 2000, increasing the burden on the Medicaid program for long-term care; and
54 WHEREAS, most states automatically provide Medicaid benefits to aged, blind and

1 disabled individuals who receive Supplemental Security Income benefits (SSI) and many
2 elderly Virginians who are not eligible for Medicaid are on fixed incomes and must
3 struggle to pay for their prescriptions; and
4 WHEREAS, a number of other states have implemented pharmaceutical assistance
5 programs for the elderly; and
6 WHEREAS, the federal financial participation level for the Medicaid program has been
7 decreasing every year, placing a burden on the Commonwealth, as over forty percent of all
8 indigent health care is provided by the Commonwealth's two teaching hospitals with the
9 remainder of the burden not equally shared among local providers; and
10 WHEREAS, various options and approaches may be available to the Commonwealth to
11 resolve this dilemma, including changes in the eligibility requirements for Medicaid, the
12 State-Local Hospitalization Program, the assessment of fees in health care institutions, the
13 creation of an indigent health risk pool, the implementation of additional home and
14 community-based programs and the implementation of a pharmaceutical assistance program
15 for the elderly; and
16 WHEREAS, all options and approaches must be carefully and judiciously analyzed for
17 efficacy and appropriateness, and proposed solutions must be in the best interest of health
18 care providers and institutions, the indigent, the elderly, the working poor and the
19 Commonwealth; now, therefore, be it
20 RESOLVED by the Senate, the House of Delegates concurring, That a joint
21 subcommittee is established to study health care for all Virginians. The joint subcommittee
22 shall be composed of seventeen members to be appointed as follows: four members of the
23 Senate to be appointed by the Senate Committee on Privileges and Elections, and five
24 members of the House to be appointed by the Speaker of the House. Six citizen members
25 shall be appointed by the Governor, one representative each from the medical community,
26 the Virginia hospital and nursing home industries, the Virginia Board of Medical Assistance
27 Services, the business community and a representative of the commercial health insurance
28 industry. The Secretary of Human Resources and the Secretary of Finance shall also serve
29 as members.
30 The joint subcommittee shall include in its deliberations the following:
31 1. The proposals advanced by the Secretary of Human Resources regarding the
32 financing of indigent health care and long-term nursing home care;
33 2. Alternative financing concepts that may be suggested by health care providers, the
34 insurance industry and others to address the problems of financing Medicaid and
35 uncompensated care;
36 3. Creation of a Virginia Hospital Care fund to assist in equalizing the burden of
37 uncompensated care among Virginia's hospitals so as to eliminate the practice of forcing a
38 few institutions to carry a disproportionate burden of uncompensated care responsibilities;
39 4. Means to control further increases in health care costs, including strengthened
40 mechanisms for rate review and rate setting;
41 5. Means for providing long-term nursing home care insurance and risk-pooling
42 mechanisms to serve the uninsured and underinsured citizens of the Commonwealth;
43 6. Mechanisms to control the dramatic increases in the budget of the Virginia Medicaid
44 program, including, but not limited to:
45 a. Selective contracting with hospitals to provide care to Medicaid patients;
46 b. Case-mix reimbursement for nursing homes;
47 c. Reimbursement for outpatient and emergency hospital services on a fee basis;
48 d. Reduction of payments for non-emergency hospital services provided in an
49 emergency room setting;
50 e. Establishment of a limit on capital cost reimbursement to hospitals;
51 f. Methods to reduce the length of hospital stays, including requirement of written
52 justification for stays extending beyond seven days;
53 g. Prior authorization of all nonemergency hospital admissions;
54 h. Expansion of the list of surgical procedures required to be performed on an

outpatient basis;

i. Reimbursement of inpatient and outpatient pharmaceutical services at prevailing free-standing pharmacy rates;

j. Revision of current cost escalation formulas to provide incentives for improved practices and operational efficiency;

k. Establishment of an "all payor" reimbursement system for hospital services which ensures that no payor shall pay more than the Medical Assistance Program rate; and

l. Evaluation of criteria by which limitations may be placed on the number of provider agreements entered into by the Medical Assistance Program; and

7. The number of aged, blind and disabled persons affected by the 209(b) restrictions, the impact of such restrictions on the ability of such persons to obtain necessary health care, and the source and funding of alternate health care coverage obtained by the aged, blind and disabled who do not have Medicaid coverage;

8. The costs and benefits incurred by the Commonwealth in assuming the 209(b) option, and the estimated costs of revising or eliminating the 209(b) restrictions with appropriate offsets;

9. Alternative funding concepts to address the problems of financing indigent care, long-term nursing home care, Medicaid, uncompensated health care and the disproportionate burden of uncompensated health care responsibilities and costs to institutions, health care providers and the Commonwealth;

10. The feasibility of establishing a cooperative state/local program for providing health coverage to the working poor, considering ways to fund such coverage or to encourage the provision of pro bono services such as tax incentives for the rendering of such services, state and local contributions and the possibility of requiring third party payors to contribute to such a program. The joint subcommittee shall also examine any similar initiatives in other states and explore the possibility of obtaining federal contributions;

11. The feasibility of establishing a pharmaceutical assistance program for the elderly; and

12. Other related matters that the joint subcommittee may deem appropriate.

Staff support for the joint subcommittee shall be provided by the staff members of the Senate Committee on Finance and the House Committee on Appropriations.

All agencies of the Commonwealth shall provide assistance upon request as the joint subcommittee may deem appropriate.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the 1989 General Assembly.

The indirect costs of this study are estimated to be $13,045; the direct costs of this study shall not exceed $11,700.

Official Use By Clerks

Agreed to By The Senate		**Agreed to By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: ______		Date: ______	
Clerk of the Senate		Clerk of the House of Delegates	