INTERIM REPORT
OF THE
COMMISSION ON

HEALTH CARE FOR ALL VIRGINIANS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 34

COMMONWEALTH OF VIRGINIA
RICHMOND
1991

THE COMMISSION ON
HEALTH CARE FOR ALL VIRGINIANS

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EXECUTIVE SUMMARY

Pursuant to Senate Joint Resolution No. 118 adopted in the 1990 Session of the General Assembly, the Joint Subcommittee on Health Care for All Virginians was continued as the Commission on Health Care for All Virginians. The Commission was charged with specific directives to guide its examinations of various health care issues in the Commonwealth.

The Commission was directed to study:

- Issues related to the Certificate of Public Need Program: a review of the current methodology for projecting the need for new nursing facility beds, recommendations for this methodology, and the future of the COPN program in Virginia.

- The feasibility of expanding the Virginia Indigent Health Care Trust Fund by adding contributors or covered services and the efficacy of consolidating the Trust Fund and the State/Local Hospitalization Program.

- The need for providing assistance to certain hospitals in order to preserve access to acute care in isolated areas of the Commonwealth and to study also the current mechanism for the state/local cooperative budget allocation to determine appropriate ways to provide for the equitable allocation of state funds.

- Health insurance issues, including incentives for businesses to offer health insurance to their employees; means to ensure that health insurance is provided for children by absent parents as an essential component of child-support orders; the impact of mandated insurance benefits on providers and a process for evaluating the social and financial effects of these mandates; means of determining fairly and objectively whether new medical technologies and procedures are reimbursable or are excluded from coverage as experimental and investigative under medical insurance policies applicable to citizens in the Commonwealth; and means to encourage the availability of private long-term care insurance which covers institutional and community-based care.

- Medicaid issues, including the impact of new federal mandates on reducing the numbers of uninsured Virginians and improving their health; the concept of managed care and its effects on access and costs; the relationship between recent expansions of Medicaid eligibility and initiatives to expand the role of local health departments in the delivery of primary care for families with children; and Medicaid reimbursement for physicians' services, hospitals, and nursing homes.

- Long-term care issues, including services that foster independence for as long as possible; the need to recognize the family as the primary source of care for elderly Virginians and to identify methods to increase support of family caregivers; the development of pilot programs to ensure appropriate types and levels of services to elderly Virginians; eligibility for and the level of auxiliary grants for residents of homes for adults; and the efficacy of making case management available to all elderly Virginians on a sliding fee basis.

Among the conclusions emerging from these several deliberations of the Commission was the recognition that while attention must be given to specific concerns, those concerns cannot be examined in isolation; rather, within the broad integration of the total health care delivery system in the Commonwealth. Solutions to the health care concerns of Virginia citizens are not singular for any issue and, indeed, are intrinsically bound to each other in the larger scope and on-going challenges of the Commonwealth to provide and ensure quality health care for all of its citizens.

The Commission also recognizes that inherent in any deliberations of health care concerns are other considerations directly impacting the state's role as provider, regulator, licensor, and consumer of health services. Complex tenets such as entitlement, ethics, service efficacy, and service outcomes necessarily accompany any examinations and proffered resolutions to health care issues.

Furthermore, the Joint Subcommittee readily accepted from its inception the implied directive that any initiatives to address health care issues must be not only morally responsible, but also fiscally responsible. That same humanitarian philosophy balanced by prudence has continued to guide the Commission on Health Care for All Virginians. Thus, while attempting to expand the accessibility and availability of health care in the Commonwealth, the Commission is cognizant that Virginia's legacy for future citizens must not include cumbersome, financial burdens devised and legislated irresponsibly as solutions to meet immediate needs. The criterion of fiscal responsibility has historically been an integral component of any proposals designed and any decisions rendered, and that criterion has gained greater significance in the present fiscal climate.

Health care--its quality, its delivery, its provision--has become an eminent issue of the 1990's in the Commonwealth and the nation and grows exponentially in its dilemmas. The Commission is aware of the issues that confront the Commonwealth:

the changing demographics of the state's aging population;

the advances in medical technology that, while enhancing recovery, drive costs;

the shortage of primary care providers in the Commonwealth's remote areas;

the cost of medical education and subsequent incurred debts affecting graduates' practice choices;

the citizens who by occupation or financial status are precluded from purchasing health insurance;

the spiraling costs of health insurance that restrict employers' coverage offerings and employees' choices of coverage; and

the most vulnerable Virginians in need of health care who do not receive that care.

The General Assembly has adopted into legislation numerous recommendations proposed by the Joint Subcommittee in its history to address health care concerns. No closure, however, is finite on any singular issue in the ever-evolving dynamics of health care; certainly, no solutions can be effected without the cooperative partnership of health care providers, health care professionals, insurers, private industry, clients, and the Commonwealth.

Summarily, the stated mission of the Commission on Health Care for All Virginians is to ensure that the Commonwealth as provider and regulator adopts the most cost effective and most efficacious means of delivery of its health care services, so that the greatest number of Virginians may receive quality health care.

To effect that goal, the Commission adopted the following recommendations and proposed them as legislation for the 1991 Session of the General Assembly:

Authorized significant changes in the statutory and regulatory framework of the Commonwealth's Homes for Adults to ensure quality of care for residents and provided for intermediate sanctions to be imposed for violations.

Authorized changes to the Virginia Medical Care Facilities Certificate of Public Need Program.

Authorized limited prescriptive authority for certain licensed nurse practitioners on a statewide basis.

Directed district health directors of the Virginia Department of Health to assess their district's primary care needs and to develop a cost effective plan to meet those needs.

Directed the Joint Legislative and Audit Review Commission to study the state Medicaid program and the indigent care appropriations to the state teaching hospitals.

Directed the Bureau of Insurance to develop proposals to increase health insurance access for small businesses.

Directed the Small Business Advisory Board to promote the low-cost insurance packages for small businesses.

Directed the Virginia Health Services Cost Review Council with the Virginia Health Planning Board to study the possible establishment of a patient level data base.

Appendix A of this document contains the legislation proposed by the Health Commission as adopted by the 1991 General Assembly.

ACKNOWLEDGEMENTS

The Commission on Health Care for All Virginians wishes to express its sincere gratitude to the numerous persons that have assisted them this year in their deliberations. Individuals from the public and private sector have shared expertise, provided insight, and offered knowledge on the multidimensional aspects of health care, its provision, and delivery. The Commission is grateful for the innumerable contributions these individuals have made.

SJR 99 in the 1988 Session of the General Assembly established the membership of the Joint Subcommittee. That defined membership remained as originally enacted in the continuation of the Joint Subcommittee as a state Commission. The membership of legislators, health professionals, health industry representatives, state administrators and private citizens clearly evinces the necessity of a public/private partnership to resolve health care issues. Thus, the willingness of those additional individuals who readily participated in the study is a further manifestation of the cooperative spirit required to address health care concerns in the Commonwealth and formulate viable solutions for those concerns.

SUMMARY OF ISSUES AND RECOMMENDATIONS

VIRGINIA MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED PROGRAM

1. *That the COPN Program be continued and current review thresholds be maintained.*

2. *That the sunset deadline for the expiration of COPN requirements for hospitals and ambulatory surgery centers be extended for one year and the Secretary of Health and Human Resources be directed to report to the Commission on the efficacy of COPN requirements for hospitals and ambulatory surgery centers.*

3. *That the nursing home moratorium be extended to June 30, 1993.*

4. *That certificates for nursing home bed projects which are not completed by June 30, 1992, be revoked.*

5. *That registration be required for initiation of clinical health services and acquisition of major medical equipment at the time of contractual obligation or other commitment to purchase equipment or upon the establishment of the service.*

6. *That registration for capital expenditures of one million dollars or more which are not presently associated with a reviewable project at the time the capital expenditures are made be mandated.*

7. *That confidentiality of data filed by providers in support of further study about the effects of deregulation be provided by excluding the data from the Virginia Freedom of Information Act.*

8. *That the Commissioner of Health be maintained as the sole decision maker on COPN applications.*

9. *That the review procedures be modified to allow for a more structured application batching process (analogous to a request for proposal procedure) and the functions of project review manager be separated from the functions of the hearing officer.*

10. *That the Board of Health be authorized to establish limitations for capital cost overruns.*

11. *That a schedule of fees for applications for the Certificate of Public Need Program be implemented.*

12. *That the Secretary of Health and Human Resources be directed to develop a comprehensive health care plan to be submitted to the Commission by December 1991.*

13. *That the Secretary of Health and Human Resources continue to study the Certificate of Public Need Program until November 1, 1992.*

14. *That the moratorium law be amended to conform the patient populations noted in the moratorium exceptions to those populations described in the Medicaid special needs contract specifications.*

BUSINESS PARTICIPATION IN THE VIRGINIA INDIGENT HEALTH CARE TRUST FUND/INSURANCE ACCESS

15. *That action this year on requiring businesses without insurance to contribute to the Virginia Indigent Health Care Trust Fund effective July 1, 1994, be deferred. During 1991, voluntary participation in the low-cost health insurance products should be monitored by the Commission, and the policy and fiscal impacts of "play or pay" options to encourage employers to provide health insurance should be evaluated.*

16. *That the Bureau of Insurance develop a feasible proposal to establish a small business risk-sharing pool with insurance reforms that improve access and moderate rate increases.*

17. *That the Bureau of Insurance evaluate options for monitoring costs and rates of health insurance carriers.*

18. *That the Small Business Advisory Board develop a public awareness campaign to publicize the availability of low-cost insurance packages for small businesses when such products are offered by multiple insurance carriers.*

MANAGED CARE FOR VIRGINIA MEDICAL ASSISTANCE SERVICES PATIENTS

19. *That the Director of Medical Assistance Services implement the pilot program proposals for managed care for Virginia's Medicaid patients.*

ALLOCATION OF STATE FUNDS TO LOCAL HEALTH DEPARTMENTS

20. *That the Commission acknowledges the inequities found by the Department of Health in the current allocation methodology for the state/local cooperative budget but recognizes that, due to the current fiscal problems facing the Commonwealth, no further action can be taken at this time. When additional moneys are available, however, the Commission requests that the General Assembly allocate those moneys for the implementation of the needs-based allocation method.*

PRIMARY CARE POLICY

21. *That the General Assembly request district health directors of the Virginia Department of Health to study and assess district primary care needs and to develop in cooperation with the community and private sector a cost-effective plan to meet those needs.*

22. *That those health departments currently providing primary care services directly develop a system to measure access, availability, utilization, and cost of those services.*

DUPLICATE BILLING

23. *None*

LIMITED PRESCRIPTIVE AUTHORITY FOR LICENSED NURSE PRACTITIONERS

24. *That statewide limited prescriptive authority for certain licensed nurse practitioners in Virginia be authorized according to the conditions established by the Subcommittee on Limited Prescriptive Authority.*

EXPERIMENTAL MEDICAL PROCEDURES

25. *That the Commission recognizes the relative newness of the issue of experimental medical technologies and their inherent ethical and legal concerns. Further, the Commission recognizes that insurers have begun the process of initiating responses to several of the questions the issue raises. They have, through self-examination of their policies, coverage and their mechanisms for assessing technology, begun to reimburse for certain patients in a selected national clinical study. In addition, some insurers are adding lists of specific treatment services that are excluded from reimbursement in an attempt to provide complete disclosure. Consequently, further action appears premature at this time, and the Commission recommends no mandated action.*

26. *That the anticipated continuing developments in insurance coverage and policy concerning experimental medical technologies continue to be monitored by the Commission.*

LONG-TERM CARE

27. *That the Commission reaffirms its regard in the principles of case management which engendered the recommendation for pilot programs in its 1990 Interim Report to the Governor and General Assembly.*

28. *That a needs assessment be made on all clients with the more intensive case management services targeted to the more at-risk population. Furthermore, at least one pilot program should be modeled as closely as possible to the Peninsula Area Agency's case management program.*

29. *That the Chairman of the Commission appoint two Commission members to meet regularly with the Secretary of Health and Human Resources and the Long-Term Care Council to monitor the progress of this program.*

HOMES FOR ADULTS

30. *That the Secretary of Health and Human Resources develop a plan to comprehensively revise the statutory and regulatory framework of the adult home system to incorporate standards for several levels of care. The Secretary is additionally directed to complete a study of the fiscal impact of this program; to develop incentives for homes for adults which do not currently accept public patients to do so in the future; and to report his findings to the Commission by October 1, 1991.*

31. *That the Secretary of Health and Human Resources pursue the development of a client needs assessment instrument and process for use in placing and monitoring auxiliary grant recipients in adult homes. The Department of Social Services, the Department of Health, and the Department of Mental Health, Mental Retardation and Substance Abuse Services should be involved in this development.*

32. *That the Secretary of Health and Human Resources develop a proposal for regulatory changes governing charges for services received by auxiliary grant recipients. Once regulatory guidelines are established, the Department of Social Services should evaluate the adequacy of the personal allowance.*

33. *That the Code of Virginia be amended to require that annual renewal inspections of homes for adults be made on an unannounced basis and that the use of intermediate sanctions by the Commissioner of Social Services be authorized.*

34. *That licensing authority for homes for adults remain with the Department of Social Services.*

35. *That the Department of Social Services establish an effective auxiliary grant rate-setting process by developing guidelines for certain cost items; establishing clear policies, procedures, and standards for the cost reporting process; adjusting the cost reporting period and revising the cost report forms; conducting financial audits of adult home reported costs; providing an adequate interim adult home rate; and consolidating agency rate setting functions in one division.*

36. *That the Commissioner of Social Services ensure that fees assessed adult home licensees are utilized to provide training for adult home staff as intended by the General Assembly. Such enforcement should be enhanced by the Department of Social Services in training and overseeing regional licensing staff to promote consistency; employing a certified dietitian to supplement enforcement of nutrition and food services; and using supplemental Security Income data to assist in obtaining search warrants for illegally operating homes.*

37. *That the State Board of Social Services promulgate additional standards regarding qualification and training of adult home administrators and staff; staffing guidelines; medical procedures performed in adult homes; medication management; and facility design and equipment. Standards regarding medical care should be developed in consultation with the State Board of Health. Further, the State Board of Social Services should modify existing standards to specify adult home staff be at least 18 years of age; to require that physicians' orders be followed; and to clarify food service requirements.*

STANDARD DEFINITION OF CHARITY CARE

38. *That the Commission recognizes that the Virginia Health Services Cost Review Council has a uniform definition of charity care which is utilized by hospitals, including the Medical College of Virginia and the University of Virginia Medical Center, when submitting data to the Council.*

39. *That the Commission further recognizes that 1990 data of the Virginia Health Services Cost Review Council indicate that the Medical College of Virginia and University of Virginia Medical Center provide 60 percent of the State's total charity care for those persons under 100 percent of poverty.*

40. *That no changes be effected in the formula for the Virginia Indigent Health Care Trust Fund at this time.*

MEDICAID

41. *That the Joint Legislative Audit and Review Commission conduct a comprehensive study of the Commonwealth's Medicaid program and the indigent care appropriations to the state teaching hospitals.*

PATIENT LEVEL DATA BASE

42. *That the Virginia Health Services Cost Review Council, in cooperation with the Virginia Health Planning Board, study all aspects of the possible establishment of a patient level data base in the Commonwealth.*

43. *That the Council and the Board prepare a grant application to the Robert Wood Johnson Foundation for its program that encourages the development of comprehensive health data collection at the state level.*

PREFERRED PROVIDER ORGANIZATIONS

44. *That the Commonwealth statutes on preferred provider organizations be studied by the Commission to determine the intent of the General Assembly.*

Report of
Commission on Health Care for All Virginians
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
1991

TO: The Honorable L. Douglas Wilder, Governor
and
the General Assembly of Virginia

AUTHORITY FOR STUDY

In the 1990 Session of the General Assembly, Senate Joint Resolution 118 continued the Joint Subcommittee on Health Care for All Virginians as the Commission on Health Care for All Virginians. Senate Joint Resolution No. 99 in the 1988 Session of the General Assembly was the original enacting legislation establishing the Joint Subcommittee.

This report is presented in compliance with the directive of SJR 118 for the Commission on Health Care for All Virginians to submit its interim findings and recommendations to the Governor and the 1991 Session of the General Assembly. Pursuant to SJR 118, the Commission's final report is to be submitted to the Governor and the 1992 Session.

HISTORY

The Joint Subcommittee on Health Care for All Virginians was established by the 1988 General Assembly in Senate Joint Resolution 99. This resolution, proposed by Governor Gerald L. Baliles and introduced by Senator Stanley C. Walker, initiated a study of indigent health care. The scope of this proposed study included hospital and long-term care, Medicaid cost containment, and the role of the Certificate of Public Need Program in the Commonwealth's health care delivery system. House Joint Resolution 78, introduced by Delegate Ford C. Quillen, initiated a proposed study to address the elimination of Virginia's 209(b) Medicaid status involving certain restrictive eligibility criteria for elderly and disabled recipients of Supplemental Security Income. SJR 99 combined these two resolutions to effect the Joint Subcommittee on Health Care for All Virginians.

Senator Walker served as Chairman of the Joint Subcommittee and Delegate Quillen was Vice Chairman. During 1988, the Joint Subcommittee developed a number of proposals which were included in its report to the Governor and the 1989 General Assembly (Senate Document No. 18). A summary of the legislation proposed by the Joint Subcommittee, as adopted by the 1989 General Assembly, is included in this document as Appendix C. Among that legislation was Senate Joint Resolution 214 which continued the Joint Subcommittee on Health Care for All Virginians.

At the conclusion of the 1989 Session, Senator Walker, recognizing the scope and complexity of health care issues, appointed two subcommittees to more thoroughly investigate concerns and options.

Senator Hunter B. Andrews chaired the Subcommittee on the Uninsured. The subcommittee's purpose was to determine the characteristics of the low-income and uninsured population, a description of available health care programs in the Commonwealth accessible to this population, a description of this population's needed services, and alternatives to meet these needs.

Major recommendations of the Subcommittee on the Uninsured, subsequently adopted by the Joint Subcommittee and enacted into legislation by the 1990 General Assembly, included authorizing the sale of low-cost health insurance products to qualifying individuals, groups or companies with a concurrent reduction in the scope of state mandated benefits and providers; requiring the insurance industry to report annually to the State Corporation Commission on the cost of state-mandated benefits; creating an Advisory Commission on Mandated Health Insurance Benefits; and establishing a primary care program within the Department of Health by authorizing a series of initiatives to expand access to primary care, including medical scholarships, loan repayment, continuing education, and primary care pilots in Virginia's local health departments.

Delegate Quillen chaired the Subcommittee on Long-Term Care. The subcommittee's purpose was to determine the characteristics of the elderly population at-risk, a description of the current public and private long-term care system, projections of the unmet needs of the at-risk population through 2005, the most appropriate state organizational structure for financing and delivery of services, and alternatives to meet these needs.

Major recommendations of the Subcommittee on Long-Term Care, subsequently adopted by the Joint Subcommittee and enacted into legislation by the 1990 General Assembly, included directing the Joint Legislative Audit and Review Commission to conduct a follow-up study of Homes for Adults licensure; providing general funds for FY 1992 to support a series of pilot projects to expand the availability of case management services for elderly Virginians and coordinate the service delivery system; and extending the moratorium on approving Certificates of Public Need for new nursing home beds from January 1 to at least June 30, 1991, to ensure that the issue of COPN could be addressed more fully during the 1991 Session.

The Joint Subcommittee's proposals were included in its Interim Report to the Governor and the 1990 General Assembly (Senate Document 35). A summary of the legislation proposed by the Joint Subcommittee as adopted by the 1990 General Assembly is included in this document as Appendix B.

SUMMARY OF ACTIONS DURING 1990

Following its continuation as the Commission on Health Care for All Virginians and under the continuing chairmanship of Senator Walker, the Commission met six times between July and December 1990. In addition to Richmond, sites of the meetings were Charlottesville, Arlington and Norfolk. Meetings were held in these areas specifically to gain insight into regional health care delivery systems and those systems' services, concerns and strengths.

Additionally, the Commission examined numerous components of the Commonwealth's health care system including the teaching hospitals' indigent care programs and appropriations, issues related to the Virginia Medical Care Facilities' Certificate of Public Need Program (COPN), alternative state roles for addressing the medically at-risk, the status of the State/Local Hospitalization Program and the Virginia Indigent Health Care Trust Fund, and the viability of expanding the Trust Fund to include small business employers. The Commission was also briefed on other states' initiatives in addressing health care needs and received recommendations and findings of specific studies by agencies and departments as directed by legislation.

Documents presented to the Commission were available for the public. The Commission received public comment at its November 26 meeting in Richmond. Public comment was also invited at the meetings of the Subcommittee on the Certificate of Public Need and the Subcommittee on Business Participation/Insurance Reform in December.

Constraints of the current fiscal conditions in the Commonwealth affected the Commission's recommendations. Moreover, budget reductions affected some legislated health care initiatives enacted in the 1989 and 1990 Sessions of the General Assembly. A summary of those reductions is included in this document as Appendix D. Thus, the Commission's directives were further compounded by the budget shortfall which precluded any new appropriations for initiatives; rather, the Commission was compelled to seek alternate means for addressing health care concerns, including redirecting available dollars.

INTRODUCTION

Health care in the Commonwealth has historically been a critical concern of the General Assembly. The availability and affordability of health insurance, primary care, and long-term care; the allocation and distribution of state funds for Medicaid, hospitals, and indigent care; the provision of acute care in remote areas of the Commonwealth; the impact and ramifications of the COPN Program; and initiatives designed to enhance and expand the Commonwealth's health care delivery system are a very few of the several health care issues that the General Assembly has examined and subsequently enacted legislation to address.

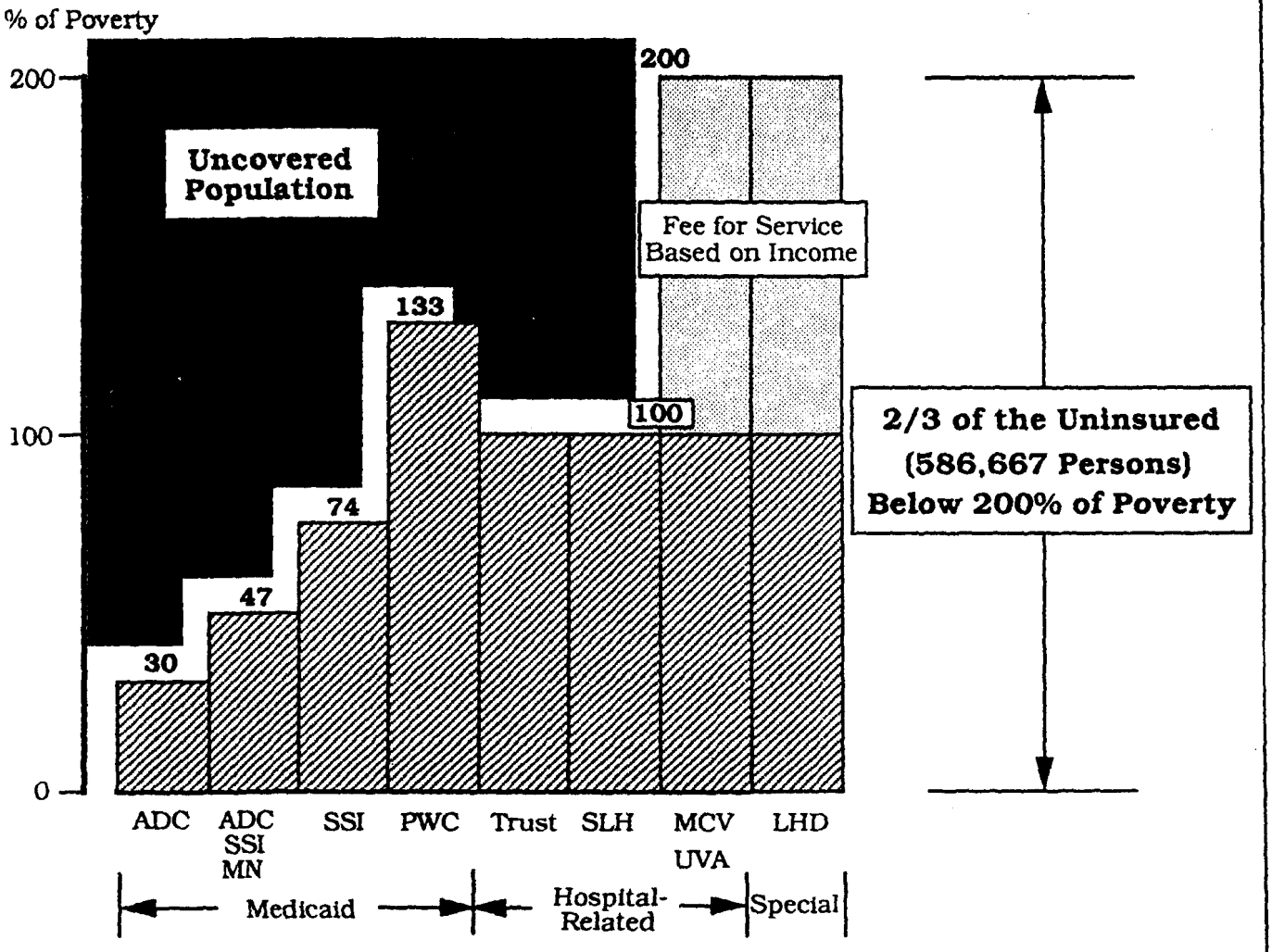
Health care issues have gained even greater magnitude in recent years. Lacking the federal government's comprehensive solution at the national level, states have and must continue to develop their own initiatives in offering solutions to the existing problems. The spiraling costs of health care and the effects of those costs have impacted the Commonwealth not only as a provider of health services, but also in its role as licensor, regulator, and consumer. Furthermore, the Commonwealth's concerns are not confined to the financing of health care; intrinsic components of health care concerns are intricate factors such as ethics, efficiency, and entitlement.

Of great concern to the General Assembly are the 800,000 Virginians who are uninsured, approximately 60 percent of whom live in families with at least one full-time employed person. The majority of the uninsured are children or young adults. In fact, 13.7 percent of children in two-parent families are uninsured even when the head of the household is employed.

As the Commonwealth enters the 1990's, the General Assembly is cognizant of the changing demographic trends occurring. America's population is aging, and projections indicate a continuation of this trend with increasing numbers of citizens in the over-65 age group and the over-85 age group. In 1990 there were about 677,000 Virginians age 65 and older. This number will increase by almost 40 percent by 2010. The most dramatic increase will occur in the more aged segment of the population; the number of those 85 and older will almost double by 2010. Clearly, the impact of these populations' health needs on the Commonwealth's health care delivery system is not only of major concern, but certainly an impact that must be well anticipated in planning future programs.

Advances in medical technology will continue to increase costs. Economic incentives for institutions to provide these sophisticated technologies exist. Hospitals, caught in the cross-fire of demand and competition, are frequently compelled to offer such advanced procedures and to provide state-of-the-art equipment. Thus, several hospitals within one region could be providing exact specializations and required equipment yet not operate or utilize such services at full volume.

Eligibility Requirements



Key:

ADC: Aid to Dependent Children.

SSI: Supplemental Security Income for Aged, Blind & Disabled.

MN: Medically Needy. Income c an be higher if medical expenses equal excess.

PWD: Pregnant Women & Children to Age 6.

LHD: Local Health Departments with Preventive & Other Special Services.

SLH: State & Local Hospitalization Program.

MCV/UVA: Teaching Hospitals Indigent Care.

Trust: Indigent Health Care Trust Fund.

Medical education costs and incurred debts frequently encourage graduates to enter specialty fields rather than general practice. The effects of such perspectives are far reaching, e.g., a shortage of primary care physicians in some areas deprives numerous Virginia citizens of primary care. Consequently, these individuals often enter the continuum of health services at the tertiary or secondary level of care; entry at these levels exacerbates health costs. Too often the emergency room is perceived by these patients as their only access to health services.

With limited new moneys available in the Commonwealth, the General Assembly is challenged to determine the greatest efficacy of dollars.

The following section of this Interim Report contains the issues that the Commission on Health Care for All Virginians examined and the Commission's recommendations premised on improving the Commonwealth's citizens' quality of health care, its access and availability while simultaneously containing costs.

ISSUES AND RECOMMENDATIONS

VIRGINIA MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED PROGRAM

Prior to 1946, construction of health care facilities in the United States was funded primarily through charitable contributions. America's health care system was neither well developed nor well financed because health insurance was virtually nonexistent, and programs providing care to the indigent were largely local, sporadic efforts or activities conducted by various religious organizations. Following World War II and in an atmosphere of promised prosperity, Congress passed the Hospital Survey and Construction Act, commonly referred to as the Hill-Burton Act, which provided federal funds for hospital construction but required states and localities to initiate health planning. Although Hill-Burton required a designated state agency to submit a state plan--referred to in the Commonwealth as the State Medical Facilities Plan--planning was unclear, and numerous hospitals burgeoned as a result. By the 1970's, hospital shortages had been reversed, private and public reimbursement systems had evolved further, and federal and state governments began examining the effects of hospital oversupply on health care costs. Consequently, to control the cost of health care by limiting the growth of facilities, Congress established two capital expenditure review programs: the Section 1122 program under the Social Security Act amendments (1972) and the National Health Planning and Resources Development Act (1974).

The COPN Program has from its inception been highly controversial. Arguments from supporters include the program's necessity as a disincentive to add unnecessary services and equipment, thus functioning as a means to improve outcomes and limit costs. Opponents maintain the program limits competition and drives smaller hospitals out of the market place. Since its implementation, varying state agencies and legislative committees have studied COPN and its effects. Significant changes have occurred as a result of these studies. The Commonwealth had long recognized that decisions made with respect to COPN should be assessed in relation to their effect on the availability of health care to the indigent. Because many nursing home beds are reimbursed through Medicaid, several moratoriums on nursing home bed construction were adopted in the 1980's. Pursuant to House Bill 30 of 1988 (general appropriations act), a moratorium was placed on nursing home beds. In 1989, the Joint Subcommittee proposed and the General Assembly adopted legislation to codify and extend the moratorium to June 30, 1991. Additionally, the 1989 legislation provided for deregulation of certain projects and the expiration of COPN requirements for hospitals and ambulatory surgery centers. Further, the Secretary of Health and Human Resources was directed to report on the projected impact of the deregulation by November 1, 1990.

During the 1990 Session, the Commission proposed and legislation was enacted that extended the moratorium on nursing home beds until July 1, 1991.

In 1990, as directed by Chapter 517 of the 1989 Acts of Assembly, the Secretary of Health and Human Resources reported to the Health Committees of the General Assembly and to the Commission on Health Care for All Virginians on the implications and effects of the repeal of COPN on the accessibility, affordability and quality of health care. The study was to include an analysis of federal, state and third-party reimbursement of medical services and its effect on the economic viability of health care providers; the effects of deregulation of certain medical care facilities, clinical health services and medical technology; the effect of deregulation upon health care price competition and affordability of primary, acute and long-term health care; and the effect of deregulation on the Commonwealth's budget.

Secretary Howard M. Cullum presented his findings and preliminary recommendations to the Commission on September 26, 1990. Following this briefing, Senator Walker appointed a subcommittee, chaired by Delegate George H. Heilig, for further study of COPN. Secretary Cullum presented the final report of that study to the subcommittee on December 16.

The Secretary's findings resulted from a multi-focused approach of study methodology and process, including among others, surveys of Virginia hospitals, nursing homes, physician specialists, and other states currently mandating COPN and those that have eliminated it; public hearings, and a cross-section of industry and agencies affected by COPN requirements.

The Secretary's findings included that the elimination of the COPN Program is premature; the budget of the Commonwealth is sensitive to nursing home bed and other health services deregulation; the assessment period of effects of recent COPN Program changes was too brief to provide an accurate evaluation of assessment; reliable data from the effects of COPN deregulation in other states is not available; further development of a data base to study the effects of deregulation in the Commonwealth is necessary; results of initiatives for controlling health care costs are yet to be determined; reliable mechanisms controlling health care costs across the health care system are unavailable; long-term effects of changed reimbursement methods on health care costs and quality are unknown; questions on competition as a means of controlling health care costs are increasing; and a comprehensive health plan for the Commonwealth as a foundation for future decisions on all facets of health care for the Commonwealth's citizens is necessary.

Following the subcommittee's report, the Commission formulated and adopted the following recommendations.

RECOMMENDATIONS

1. *That the COPN Program be continued and the following current review thresholds be maintained:*

   •establishment of a new medical care facility such as a nursing home or psychiatric hospital;
   •medical care facility bed increases and relocations;
   •introduction of nursing home service in any existing facility; and
   •introduction of open heart surgery, psychiatric, medical rehabilitation, or substance abuse treatment service in existing facility.

2. *That the sunset deadline for the expiration of COPN requirements for hospitals and ambulatory surgery centers be extended for one year and the Secretary of Health and Human Resources be directed to report to the Commission on the efficacy of COPN requirements for hospitals and ambulatory surgery centers.*

3. *That the nursing home moratorium be extended to June 30, 1993.*

4. *That certificates for nursing home bed projects which are not completed by June 30, 1992, be revoked. This recommendation provides at least three years for the completion of projects approved prior to the moratorium.*

5. *That registration be required for initiation of clinical health services and acquisition of major medical equipment at the time of contractual obligation or other commitment to purchase equipment or upon the establishment of the service for the following:*

- *radiation therapy*
- *obstetrics*
- *cardiac catheterization*
- *neonatal special care*
- *lithotripsy*
- *magnetic resonance imaging*
- *positron emission tomography scanning*
- *CT scanning*
- *all transplantation services*
- *other specialized services designated by the Commissioner of Health*

6. *That registration for capital expenditures of one million dollars or more which are not presently associated with a reviewable project at the time the capital expenditures are made be mandated.*

7. *That confidentiality of data filed by providers in support of further study about the effects of deregulation be provided by excluding the data from the Virginia Freedom of Information Act.*

8. *That the Commissioner of Health for the State of Virginia be maintained as the sole decision maker on COPN applications.*

9. *That the review procedures be modified to allow for a more structured application batching process (analogous to a request for proposal procedure) and the functions of project review manager be separated from the functions of the hearing officer.*

10. *That the Board of Health be authorized to establish limitations for capital cost overruns.*

11. *That a schedule of fees for applications for the Certificate of Public Need Program be implemented.*

12. *That the Secretary of Health and Human Resources be directed to develop a comprehensive health care plan to be submitted to the Commission by December 1991.*

13. *That the Secretary of Health and Human Resources continue to study the Certificate of Public Need Program until November 1, 1992.*

14. *That the moratorium law be amended to conform the patient populations noted in the moratorium exceptions to those populations described in the Medicaid special needs contract specifications.*

BUSINESS PARTICIPATION IN THE VIRGINIA INDIGENT HEALTH CARE TRUST FUND/INSURANCE ACCESS

Established by legislation in 1989, the Virginia Indigent Health Care Trust Fund is a partnership between the Commonwealth and the hospital industry established to equalize the burden of charity care costs among all private acute care hospitals within Virginia. The Trust Fund's important characteristics are all Virginia licensed acute care hospitals are required to contribute to the Trust Fund; the Trust Fund is not an entitlement program and the Commonwealth's liability is limited to the amount appropriated for the year; charity care, as defined for purposes of the program, is hospital care for which no payment is received and which is provided to any person whose gross annual family income is at or below the federal poverty level.

Chapter 394 of the 1990 Acts of Assembly directed the Technical Advisory Panel of the Trust Fund (TAP) to study the technical and operational considerations related to requiring employers who do not provide minimum health insurance benefits, as defined by the Commissioner of Insurance, to their employees or whose employees are not otherwise provided such benefits to make reasonable contributions to the Trust Fund.

Additional legislation in the 1990 Session of the General Assembly required that three representatives from private enterprise be appointed by the Board of Medical Assistance Services to serve on TAP. The purpose of adding members from the business community was to ensure the panel's ability to address the many technical questions which would be raised during the consideration of a business contribution to the Trust Fund from employers who do not offer or contribute to health insurance for their employees.

TAP's study methodology included, among other actions, a review of nearly 200 articles, reports, and government documents related to the working uninsured and health insurance; a study of other states' programs; a random survey of 3,667 Virginia employers conducted by the Department of Medical Assistance Services and the Virginia Employment Commission (note: 1,511 employers responded, a 41 percent response); an evaluation of alternatives that addressed the financial burden to employers of providing health insurance; and an investigation of alternatives to reduce the number of working uninsured, i.e., voluntary, employment-based insurance incentives and mandatory requirement with penalties.

TAP's study describes the extent of the problem of the working uninsured in Virginia and contains a profile of uninsured workers. Specifically, Virginia's uninsured is a population of 800,000 with 60 percent of that population living in households where at least one person works full-time. Additionally, the employer survey revealed that 64 percent of the employers who responded indicated that they do provide health insurance to their full-time employees, and 36 percent do not.

Many uninsured workers are employed by small businesses. About 41 percent of the businesses with 25 or fewer employees do not offer health insurance, accounting for an estimated 205,000 employees. Also, certain industries have a larger uninsured problem. Among those cited with the largest number of uninsured are agriculture, forestry, fishing, construction, and retail trade.

Data indicating employers' reasons for not providing health insurance illustrate that 35 percent cite the high cost of insurance; 31 percent cite the low number of employees; 15 percent cite other coverage, i.e., employers' assumption that workers are already covered through other sources, such as spousal or individual policies; seven percent cite coverage is not available; 12 percent cite part-time workers/turnover in their workers; and one percent cite the waiting period for insurance to begin coverage.

Several factors affect the high cost of insurance to the small business:

Uncertainty in claims' predictions--Within a small employer group, one large claim could well deplete all employee contributions made during a year; hence, insurers frequently add an allowance to premiums to cover these costs.

Higher administrative costs--Small businesses usually lack an employee benefits administrator; thus, the insurer administers the plan and adds that cost onto the premium.

Marketing costs in the small group market--Marketing costs are higher because marketing is frequently done by sales agents and brokers, and their commissions are added to the premium.

Lack of information and bargaining power--Again because of the absence of an employee benefits administrator, small businesses are ineffective in negotiating with insurers.

Premium tax--Many large companies can self-insure and consequently avoid this tax; small businesses, however, cannot afford to self-insure.

Turnover--Turnover occurs not only in employees, but also in insurance purchasing. These shifts happen more frequently in small businesses than large companies and are factors which also drive administrative costs.

Erosion of community rating--Historically, community rating based on the average actual or projected claims rate of individuals within a geographic area was utilized; today, community rating does not occur as often. Mid-size and large businesses often self-insure, taking the lower risk group out of the community pool and subsequently raising premiums within the community pool because the pool is at a higher risk.

Underwriting and rating practices competition--Competition allows insurers to pursue more aggressive marketing and to select out the best risks, leaving behind those that require a higher premium.

Structural changes in the economy--A shift of jobs from larger businesses to smaller businesses has occurred, resulting in less insurance coverage. Employment and industries which traditionally do not have a great amount of insurance coverage, e.g., services, retail, construction, have experienced growth. This past decade has also witnessed increases in part-time and temporary employees, workers who have rarely been offered health insurance coverage by employers.

While other sources of payment for health care for the uninsured do exist in Virginia, these sources do not provide a comprehensive system of health care to meet most of the primary and preventive needs of the working uninsured. Further, these programs are only available to individuals that have income low enough to qualify.

In addition, low-income persons without employer sponsored health insurance do not necessarily qualify for available public health services: two-thirds of the uninsured have incomes up to 200 percent of the federal poverty level; the maximum eligible income for some components of the Medicaid program is 30 percent of the poverty level; and access to primary care for health maintenance is far more limited than hospital services.

TAP found that small businesses should be provided incentives or assistance, so that they might voluntarily obtain health insurance for their employees. Such voluntary programs could include the formation of a state-sponsored small business insurance pool to aggregate small businesses seeking to purchase health insurance. This insurance pool may be administered by a nonprofit, public service corporation which would negotiate contracts with insurers and providers and determine eligibility enrollment, billing and collection procedures. Another possible voluntary program is the establishment of a reinsurance pool to cover losses of higher risk groups. All insurers in the small group market would participate, with possible restrictions on rate increases to small employers, prohibitions against cancelling policies with adverse experience, restrictions on pre-existing conditions, and requirements to accept or reject entire employer groups without excluding high risk individuals. Finally, the Small Business Advisory Board, the Virginia Employment Commission or some other agency of state government could be utilized to publicize the availability of low-cost minimum benefit plans for small businesses.

The Technical Advisory Panel further recommended that a mandatory assessment on businesses which do not voluntarily offer insurance--a practice commonly referred to as "play or pay"--be instituted by July 1, 1994. TAP'S proposed play or pay components include that employers without health insurance offerings be required to pay a tax by July 1, 1994; that the assessment be established at approximately the cost of purchasing insurance for uninsured workers, but rates would be adjusted according to the income of the employees; and that employees be charged for up to half of the insurance premium on a limited benefit package, such benefits being authorized by § 38.2-3425 of the Code of Virginia.

Yet, legal constraints of mandating that employers provide health insurance for their employees exist. Enacted in 1974, the Employee Retirement Income Security Act (ERISA) preempts all state laws and regulations that have an impact on employee benefit plans which are defined broadly by ERISA as "any plan, fund or program established or maintained by an employer or an employee organization, whose purpose is to provide for its participants or beneficiaries medical, surgical, or hospital care, or benefits in the event of accident, sickness, disability or death, through the purchase of insurance or otherwise."

ERISA does not, however, preempt states from regulating the business of insurance; thus, any insurance product can be regulated in itself. States can regulate insurance and impose certain mandated benefits. Because most employers are protected by ERISA from states' mandating that employers provide a minimum level of health insurance benefits, the play or pay program offers an alternative to a mandate of requiring employers who do not provide health insurance to pay a tax that is equivalent to the cost of health insurance.

TAP cited specific problems with play or pay programs: a play or pay program based directly on actuarial equivalent tax may be interpreted as forcing employers to provide a certain mandated level of health insurance to avoid the tax, and the administration of such a program

based on actuarial equivalents would be difficult as the actuarial cost of the minimum health insurance for each employee would be different and would vary from year to year. Massachusetts has a play or pay program that is directly/actuarially equal to the tax that the employer has to pay; this program is expected to be challenged in the court under ERISA.

To avoid such difficulties with the play or pay program, TAP formulated a plan based on a payroll tax where employers' tax liability varies with their employees' average wage: the tax is set at a level at which the average tax payment by employers is equal to the average employer's share of the minimum benefit package's cost per worker. This plan is not the same as requiring each employer to pay a tax that is directly/actuarially equivalent to the cost of a minimum benefit insurance premium.

On average, the tax rate should be equal to the employer's share of the premium for a minimum benefit insurance product. The calculation of the tax rate is based on the average of all employers' contributions to the annual premium for individual coverage for a minimum benefit insurance product, divided by the average wage base of their employees. Thus, employers whose workers earn a low average wage would have a lower tax liability than employers whose workers earn a higher average wage. According to VEC data, the average wage base for the majority of uninsured workers is $21,000. If the tax rate is higher than based on the averages, then employers with a lower wage base than average would have the incentive to purchase insurance rather than pay the tax. Conversely, if the tax rate is lower, then employers with a higher wage base would likely have to pay the tax rather than purchase insurance.

Certainly, a balance must be achieved in a play or pay program between encouraging employers to provide health insurance and minimizing the economic consequences for low-wage workers and their employers. Furthermore, the tax must be adjusted annually to reflect premium increases. Employers offering insurance would be exempt from the tax if their insurance benefits are equivalent or greater than the minimum benefit plan on an actuarial basis; and those employers whose offered insurance benefits are less than the minimum would incur a tax liability equal to the calculated rate minus their contribution to the purchase of insurance.

Finally, TAP recommended that the Indigent Health Care Trust Fund be restructured to serve as a repository for employer assessments which will be used to purchase insurance for uninsured workers. That modification results in insurance premiums for uninsured persons being funded rather than hospitals' charity care being directly reimbursed. State and hospital contributions to the Trust Fund would subsidize the cost of the reinsurance pool for higher risk groups and would contribute to the administration of the small business insurance pool. Further, if additional Trust Fund moneys were available, these would be used for insurance subsidies for small businesses, tax credits, and insurance reforms. Greater insurance coverage will reduce the level of unreimbursed care provided by hospitals.

Following TAP's report and their recommendations specifically in the areas of voluntary programs, the play or pay concept, and alteration of the Indigent Health Care Trust Fund, Senator Walker appointed a subcommittee chaired by Senator Dudley J. Emick, Jr., to further study these issues.

After receiving the subcommittee's report, the Commission formulated and adopted the following recommendations.

RECOMMENDATIONS

15. *That action this year on requiring businesses without insurance to contribute to the Virginia Indigent Health Care Trust Fund effective July 1, 1994, be deferred. During 1991, voluntary participation in the low-cost health insurance products should be monitored by the Commission, and the policy and fiscal impacts of "play or pay" options to encourage employers to provide health insurance should be evaluated.*

16. *That the Bureau of Insurance develop a feasible proposal to establish a small business risk-sharing pool with insurance reforms that improve access and moderate rate increases.*

17. *That the Bureau of Insurance evaluate options for monitoring costs and rates of health insurance carriers.*

18. *That the Small Business Advisory Board develop a public awareness campaign to publicize the availability of low-cost insurance packages for small businesses when such products are offered by multiple insurance carriers.*

MANAGED CARE FOR VIRGINIA MEDICAL ASSISTANCE SERVICES PATIENTS

Chapter 972, Item 466N of the 1990 Appropriations Act of the General Assembly directed the Department of Medical Assistance Services to develop a plan to test the feasibility of establishing a statewide managed care system for Medicaid patients and to report its findings to the Commission by October 1, 1990.

In the concept of managed care, the primary care provider serves as the gatekeeper to patients' utilization of care and services by directing patients to the most appropriate site for their health care, thus offering a health care coordinating strategy. In the private sector, those insurers such as a health maintenance organization (HMO) and primary provider organization (PPO) are established on this premise with the primary care physician initially addressing patients' health concerns and, if necessary, referring the patient to specialists through an established network of participating physicians. In its 1990 Interim Report, the Joint Subcommittee recommended that the Department of Medical Assistance Services study the feasibility of developing a managed care or buy-in demonstration project under the authority of the Omnibus Budget Reconciliation Act (OBRA) 1989 package or separately without federal funds. The project was intended to test the concepts of coordinated care for recipients, income-related premiums, and capitated payments to providers.

Managed care's advantages for the medically indigent include enhanced quality of care through continuity of care and a savings of health care dollars. Furthermore, patients' access to primary care, appropriate services, and the sources of those services are improved. Outcomes also include a reduction in inappropriate emergency and in-patient services. The DMAS study recommended pilot programs that utilize the most successful aspects of case management Medicaid programs in other states, the successful aspects of Virginia's Client Medical Management program, Community-based Care program, Pre-admission Screening program, and the Hospital Utilization Review program, and an innovation that allows providers to share in the savings to be realized under the program. The unique aspects of the Virginia proposal are performance-based financial incentives for providers and the inclusion of a primary pharmacist in the managed care models.

Those providers include general practitioners, family practitioners, pediatricians, obstetricians, gynecologists, internists, and clinics or group practices with one or more of the cited specialists.

Two pilot proposals were recommended by DMAS: specifically, one pilot site may incorporate both a case management fee and a financial incentive for physicians. In this pilot, physicians are paid a case management fee of $2 per month for their enrolled panel, not to exceed 1000 patients or $2000 per month. A supplemental incentive of $2 is paid to physicians whose over-all utilization remains below the median for their specialty group, not to exceed $2000 per month. Total case management fees cannot exceed $4000 per month. This payment will be made after the end of the year for which the savings were generated.

A second pilot site may not pay a monthly case management fee. Its physician incentive is the opportunity to share in the savings generated by the managed care program without physicians' having to share the risk for additional expense. For their enrolled panel, not to exceed 1000, an expected annual utilization cost will be projected, based upon prior experience. These costs will be compared to the costs of services delivered to the enrolled panel after a year's experience with the managed care program. If utilization expense has declined in comparison to forecasted expense, physicians will be entitled to fifty percent of the savings, paid after the end of the year in which the savings were realized.

The two pilots may incorporate a primary pharmacy component. If this component is included, recipients may enroll with a primary pharmacy for all prescriptions and pharmacy services. Pharmacies will be able to monitor inappropriate or over-utilized drugs for their enrolled panel. Additionally, the pharmacist will partner with the enrollee's primary care provider. The pharmacy expense for its enrolled panel will be compared before and after managed care intervention, and the pharmacy will receive fifty percent of the savings from reduced utilization. Pharmacies that remain at or exceed the expenditure levels of the previous year are at no risk.

Two different proposals were offered as a means to test for physician financial incentive. Both proposals, however, share similarities: the existing fee-for-service payment method is retained; management fee and incentive supplements are paid in addition to fee-for-service; true emergency services are excluded in that preauthorization from the primary care provider will not be required; savings will come from reduced utilization expense; a patient assessment fee for emergency room determination of true emergency service need is required; and a primary pharmacy program will exist at both sites.

First year implementation costs are estimated at $632,000 from general funds. By redirecting service utilization to more appropriate sites, specifically, the primary care practitioner, and away from continued reliance on emergency room use and the often resulting necessity of hospitalization, utilization expense reductions of 3 to 10 percent would generate savings of $30,000 to $1,300,000 in the first year for the pilot population. The break-even point for the first year is projected at a utilization expense reduction of 2.5 percent. Those reductions are expected in inpatient and outpatient hospitalization (includes ER), physician, lab, X-Ray, and pharmaceutical services. With utilization expense reductions between 3 and 10 percent in years two and three of the pilot, savings from $65,000 to $1.5 million annually to the Medicaid program are projected.

Total predicted savings for the first three years of the pilot, based upon utilization expense reductions between 3 and 10 percent, range from $187,000 to $4,200,000.

RECOMMENDATION

19. *That the Director of Medical Assistance Services implement the pilot program proposals for managed care for Virginia's Medicaid patients.*

ALLOCATION OF STATE FUNDS TO LOCAL HEALTH DEPARTMENTS

The Virginia Department of Health (VDH) is assigned the primary responsibility for protecting and enhancing the health and well-being of all citizens of the Commonwealth. Section 32.1-30 of the Code of Virginia requires that each city and county establish and maintain a local health department. The state is divided into four regions with regional offices: Northern Region (Manassas); Southwest Region (Roanoke); Central Region (Richmond); and the Eastern Region (Virginia Beach); and is organized into thirty-six districts. One hundred and eighteen health departments serve all localities.

The Commonwealth's system of statewide administration of all local health services is found in few other states. This system manifests Virginia's commitment to public health, supports a basic level of services consistent across the state, and creates a unique relationship between the state and local governments in determining public health needs for each locality.

A locality may enter into a contract with the Board of Health for the operation of the local health department. All localities except the County of Arlington use this option of contracting with the Board. State funds are appropriated to operate each local health department. The locality is required to matched these state funds with local funds based upon a formula recommended by the Joint Legislative and Audit Review Commission. A locality may operate its own local health department with its own local board of health. No state dollars would be provided under this method, and no localities currently use this option. Special legislation passed in the 1988 Session of the General Assembly enabled Arlington County to operate a locally administered health department, receiving state funds under a contract with the Board of Health as a pilot program.

Certain inequities have arisen under the current allocation system for various reasons: the inability of some localities to provide sufficient local matching funds has resulted in uncommitted state dollars being moved to those localities which are able to match them; some localities have been successful in obtaining federal grants for specific programs with state funds being used to match or continue programs; some local health departments have received specific funding from the General Assembly for certain activities; some funding from the General Assembly for either specifically targeted issues, such as the AIDS population, or as a challenge grant for which a locality must apply, i.e., primary care grants, has occurred; and older cities' operating local health departments outside the state system until the 1960's and early 1970's generally had much larger and sophisticated departments which consequently resulted in their entering the system with much larger budgets than did the suburban and rural localities.

Furthermore, the cooperative budget expenditures for FY 1989 illustrate that while the median per capita expenditure statewide is $18.86, the median per capita locally ranges from a high of $57.06 for Northampton County to a low of $8.16 for the City of Poquoson. Additionally, while some localities enjoy special grant support for certain services, others do not, e.g., two localities do not receive federal family planning dollars due to decisions made when entering the state system years ago; primary care grant proposals were received from twelve local districts, but only four could be awarded, etc.

During the 1990 Session of the General Assembly, Senator Clarence A. Holland of Virginia Beach proposed SJR 126 which called for the establishment of "a joint subcommittee to study the state/local cooperative budget formula." Ultimately, that resolution was incorporated into SJR 118 and directed the Commission to "examine the current mechanism for the state/local cooperative budget allocation to determine appropriate ways to provide for the equitable allocation of state funds."

A study by the Virginia Department of Health identified the previously cited reasons for inequities in the current allocation method, reviewed methods used in other states, and developed alternative methods of allocation for consideration.

In the study of the allocation methodologies used in the fifteen states responding to the its survey, the Department of Health identified three general methodologies: specific dollar amounts are allocated to every local health department; an allocation method based on population is utilized; or a program specific needs-based allocation method is employed.

The alternative methods of allocation developed by VDH and offered to the Commission for consideration included a basic health department model; a model providing 100 percent state funding of mandated services; a model based on per capita/per capita indigent; and a program specific or "needs-based" model.

The Department concluded in its findings that the needs-based model would, in fact, be the most effective and responsive to public health needs in the locality; correlates well with current planning and evaluation systems; is program specific, responsive to changing priorities, and compatible with the current budget process; and does provide a system for allocating funds from multiple sources.

A needs-based model does, however, have certain intrinsic disadvantages: its implementation requires $4,064,261 of new state funding; a major shifting of funds among local departments may be required; all programs delivered by local health departments are not addressed; consistent, reliable data for each locality must be available; and indigent population data is available only from the U.S. Census Bureau on a consistent basis for each locality, and that data is inherently outdated.

Regardless, the advantages of a needs-based program far outweigh its disadvantages and would promote a more equitable state/local cooperative budget. Within this model, state dollars are allocated within each of nine sub-program areas described in the Community Health Services Program, and those allocations are based upon formulas using selected indicators to identify local need.

Those nine areas are maternal and child health; family planning; infectious disease; health promotion and education; primary care; long term care; environmental health; oral health; and management and support services. Funding levels for each of the nine areas would have to be established during the regular biennial budget process.

RECOMMENDATION

20. *That the Commission acknowledges the inequities found by the Department of Health in the current allocation methodology for the state/local cooperative budget but recognizes that, due to the current fiscal problems facing the Commonwealth, no further action can be taken at this time. When additional moneys are available, however, the Commission requests that the General Assembly allocate those moneys for the implementation of the needs-based allocation method.*

PRIMARY CARE POLICY

In both its 1989 and 1990 Interim Reports to the Governor and the General Assembly, the Joint Subcommittee urged a refocusing of the state's direction and health policy towards the provision of primary care. Specifically, the Virginia Department of Health was requested to become engaged in moving the state towards that direction.

Congruent with its mission, "to protect and enhance the health and well-being of all citizens of the Commonwealth," the Virginia Department of Health recognizes the necessity of local health departments' expanding their role in the provision of primary care. Those citizens who lack a primary care physician are frequently forced to enter the health care system at a level of need far above basic services; thus, inappropriate utilization of emergency room services occurs and larger costs are incurred by all parties involved. Additionally, many Virginians do not have a family physician and do not receive basic medical services because of their residing in medically underserved areas. Furthermore, an individual's entering the continuum of health services at the primary level of care rather than at the tertiary or secondary care level mitigates both personal suffering and personal financial expense. Certainly, the provision of primary care is also a means of cost containment for the Commonwealth in its role as health care provider.

Given the numbers of the state's uninsured and those citizens' lacking access to primary care services combined with a limited provider community, the Commonwealth must expand its role to ensure the availability of primary care at the local level. The Virginia Department of Health has local health departments that serve each locality in the Commonwealth and organized within 36 health districts. Each district is led by a physician health director responsible for providing public health, preventive medicine, and environmental health services to their communities. Several local health departments directly provide primary care services in addition to traditional public health activities.

These health directors have knowledge of the health care delivery system in their communities and are best able by the nature of their positions to facilitate the strengthening of that system. Thus, primary care could be more readily available through the efforts of the departments' local directors working in conjunction with the private sector. The local health departments' role in addressing the problems of delivery of primary health services could be expanded to lead in the development of greater public/private partnerships, with the departments' possibly serving as enablers and catalysts to optimize delivery of services. Creative means to access the availability of private providers for the populations that the health departments identify could be devised.

The Joint Subcommittee proposed legislation enacted in 1989 which established funding for primary care pilot programs. Of Virginia's 36 health districts, 12 submitted primary care grant applications. Due to budget constraints, however, only four were awarded grants with a combined budget of $500,000 in state general funds for FY 1991. The FY 1992 budget for these initiatives is $1.0 million.

Virginia's primary care projects and the populations they serve include:

- City of Portsmouth: This project continues long-standing general medical services offered by the local health department. These services have become an integral part of the Portsmouth primary care delivery system and were jeopardized by inadequate state funding to meet service demands, loss of other state programs' funding, and inadequate reimbursement by Medicaid.

- Roanoke and Alleghany Districts: This project expands the Comprehensive Health Investment Project--also known as CHIP--which is a public/private partnership involving two local health departments, the local medical society, the business community in the Roanoke Valley and the local community action program. Participating private physicians agree to accept children in CHIP whose family incomes are below the federal poverty level. Physicians are compensated at Medicaid payment rates from private, federal and state resources. The local health department with the community action program provides case management and transportation, ensuring that patients make their appointments, understand and follow their doctors' advice, and are knowledgeable of other family support services. This program was initiated under a Kellog Foundation Grant and is being expanded through state support and federal Maternal and Child Health block grant funds. Kellog has also supported a grant to replicate CHIP in other areas of the Commonwealth. The pilot program grant expanded the area that CHIP can reach and increased patient enrollment to 2,200. Additionally, a volunteer program was established and a nurse practitioner employed. This pilot serves four cities and four counties in Southwest Virginia.

- Hampton District: A full-time pediatric clinic resulting from a cooperative arrangement between the Health Department and a local hospital is now operating with 24-hour provision of acute ambulatory care for infants, children, and adolescents with primary care funding. Care coordination for patients is also provided.

- Fairfax District: In Virginia's largest urban county with approximately 10 percent of the state's entire population, two primary care clinics have been established to serve the uninsured population. These are free-standing clinics which contract out with a private corporation. This project offers approaches through special programs or incentives to increase the use of preventive care through special well-child and medical clinics. Patient visits have increased from 20,600 to 25,000 and contracts for ancillary services and medical special referrals are expanded. The experience of this particular project demonstrates that even in those areas where data reveals an adequate number of primary care providers exist, a significant number of citizens still lack access to a basic level of health care. These sites have served significant numbers of persons with untreated chronic disease, foreign born residents, pregnant women, the working poor, the homeless, and Medicaid recipients with no primary care physician.

Just as no singular answer to any health care policy concern exists, no one pilot model will meet all needs of Virginia's medically underserved areas. Virginia's population is diverse, as is its health care needs. The Department of Health and the Commission believe district health directors are able to assess the availability and accessibility of primary care services to the district's residents and are able to facilitate the development of a cost-effective community plan to address identified gaps in services.

RECOMMENDATIONS

21. *That the General Assembly request district health directors of the Virginia Department of Health to study and assess district primary care needs and to develop in cooperation with the community and private sector a cost-effective plan to meet those needs.*

22. *That those health departments currently providing primary care services directly develop a system to measure access, availability, utilization, and cost of those services.*

DUPLICATE BILLING

Duplicate billing is defined as double billing where the same service or product is charged for twice. In the health industry, the practice refers to the billing of a service to multiple insurance companies to guarantee maximum payment in the event the individual is insured under more than one policy. Duplicate billing can result from varying situations and designs of hospital billing data, e.g., patients are assigned a regular room, but due to surgical complications or some other unforeseen factor, remain in intensive care and are never moved during that designated day to the regular room being held for them.

Following a citizen's complaint in February 1988 of a Richmond area hospital's charging a patient for both a regular hospital room as well as intensive care treatment during the same period of time, the Commission was requested to determine the number of hospitals charging a patient assigned two rooms simultaneously. In this instance, the third-party payor rejected payment for the regular room and requested payment by the individual. Largely, third-party payors negotiate rates with individual hospitals, pay the agreed upon usual and customary rate (UCR), and relieve the individual from any additional charge other than the standard deductible for that patient's policy. The Commission was further requested to determine the amount of moneys being spent in the health care system in compensation for similar fiscal accounting practices.

The methodology to determine whether the practice of duplicate billing is a current accounting procedure in the Commonwealth and, if so, its extent, included a survey of Virginia hospitals on current billing practices, as well as their history of duplicate billing; independent contact with hospitals for informational purposes; a study of relevant literature; and contacts with insurance carriers and associations to determine their audit and reimbursement procedures for duplicate billing.

In their survey of 88 of Virginia's 95 hospitals, the Virginia Hospital Association and the Virginia Chapter of the Health Care Financial Management Association found that no hospital in Virginia currently applies duplicate billing in its accounting procedures. Only three of the surveyed hospitals did not have ICU units.

Additionally, the VHA and HFMA survey revealed that at one time three hospitals did practice duplicate billing but voluntarily ceased the practice four years ago as a result of requiring more efficient accounting procedures. The particular hospital in question ceased its duplicate billing practice during July 1989. Presently, all hospitals determine the location and appropriate billing of patients by what is termed the "midnight census," i.e., wherever the patient is at midnight determines how he will be billed.

Third-party payors do not generally reimburse for duplicate billings and that policy positively affects unnecessary expenditures for health care. Formal, comprehensive hospital bill audit programs, increased educational efforts towards subscribers, automated billing systems, and hospitals' hiring internal auditors to verify billings have greatly contributed to the reduction of billing errors. The National Health Care Anti-Fraud Association, a membership organization

of primary insurance carriers, government payors such as Medicare, state and federal district attorneys, and various law-enforcement officials, has as its premise increasing awareness of payment/collection abuse as well as the sharing of successful detection techniques, advocacy for abuse detection, and fostering environments which allow insurance companies to pursue fraudulent claims.

Moreover, third-party payors continue to perform on-site charge audits of randomly selected cases. Claims processing and provider payment systems contain edits which identify total duplicate bills, although duplicate billing of individual ancillary charges remains difficult to detect.

In the 1990 Session of the General Assembly, House Bill 246 mandated patients' being allowed an itemized statement of services and charges during a hospital stay, thus encouraging subscribers to evaluate their bills for errors and to become more fully engaged as consumers of health care services.

In conclusion, current hospital billing practices in conjunction with improved technology and insurance companies' audit and review systems reduce the possibility of duplicate billing. In fact, the issue of duplicate billing appears to be of no consequence at this time. Additionally, with increased subscriber education and engagement, the percentage of hospital billing mistakes could likely be reduced to an even larger degree to effect additional savings in health care cost.

RECOMMENDATION

23. None

LIMITED PRESCRIPTIVE AUTHORITY FOR LICENSED NURSE PRACTITIONERS

Nurse practitioners are licensed to practice advanced nursing care independently and perform certain services defined as the practice of medicine, i.e., diagnosing and treating common illnesses under the supervision of a physician. Nurse practitioners obtain health histories, assess health status, perform physical examinations, order laboratory tests and interpret such tests' results, decide a course of management for a patient that includes recommending medication and monitoring care, provide primary care for patients with acute self-limited illness, facilitate access to the health care system, plan for health maintenance and disease prevention, teach and counsel about health risks, monitor and evaluate patients with chronic illnesses and consult with and refer patients to physicians when necessary.

Currently, nurse practitioners are authorized to perform all tasks relating to issuing a prescription except sign the prescription. Nurse practitioners evaluate and diagnose the patient and plan treatment, including selecting medications and completing the prescription form with medication, dosage and precautions. In Virginia, however, the nurse practitioner is required by law to have a physician sign the prescription order.

In an effort to improve access to health care and following their year-long study of nurse practitioners, the Department of Health Professions recommended in 1989 that limited prescriptive authority be extended to nurse practitioners. "Limited prescriptive authority" would give nurse practitioners the authority to prescribe only specific drugs for specific conditions; nurse practitioners would not have full authority to prescribe all medications as physicians do.

In the 1990 Session of the General Assembly, Delegate Mary Marshall introduced House Bill No. 768 which would have granted nurse practitioners prescriptive authority. This bill was carried over to the 1991 Session. Additionally in the 1990 Session, a measure was added to the Appropriations Act directing the Virginia Health Planning Board to study means to optimize the use of alternative health providers to improve access to primary care services and to report their findings to the Commission on Health Care for All Virginians. Also, the Department of Health Professions was asked to continue its work in examining the practice of nurse practitioners.

Following the 1990 Session, the Secretary of Health and Human Resources established the Subcommittee on Limited Prescriptive Authority which consolidated the work on prescriptive authority by the Virginia Health Planning Board's Task Force on Alternative Providers in Underserved Areas and the Department of Health Professions' Task Force on the Practice of Nurse Practitioners. The subcommittee's membership reflected representation from these task forces and was composed of five physicians; four nurse practitioners; a nurse; a pharmacist; a hospital administrator; and an expert on health policy. The Commission received the report of the subcommittee at their December meeting.

The study methodology of the Secretary's subcommittee included an evaluation of existing research and information received from the two previous task forces and an examination of thirty-five states that currently allow limited prescriptive authority for nurse practitioners. Further, the subcommittee examined the current practice and regulation of nurse practitioners in the Commonwealth.

Since 1973 the Board of Nursing and the Board of Medicine have jointly regulated nurse practitioners in Virginia. In thirty-five states, nurse practitioners have some degree of limited prescriptive authority. In slightly less than half of these states, the Board of Nursing is the sole regulatory body. Approximately half of the thirty-five states are similar to Virginia and have a joint regulatory mechanism between the Board of Nursing and the Board of Medicine. In only one state is the Board of Medicine the sole regulator.

Within the states that do extend limited prescriptive authority to nurse practitioners, highly restrictive systems and less restrictive systems exist. The spectrum of authority ranges from states with precise authority granted by law with specific rules and regulations addressing each aspect of nurse practitioner practice to states with general authority granted by law and general rules and regulations addressing only major aspects of nurse practitioner practice. The subcommittee studied four states including Mississippi and West Virginia (only physician assistants have limited prescriptive authority) which fall at the extreme ends of the spectrum, and Maryland and North Carolina which represent the middle ground.

In 1990 the Department of Health Professions conducted a survey of Virginia physicians and nurse practitioners that indicated that 65 percent of physicians would accept limited prescriptive authority for nurse practitioners under conditions such as those recommended by the subcommittee. Additional data indicated that 38 percent of nurse practitioners in Virginia work in urban areas, and 23 percent work in rural areas. Seven percent of the Commonwealth's nurse practitioners work in non-metropolitan, medically underserved areas.

The subcommittee concluded that limited prescriptive authority should be extended to certified nurse practitioners and certified nurse midwives. The current practice of certified registered nurse anesthetists should not be expanded or limited. In addition to the requirement of supervision by a physician, nurse practitioners' supervision should consist of written protocols incorporating prescriptive information and weekly random review of medical charts by the physician. The subcommittee did allow for special consideration to be given to these time requirements for the health department because of its geographical difficulties. Supervision is currently defined by the Virginia Department of Health Professions' rules and regulations as "the physician documents being readily available for medical consultation by the licensed nurse practitioner or the client, with the physician maintaining ultimate responsibility for the agreed-upon course of medical treatments."

The subcommittee further concluded that Schedule VI drugs and devices, those that have no potential for psychological or physical abuse or dependency, should be the basis for a state formulary for nurse practitioners. Specific medications that the nurse practitioner may prescribe will be identified in the written protocol and limited by the nurse practitioner's practice specialty. Medications may be further limited in the written protocol if desired by the supervising physician and nurse practitioner.

The subcommittee also recommended that the Committee of the Joint Boards of Nursing and Medicine continue to regulate nurse practitioners. In addition, these Boards should consult with the Board of Pharmacy. The Committee of the Joint Boards of Nursing and Medicine should determine and assure that nurse practitioners granted prescriptive authority meet specific educational requirements in pharmacology and satisfy a continuing educational or continuing competency requirement.

Finally, limited prescriptive authority for nurse practitioners should have statewide application. (Note: Dissension occurred within the subcommittee on this recommendation. Six members felt that limited prescriptive authority should be restricted to nurse practitioners working in federal, state or local government funded agencies or legitimate non-profit or charitable organizations.)

Nurse practitioners have been found to deliver safe and quality primary care services and are one part of an effective primary care delivery system. The partnership between a nurse practitioner and supervising physician is a collaborative effort to enhance care and the delivery of that care. Further, authorizing limited prescriptive authority to nurse practitioners serves as a means to expand access to care.

Following the report of the Subcommittee on Limited Prescriptive Authority, the Commission formulated and agreed to the following recommendation.

RECOMMENDATION

24. *That statewide limited prescriptive authority for certain licensed nurse practitioners in Virginia be authorized according to the conditions established by the Subcommittee on Limited Prescriptive Authority.*

EXPERIMENTAL MEDICAL PROCEDURES

In the 1990 Session, Delegate Gladys Keating introduced HJR 213 requesting the Commission on Health Care for All Virginians to study an objective means of determining whether new medical technologies and procedures are "experimental" and "investigative" and therefore not covered under medical insurance policies.

This issue has become of interest most specifically in relation to the procedure of Autologous Bone Marrow Transplantation (ABMT) now beginning to be used with high dose chemotherapy as a new therapy for metastatic breast cancer. Patients with advanced breast cancer denied coverage for ABMT with high dose chemotherapy have litigated, generally successfully, against their medical insurance carriers.

In *Pirozzi v. Blue Cross/Blue Shield of Virginia* (1990), Pamela Pirozzi, a thirty-five year old with advanced breast cancer, brought suit against Blue Cross Blue/Shield of Virginia for their refused reimbursement for treatment with high dose chemotherapy and ABMT. Blue Cross/Blue Shield deemed the procedure "investigative" and thus, not covered by Ms. Pirozzi's policy. The judge ruled in favor of Ms. Pirozzi, writing that although BC/BS had followed its policy in denying Ms. Pirozzi coverage, the policy had critical flaws. During the non-jury trial, Ms. Pirozzi's doctors stated she would die within the year if she did not receive high dose chemotherapy with ABMT. The judge made his ruling

> on the basis of its [the court] de novo review of the evidence that the plaintiff has borne her burden of proving that this treatment is not experimental and there is evidence that this treatment has proven medical value and that it is in accordance with generally accepted standards of medical practice. The court finds that based on the evidence of [two doctors] both of whom are Board certified oncologists, both of whom testified to that effect forcefully.

Blue Cross/Blue Shield's position in this case was not unique among medical insurance carriers. In fact, most insurance companies will not cover or reimburse for procedures that they deem experimental. Largely, carriers refuse such reimbursement because they maintain that sufficient data demonstrating the technology's efficacy do not exist; that the risks outweigh the benefits; or in some instances, that the new procedure is not an improvement over existing procedures. Carriers also express liability concerns about reimbursing for a procedure whose outcome is unknown or unproven. Furthermore, some insurers, particularly those financed by governments, such as Medicaid and Medicare, have begun to consider cost in their criteria for coverage.

HJR 213 actually addressed two separate processes: the assessment of a technology's status to determine if the technology is experimental; and the determination by insurers as to whether or not they will cover and reimburse for such procedures.

No uniform method for evaluating new technologies currently exists in the United States nor is there an accepted definition of "experimental" or "investigative." Because no standards exist, different groups, including physicians, researchers, insurers, consumers, national government and state government policy makers, and legal practitioners, have attempted to gain some control over the process.

Examples of various groups and the assessment methodologies they employ include: the American College of Physicians and Blue Cross/Blue Shield Association, both utilizing group expert opinions ascertained via scientific review and analysis; the American Medical Association, utilizing an expert opinion poll; the Office of Health Technology Assessment, utilizing professional opinion, ascertained via scientific review and analysis; and the Virginia Department of Medical Assistance Services and smaller insurers, utilizing individual opinion based on scientific review.

The issue of experimental technology engenders additional questions such as to what extent and at what cost should the insurance industry be funding health care costs. Should insurers be forced to cover and reimburse for experimental procedures, thus partially providing funding for research? And if so, what is the balance between the costs and benefits of that coverage for the individual policy holder? In addition, philosophical and ethical questions surround these issues, e.g., is an individual entitled to complete access to technology, regardless of cost or efficacy? Finally, what is the appropriate and most effective role of the State in addressing these issues of experimental medical procedures?

Furthermore, an accompanying issue of experimental medical technologies emerging from examination is that of a consumer's rights to full disclosure of coverage by his insurance carrier. The consumer of health care is often caught between his physician and his insurer in this issue. He expects his health insurance policy to cover his routine and necessary medical treatment costs and that the recommendations of his physician fall within that category of medically reasonable and necessary. In some instances, the consumer is being mislead by his insurer's lack of full disclosure or by physicians' lack of full disclosure. Conversely, mandating health insurance companies to provide more complete disclosure about procedures they will not cover might result in definitions or policies that have unintended consequences. Options to do this have not been thoroughly evaluated.

Another issue of concern is that the determination of "experimental" technologies and health insurance coverage policy are presently at the sole discretion of the insurer. Various consumer groups have begun to advocate for review of this process.

In evaluating possible proposals to address the issue of experimental medical technology, the Commission considered establishing a task force to further study this issue. The Commission also considered appointing a state panel to assess new technologies and/or recommend coverage policy. An additional consideration was recommending the establishment of a national entity to provide uniform standards of technology assessment and coverage policy.

The Commission recognized that experimental medical procedures are an intricate and often emotional issue with many interest groups involved. Possible solutions are only beginning to be formulated. Yet, many assessment mechanisms are currently in place. The State will only be able to devise a similar process to those that exist, but simply with different people engaged. The same organizational interests will be represented, and any bias or partiality will be replicated. In addition, establishment of state organizations would add 50 new assessment groups that will further complicate the issue and waste resources.

Moreover, a single process may not satisfy the needs of different insurers. Unlike large commercial insurers such as Blue Cross/Blue Shield, Medicaid and Medicare must consider cost as a criterion for coverage. Small insurers, to a lesser extent, must also consider cost. The government must consider Medicaid and the cost of its state employee insurance as well as the cost of medical insurance premiums to the public. The government is obligated to weigh any considerations in view of global health care costs.

The Commission has made demonstrated efforts to emphasize primary care and attempt to shift incentives and State resources to primary care rather than tertiary care. Mandating and/or paying for experimental procedures will encourage the expenditure of resources and money for tertiary care services and high technology research. Paying for experimental technology will greatly increase health care costs. Given limited financial resources, paying for expensive experimental procedures in lieu of funding preventive care may not be in the public's best interest.

RECOMMENDATIONS

25. *That the Commission recognizes the relative newness of the issue of experimental medical technologies and their inherent ethical and legal concerns. Further, the Commission recognizes that insurers have begun the process of initiating responses to several of the questions the issue raises. They have, through self-examination of their policies, coverage and their mechanisms for assessing technology, begun to reimburse for certain patients in a selected national clinical study. In addition, some insurers are adding lists of specific treatment services that are excluded from reimbursement in an attempt to provide complete disclosure. Consequently, further action appears premature at this time, and the Commission recommends no mandated action.*

26. *That the anticipated continuing developments in insurance coverage and policy concerning experimental medical technologies continue to be monitored by the Commission.*

LONG-TERM CARE

In its 1990 Interim Report, the Joint Subcommittee recognized that the financing and provision of long-term care for the elderly population is a major issue facing state and federal governments. Virginia's elderly population is projected to grow from 677,000 in 1990 to 743,000 in 1995 to 790,000 in 2000.

Based upon their examination of other states and other countries, the Joint Subcommittee concluded that the most fiscally and morally responsible approach to the issue of an aging population that is steadily increasing is to develop a comprehensive system of care which includes a broad range of both community and institutional services to meet individual needs. As a complement to this system, appropriate financial incentives must be established to encourage families to assist in the care of their disabled family members and to promote the use of community-based services when appropriate.

Although many long-term care services are available in most communities, the delivery of these services is often fragmented: various agencies provide various services and frequently use different eligibility requirements. Furthermore, though some localities appear to have enviable systems of coordinated care, some are significantly weaker. The client or his family is frequently engaged in learning about available services and requirements of multiple agencies without central guidance.

Hence, the Joint Subcommittee recommended that case management pilot programs be implemented as an initiative to assist families in their care of elderly disabled family members and to promote the full use of community-based services. Case management assists persons in identifying appropriate services and provides assurances that services are accessed. Additionally, case management assists in managing resources by ensuring that the least costly services appropriate to the client's needs are utilized. The pilot programs would serve further as a laboratory with which to develop a statewide system of case management.

Pilot programs were to include the following components in the Commission's proposal:

- All Virginians should be eligible for services;
- A sliding fee schedule should be required for those who can afford to pay;
- Case managers should act as brokers for all long-term care services to assess the client's needs, identify appropriate services, assist the client in receiving such services, and monitor current needs;
- Case managers should seek to match clients with the most cost-effective care appropriate to their needs;
- Case management services should be provided by local private or public agencies that meet statewide standards; one agency should oversee the delivery of case management services in each locality; and
- A common patient assessment instrument should be used throughout the Commonwealth.

The Joint Subcommittee recommended that $4.4 million be appropriated from the general fund for the implementation of six pilot case management programs. During the 1990 Session, the appropriation was reduced to $3.0 million; additional budget reductions in 1990 resulted in three pilot programs being funded for $2.0 million.

Howard M. Cullum, Secretary of Health and Human Resources and chairman of the Long-Term Council, offered the Council's proposals for implementation of pilot programs to the Commission at the October meeting. Secretary Cullum defined the targeted population as those individuals 60 years of age and over who are unable to maintain independent living and self-sufficiency and unable to define, locate, secure, or retain necessary services on ongoing basis.

Pilots must also offer to serve one or more additional populations. Those populations may be individuals 60 years of age and over, regardless of income with the possibility of a sliding fee scale; elderly individuals screened for nursing home or Medicaid funded community-based care or who are at substantial risk of institutional care; auxiliary grant recipients residing in homes for adults and adult family care homes; or elderly individuals dependent in three or more activities of daily living which result in substantive limitations in major life activities such as self-care and mobility.

In its deliberations on the Long-Term Council's proposals, the Commission concurred that while the council's decision to restrict eligibility for this program to persons at imminent risk of nursing home placement is fiscally responsible, that decision actually defeats the intent and purpose of the case management pilots. Although limiting comprehensive case management to the most at-risk population may be appropriate, functional assessment and care requirements should be done on all functionally impaired clients.

RECOMMENDATIONS

27. *That the Commission reaffirms its regard in the principles of case management which engendered the recommendation for pilot programs in its 1990 Interim Report to the Governor and General Assembly.*

28. *That a needs assessment be made on all clients with the more intensive case management services targeted to the more at-risk population. Furthermore, at least one pilot program should be modeled as closely as possible to the Peninsula Area Agency's case management program.*

29. *That the Chairman of the Commission appoint two Commission members to meet regularly with the Secretary of Health and Human Resources and the Long-Term Care Council to monitor the progress of this program.*

HOMES FOR ADULTS

In response to the directive of Item 545 of the 1990 Appropriations Act, the Joint Legislative Audit and Review Commission presented its findings on its study of the Commonwealth's homes for adults at the Commission's October meeting. Residents of homes for adults are those Virginia citizens who are mentally or physically disabled or elderly and in need of supervision and maintenance of care.

JLARC had initially studied the Commonwealth's homes for adults in 1979. Since then, various components of the homes for adults' system in Virginia have been further examined by JLARC, other state agencies, a legislative subcommittee, and a private consulting firm. None of the major recommendations offered by these entities, however, were enacted into legislation.

JLARC'S study methodology in 1990 encompassed a review of studies completed on the adult home system between 1979 and 1990; field visits to twenty of the twenty-nine homes visited by JLARC in 1979; field visits to twenty-four additional adult homes; structured interviews with, among others, administrators of thirty-three adult homes; selected local community services boards, local social services departments, and local area agencies on aging; and various state agencies. The adult home financial cost analysis was formulated by reviewing 332 adult homes' reported costs, comparing reporting costs to the maximum auxiliary grant rates, and calculating the median adult home cost.

JLARC's study findings included:

Measures are needed to ensure appropriate resident placements;
System changes are needed in the current regulatory framework as residents who have serious mental health or medical needs are not adequately protected;
The regulatory system should be redesigned to a three-tiered system of care, thus more appropriately meeting residents' needs and requirements for care;
The cost for implementing the tiered regulatory system is negligible;
Weaknesses exist in the present standards related to staffing requirements, medical care, facility design, and food services;
Enforcement activities are limited, i.e., training of licensing staff is not comprehensive, annual renewal inspections are not made on an unannounced basis, special diets and menus are not reviewed by a dietitian, and the oversight of regional licensing activities is weak;
The current auxiliary grants program is unable to link adult home rates to levels of services provided by adult homes; and
Deficiencies exist in the auxiliary grant rate setting process.

The Commission favored the development of a three-tiered system of licensure. However, implementation of the new licensure system should be linked to changes recommended for the auxiliary grant reimbursement system. Because of funding difficulties, the tiered system should not be implemented until funds become available. In the meantime, some changes affecting licensing could be implemented with little cost.

RECOMMENDATIONS

30. *That the Secretary of Health and Human Resources develop a plan to comprehensively revise the statutory and regulatory framework of the adult home system to incorporate standards for several levels of care. The Secretary is additionally directed to complete a study of the fiscal impact of this program; to develop incentives for homes for adults which do not currently accept public patients to do so in the future; and to report his findings to the Commission by October 1, 1991.*

31. *That the Secretary of Health and Human Resources pursue the development of a client needs assessment instrument and process for use in placing and monitoring auxiliary grant recipients in adult homes. The Department of Social Services, the Department of Health, and the Department of Mental Health, Mental Retardation and Substance Abuse Services should be involved in this development.*

32. *That the Secretary of Health and Human Resources develop a proposal for regulatory changes governing charges for services received by auxiliary grant recipients. Once regulatory guidelines are established, the Department of Social Services should evaluate the adequacy of the personal allowance.*

33. *That the Code of Virginia be amended to require that annual renewal inspections of homes for adults be made on an unannounced basis and that the use of intermediate sanctions by the Commissioner of Social Services be authorized.*

34. *That licensing authority for homes for adults remain with the Department of Social Services.*

35. *That the Department of Social Services establish an effective auxiliary grant rate setting process by developing guidelines for certain cost items; establishing clear policies, procedures, and standards for the cost reporting process; adjusting the cost reporting period and revising the cost report forms; conducting financial audits of adult home reported costs; providing an adequate interim adult home rate; and consolidating agency rate setting functions in one division.*

36. *That the Commissioner of Social Services ensure that fees assessed adult home licensees are utilized to provide training for adult home staff as intended by the General Assembly. Such enforcement should be enhanced by the Department of Social Services in training and overseeing regional licensing staff to promote consistency; employing a certified dietitian to supplement enforcement of nutrition and food services; and using supplemental Security Income data to assist in obtaining search warrants for illegally operating homes.*

37. *That the State Board of Social Services promulgate additional standards regarding qualification and training of adult home administrators and staff; staffing guidelines; medical procedures performed in adult homes; medication management; and facility design and equipment. Standards regarding medical care should be developed in consultation with the State Board of Health. Further, the State Board of Social Services should modify existing standards to specify adult home staff be at least 18 years of age; to require that physicians' orders be followed; and to clarify food service requirements.*

STANDARD DEFINITION OF CHARITY CARE

In the 1990 Session, Senator Clarence A. Holland introduced Senate Bill 466 to raise the income criteria under the Virginia Indigent Health Care Trust Fund from 100 percent to 130 percent of the federal nonfarm poverty level.

As cited earlier within this text, the Trust Fund was created during the 1989 session as a partnership between the Commonwealth and the hospital industry established to equalize the burden of charity care costs among are private acute care hospitals within Virginia. Charity care was defined as care provided for persons whose gross family income is equal or less than 100 percent of poverty. At the time, the definition was established to conform to the definition of charity care used by the Virginia Health Services Cost Review Council.

While the Trust Fund legislation was being debated, representatives of Northern Virginia hospitals requested a Northern Virginia differential for charity care. While members of the Joint Subcommittee recognized this as a legitimate issue of the Commonwealth, the Joint Subcommittee felt the issue required further study before recommending any changes. In consideration of the higher cost of living in that area, the following language was included in Chapter 668 of the 1989 Acts of Assembly:

> The Board of Medical Assistance, with the assistance of the Indigent Health Care Advisory Panel, shall consider the feasibility of adjusting the definition of hospital care for this program to account for variances in the cost of living in various regions of the state. The Board of Medical Assistance Services shall submit recommendations on this issue by November 1, 1989, to the Governor, the Chairmen of House Appropriations and Senate Finance Committees, and the Chairman of the Joint Subcommittee Studying Health Care for All Virginians, created pursuant to House Joint Resolution 399 and Senate Joint Resolution 214 of 1989.

On November 1, 1989, the Board of Medical Assistance Services presented its report recommending that the income criteria used to define charity care be raised from 100 percent to 200 percent of the federal poverty guidelines across the State. The concept of a regional differential was not endorsed. (Note: Hospital representatives on the Technical Advisory Panel were not inclined toward a regional differential; the Virginia Hospital Association lobbied for this definition.)

While changing the definition of charity care will not have a direct impact on the state general fund, as the Trust Fund formula is limited by the appropriation level, that definition should relate to the State's "moral obligation" to subsidize health care for the poor. Elevating the income criteria for charity care from 100 percent to 200 percent of the poverty level expands the population covered under this program while simultaneously further limiting the ability of the state to reimburse for this care. (While the original formula for the Trust Fund assumed reimbursement at 60 percent, adding more care may reduce this percentage.)

Several programs currently apply a Northern Virginia differential, the most appropriate comparison being the State/Local Hospitalization Program. Until July 1, 1989, local governments could establish their own income criteria. When the Joint Subcommittee standardized the income criteria two years ago, localities who had income criteria higher than 100 percent were able to maintain the same standard. Arlington, Fairfax, and Alexandria received exemptions (150-200 percent).

A related issue emerged at the Commission's meeting in October 1990 when administrators of the Medical College of Hampton Roads raised concerns over the lack of a uniform definition of charity care. MCHR stated that since the two state teaching hospitals are authorized to include a portion of care provided to persons between 100 percent and 200 percent of poverty (sliding scale basis) and the cost of care not reimbursed by Medicaid and the State/Local Hospitalization Program, the Commission was using an inequitable formula and has requested the Commission to adopt this broader definition of charity care for all hospitals.

But the definition of charity care under the Indigent Care Trust Fund is consistent with the definition utilized for the Health Care Cost Review Council's report. All hospitals including the Medical College of Virginia and University of Virginia Medical Center submit data to the Council on standard forms.

However, the formula for MCV and UVA's general fund appropriation for indigent care allows these two hospitals to not only count care for persons at or below 100 percent of federal poverty guidelines, but also allows the two state teaching hospitals to count the hospital's share of care provided on a sliding scale basis for persons with income between 100 percent and 200 percent of the federal poverty guidelines and some unreimbursed care for Medicaid patients, i.e., days beyond the twenty-one day limit for Medicaid.

Concerns of the Medical College of Hampton Roads are far broader than the scope of the Trust Fund's eligibility criteria. MCHR believes that all hospitals should use the exact definition in the reporting of charity care data. While MCHR raises a very legitimate issue regarding the validity of the 1987 data compiled by the Joint Subcommittee two years ago, since that time the Virginia Health Services Cost Review Council has adopted and enforced uniform definition of charity care (100 percent of federal poverty guidelines).

But, MCHR's request to conform private acute care hospitals' definition of charity care to the two state teaching hospitals' formula for indigent care appropriations is a request with far greater policy implications. This raises the question as to whether the State should have the flexibility to set guidelines for its two state-operated facilities apart from guidelines for the broader health care community.

RECOMMENDATIONS

38. *That the Commission recognizes that the Virginia Health Services Cost Review Council has a uniform definition of charity care which is utilized by hospitals, including the Medical College of Virginia and the University of Virginia Medical Center, when submitting data to the Council.*

39. *That the Commission further recognizes that the 1990 data of the Virginia Health Services Cost Review Council indicate that the Medical College of Virginia and University of Virginia Medical Center provide 60 percent of the state's total charity care for those persons under 100 percent of poverty.*

40. *That no changes be effected in the formula for the Virginia Indigent Health Care Trust Fund at this time.*

MEDICAID

Federal law mandated Medical Assistance Services (Medicaid) in 1965. Originally intended to be a medical care program for poor families and children who met traditional welfare-related definitions, the program has evolved today to include in its service population the elderly and the disabled as well as becoming the major source of health care funding for the poor. Accordingly, as the population Medicaid serves has grown, so have its expenditures.

Funding for care of Medicaid clients is shared equally by the federal government and Virginia government on a 50/50 basis. As Virginia's per capita income has risen relative to the rest of the nation, the federal matching share has declined from 57 percent to 50 percent during the past decade. In Virginia, Medicaid costs now exceed $1.0 billion annually.

As stated in its 1990 Interim Report, the Commission is cognizant of the impact of continuing federal mandates that expand the number of persons eligible for health care paid by the Medicaid program. Clearly, such mandates will contribute to improved access to care for low-income, uninsured persons; but the Commonwealth's costs will increase significantly.

The Congressional Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandated additional coverage of lower-income families and children. Effective April 1990, pregnant women and children up to age six, with family incomes up to 133 percent of the federal poverty level, became eligible for Medicaid. This mandate is projected to possibly impact 74,000 people at a cost of $65 million to the Commonwealth.

Provisions in the Catastrophic Coverage Act of 1988 mandate Medicaid coverage for additional elderly and disabled persons as the definition of "low-income" expands. Eligibility will expand from 85 percent of the federal poverty level as of January 1, 1989, to 100 percent of poverty by January 1, 1992.

Virginia's total Medicaid budget for 1990-92 is $2.8 billion, representating federal and state funds. Costs of Medicaid in this biennium are expected to be more than 40 percent greater than the costs in the 1988-90 biennium. Medicaid now represents about 12 percent of the general fund's budget with an estimated $1.4 billion paid out by Virginia. Virginia hospitals expect to receive $310 million in state money over the biennium in Medicaid reimbursements for inpatient services. Approximately 330,0000 people in Virginia are currently served by Medicaid; and the Department of Medical Assistance Services estimates that by 1992, 500,000 Virginians will be Medicaid clients.

While 330,000 Virginians are currently eligible for Medicaid, an additional 300,000 are in poverty with no health insurance. The number of Virginians eligible for Medicaid has increased by only 10 percent in the last decade, but Medicaid expenditures in Virginia have tripled.

New federal mandates are likely to continue to expand eligibility for the elderly, the disabled, and poor. Though federal mandates establish the core services of the Medicaid program, states can partially shape the benefits and costs through policy adjustments in reimbursement rates for service providers; services offered to recipients; utilization review to ensure appropriate care; and eligibility for groups of persons, and to some extent, how much recipients pay for their own care.

Furthermore, the state teaching hospitals provide a significant amount of care to low-income persons and receive state support for this care through Medicaid and direct general fund appropriations.

RECOMMENDATION

41. That the Joint Legislative Audit and Review Commission conduct a comprehensive study of the Commonwealth's Medicaid program and the indigent care appropriations to the state teaching hospitals.

PATIENT LEVEL DATA BASE

Total health care expenditures continue to grow at an increasing rate, and the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Resources estimates that the expenditures will comprise 15 percent of the Gross National Product by the year 2000. HCFA also estimates that, absent fundamental change, employers will have to absorb a 529 percent increase from 1980 to 2000 for employer-based health coverage. The Commonwealth, as a payor, is expected to spend over $3 billion in the next biennium on health care services through the Department of Medical Assistance Services, the Department of Health in Community Health Services and State Health Services, and State employee medical benefits plan. Policy makers are increasingly concerned that health care services be made available to all citizens both now and in the future. In order to manage health care expenditures, increase system efficiency and effectively plan for the future, health care providers, purchasers, and users agree that reliable and accessible data are needed to make prudent purchasing and policy decisions.

Yet, the need to contain these costs must be simultaneously combined with efforts to improve the quality of health care and expanding access to necessary care. Many states have undertaken initiatives to deal with these issues; and thirty-five states, including the Commonwealth, have created health data organizations to collect and disseminate information regarding health care costs. Thirty-two states have established statewide patient level data bases to assist in the review and comparison of costs, utilization, quality, and effectiveness of health services. The objective of a patient level data base is to improve the quality of care by providing payors and consumers, including employers and governments, with information needed to make intelligent buying decisions; evaluate medical technologies and services; and establish guidelines to improve treatment and limit unnecessary procedures. Many health care providers already utilize data from patient level data bases to review internal operations, pinpoint inefficiencies, and plan future services; and other providers would benefit from such information in the future. Information from a patient level data base would provide information regarding access to care issues and provide for effective planning for future needs.

The Virginia Health Services Cost Review Council is the state-level health data organization created by legislation to collect and disseminate information concerning health care costs, and the Virginia Health Planning Board has the statutory responsibility to supervise the development of a health data system in order to provide necessary information to support health policy recommendations.

RECOMMENDATIONS

42. *That the Virginia Health Services Cost Review Council, in cooperation with the Virginia Health Planning Board, study all aspects of the possible establishment of a patient level data base in the Commonwealth.*

43. *That the Council and the Board prepare a grant application to the Robert Wood Johnson Foundation for its program that encourages the development of comprehensive health data collection at the state level.*

PREFERRED PROVIDER ORGANIZATIONS

A preferred provider organization (PPO) is a type of managed health care delivery system by which health care providers contract with an insurer to provide health care services to a

defined group of patients at a lower charge based on a negotiated fee schedule. Generally, these patients have an economic incentive to use the PPO, such as lower or no co-payments or deductible. Because of this, the PPO maintains a steady flow of patients which enables it to offer savings to the insurer as a result of the discounted fee schedule.

The statutory authority which establishes the PPO is found in Virginia Code §§ 38.2-3407 and 38.2-4209. Each statute allows the insurer to offer preferred provider policies or contracts that "limit the numbers and types of providers of health care services eligible for payment as preferred providers." However, confusion has arisen over the insurer's ability to restrict the PPO network due to the following language:

> No hospital, physician or type of provider listed in [the mandated provider statutes] willing to meet the terms and conditions offered to it or him shall be excluded. §§38.2-3407 B. and 38.2-4209 C.

This wording can and has been read to mean that insurers must open the PPO to all providers. Such an interpretation would be more understandable if the statutes imposed a duty on the insurer to offer the PPO terms to all providers. They do not. This, however, does not mean that the insurer can discriminate among providers. Both statutes specifically state that "terms and conditions shall not discriminate unreasonably against or among such health care providers." §§ 38.2-3407 B. and 38.2-4209 C. For a PPO to work effectively, an insurer must distinguish or discriminate in selecting providers. The statutes allow this, provided such discrimination is not unreasonable.

Furthermore, the interpretation above seems to conflict with the provision that a PPO may "limit the number and types of providers of health care services ..." A more neutral reading would allow insurers to reasonably restrict the PPO membership provided there is no unreasonable discrimination among providers.

RECOMMENDATION

44. *That the Commonwealth statutes on preferred provider organizations be studied by the Commission to determine the intent of the General Assembly.*

CONCLUSION

The recommendations of the Commission on Health Care for All Virginians contained within this Interim Report propose means to enlarge access and availability of health care; to contain the Commonwealth's costs in its delivery of health care; and to ensure equity of health care provision.

Numerous health care issues remain to be addressed by the Commission and the Commonwealth. The state's role as provider, regulator, and consumer of health care must continue to be defined. The Commonwealth, like all states, does not have an unlimited supply of dollars to fund health care. Public policy must be clearly established and not allowed to merely develop unfocused. Decisions on health care policy are inevitably difficult--but must be forthcoming. Unanswered issues will only effect an irresolute direction for the Commonwealth that is neither morally or fiscally responsible for the public good.

The Commission is challenged by the issues to be examined in 1991. Cost containment, insurance access, worksite health promotion, reimbursement methodologies, and primary care availability are some of the Commission's several concerns to be included in their deliberations.

The Commission on Health Care for All Virginians reaffirms its goal--to ensure that the Commonwealth as provider and regulator adopts the most cost-effective and most efficacious means of delivery of its health care services so that the greatest number of Virginians may receive quality health care--and recognizes that the mechanism to effect that goal lies in a public/private partnership. Valid solutions can be devised; realistic innovations, implemented; and necessary obligations, balanced, if those individuals who affect the provision and delivery of health care in the Commonwealth are fully engaged in seeking resolutions.

Respectfully Submitted,

Senator Stanley C. Walker, Chairman
Delegate Ford C. Quillen, Vice Chairman
Senator Dudley J. Emick, Jr.
Senator Clarence A. Holland
Senator Edward M. Holland
Senator Elliot S. Schewel
Delegate Robert B. Ball, Sr.
Delegate J. Samuel Glasscock
Delegate George H. Heilig, Jr.
Delegate Mary A. Marshall
Delegate S. Wallace Stieffen
The Honorable Howard M. Cullum
The Honorable Paul W. Timmreck
Eleanor F. Bradshaw
Stuart W. Connock
Richardson Grinnan, M.D.
Samuel B. Hunter, M.D.
Robert G. Jackson II
Eva S. Teig
Charles B. Walker

Appendices

APPENDIX A

Summary of 1991 Legislation, As Adopted

Bill Number	Purpose of Bill
SB 606/HB 1402	Authorizes limited prescriptive authority for certain licensed nurse practitioners.
SB 608	Requires the State Board of Social Services to promulgate specific standards for homes for adults.
HB 1331	Revises requirements for the Virginia Medical Care Facilities Certificate of Public Need Program.
SJR 178	Requests the Virginia Health Services Cost Review Council and the Virginia Health Planning Board to study the possible establishment of a patient level data base.
SJR 179	Requests each district health director to assess the district's primary care needs and develop a plan to meet those needs.
SJR 180	Requests the Joint Legislative Audit and Review Commission to make a comprehensive study of the Virginia Medicaid Program and indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.
SJR 181	Requests the Bureau of Insurance to develop a small business risk-sharing pool with insurance reforms that improve access and moderate rate increases.

An Act to amend and reenact §§ 54.1-3303, 54.1-3401 and 54.1-3408 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 54.1-2957.01, relating to prescriptive authority for licensed nurse practitioners.

[S 606]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-3303, 54.1-3401 and 54.1-3408 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 54.1-2957.01 as follows:

§ 54.1-2957.01. Prescription of certain controlled substances and devices by licensed nurse practitioners.—A. A licensed nurse practitioner, other than a certified registered nurse anesthetist, shall have the authority to prescribe Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.) of this title pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.) upon the provision to the Board of Medicine and the Board of Nursing of such evidence as they may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written agreement with a licensed physician which provides for the direction and supervision by such physician of the prescriptive practices of the nurse practitioner.

B. It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the written agreement between the licensed nurse practitioner and the licensed physician.

C. The Board of Nursing and the Board of Medicine, in consultation with the Board of Pharmacy, shall promulgate such regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients.

The Board of Medicine and the Board of Nursing shall be assisted in this process by an advisory committee composed of two representatives of the Board of Nursing and one nurse practitioner appointed by the Board of Nursing, and four physicians, three of whom shall be members of the Board of Medicine appointed by the Board of Medicine. The fourth physician member shall be jointly appointed by the Boards of Medicine and Nursing. Regulations promulgated pursuant to this section shall include, at a minimum, (i) the formulary of the specific Schedule VI drugs and devices that nurse practitioners are eligible to prescribe pursuant to this section to the extent, and in the manner, authorized in a written protocol between the nurse practitioner and the supervising physician, and (ii) requirements for periodic site visits by physicians who supervise and direct nurse practitioners who provide services at a location other than where the physician regularly practices.

D. This section shall not limit the functions and procedures of certified registered nurse anesthetists or of any nurse practitioners which are otherwise authorized by law or regulation.

E. The following restrictions shall apply to any nurse practitioner authorized to prescribe drugs and devices pursuant to this section:

1. The nurse practitioner shall disclose to his patients the name, address and telephone number of the supervising physician, and that he is a licensed nurse practitioner.

2. Physicians, other than physicians employed by, or under contract with, local health departments, federally funded comprehensive primary care clinics, or nonprofit health care clinics or programs to provide supervisory services, shall not supervise and direct at any one time more than two nurse practitioners. In the case of nurse practitioners, other than certified nurse midwives, the supervising physician shall regularly practice in any location in which the nurse practitioner exercises prescriptive authority pursuant to this section. A separate office for the nurse practitioner shall not be established. In the case of certified nurse midwives, the supervising physician either shall regularly practice in the location in which the certified nurse midwife practices, or in the event that the certified nurse midwife has established a separate office, the supervising physician shall be required to make periodic site visits as required by regulations promulgated pursuant to this section.

3. Physicians employed by, or under contract with, local health departments, federally funded comprehensive primary care clinics, or nonprofit health care clinics or programs to provide supervisory services, shall not supervise and direct at any one time more than

four nurse practitioners who provide services on behalf of such entities. Such physicians either shall regularly practice in such settings or shall make periodic site visits to such settings as required by regulations promulgated pursuant to this section.

F. This section shall not prohibit a licensed nurse practitioner from administering Schedule VI controlled substances in compliance with the definition of "administer" in § 54.1-3401. However, this section shall not otherwise authorize the dispensing or the sale of Schedule VI controlled substances by licensed nurse practitioners unless pursuant to the lawful order of a physician.

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.—A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances. The prescription shall be issued for a medicinal or therapeutic purpose and may be issued only to persons or animals with whom the practitioner has a bona fide physician-patient relationship.

For purposes of this section, a bona fide physician-patient-pharmacist relationship is one in which a physician prescribes, and a pharmacist dispenses, controlled substances in good faith to his patient for a medicinal or therapeutic purpose within the course of his professional practice. Any practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than medicinally or for therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

B. No prescription shall be filled which does not result from a bona fide physician-patient-pharmacist relationship. A prescription not issued in the usual course of treatment or for authorized research is not a valid prescription.

In order to determine whether a prescription which appears questionable to the pharmacist results from a bona fide physician-patient-pharmacist relationship, the pharmacist shall contact the prescribing physician or his agent and verify the identity of the patient and name and quantity of the drug prescribed. The person knowingly filling an invalid prescription shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the sale, distribution or possession of controlled substances.

C. A pharmacist may dispense a controlled substance pursuant to a prescription of an out-of-state practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine authorized to issue such prescription if the prescription complies with the requirements of this chapter and Chapter 34 (§ 54.1-3400 et seq.) of this title, known as the "Drug Control Act."

D. A licensed nurse practitioner who is authorized to prescribe controlled substances pursuant to § 54.1-2957.01 may issue prescriptions for Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.) of this title in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

§ 54.1-3401. Definitions.—As used in this chapter, unless the context requires a different meaning:

"Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the body of a patient or research subject by (i) a practitioner or by his authorized agent and under his direction, or (ii) the patient or research subject at the direction and in the presence of the practitioner.

"Advertisement" means all representations disseminated in any manner or by any means, other than by labeling, for the purpose of inducing, or which are likely to induce, directly or indirectly, the purchase of drugs or devices.

"Animal" means any nonhuman animate being endowed with the power of voluntary action.

"Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser. It does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman.

"Board" means the Board of Pharmacy.

"Compound" means the taking of two or more ingredients and fabricating them into a single preparation, usually referred to as a dosage form.

"Controlled substance" means a drug, substance or immediate precursor in Schedules I through VI of this chapter. The term shall not include distilled spirits, wine, malt beverages, or tobacco as those terms are defined or used in Title 3.1 (§ 3.1-1 et seq.) or Title 4 (§ 4-1 et seq.).

"Cosmetic" means all articles intended to be rubbed, poured, sprinkled or sprayed on, introduced into or otherwise applied to the human body for cleansing, beautifying, promoting attractiveness or altering the appearance, and articles intended for use as a component of any such articles except soap.

"DEA" means the Drug Enforcement Administration, United States Department of Justice, or its successor agency.

"Deliver" or "delivery" means the actual, constructive, or attempted transfer of any item regulated by this chapter, whether or not there exists an agency relationship.

"Device" means instruments, apparatus, and contrivances, including their components, parts and accessories, intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals or to affect the structure or any function of the body of man or animals.

"Dispense" means to deliver a drug to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling or compounding necessary to prepare the substance for that delivery.

"Dispenser" means a practitioner who dispenses.

"Distribute" means to deliver other than by administering or dispensing a controlled substance.

"Distributor" means a person who distributes.

"Drug" means (i) articles or substances recognized in the official United States Pharmacopoeia National Formulary or official Homeopathic Pharmacopoeia of the United States, or any supplement to any of them; (ii) articles or substances intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or animals; (iii) articles or substances, other than food, intended to affect the structure or any function of the body of man or animals; or (iv) articles or substances intended for use as a component of any article specified in clause (i), (ii) or (iii). "Drug" does not include devices or their components, parts or accessories.

"Hashish oil" means any oily extract containing one or more cannabinoids, but shall not include any such extract with a tetrahydrocannabinol content of less than twelve percent by weight.

"Immediate precursor" means a substance which the Board of Pharmacy has found to be and by regulation designates as being the principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance, the control of which is necessary to prevent, curtail, or limit manufacture.

"Label" means a display of written, printed or graphic matter upon the immediate container of any article. A requirement made by or under authority of this chapter that any word, statement or other information appear on the label shall not be considered to be complied with unless such word, statement or other information also appears on the outside container or wrapper, if any, of the retail package of such article, or is easily legible through the outside container or wrapper.

"Labeling" means all labels and other written, printed or graphic matter on an article or any of its containers or wrappers, or accompanying such article.

"Manufacture" means the production, preparation, propagation, compounding, conversion or processing of any item regulated by this chapter, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container. This term does not include the preparing, compounding, packaging or labeling of a controlled substance by a practitioner as an incident to his administering or dispensing of a controlled substance or marijuana in the course of his professional practice, or by a practitioner, or by his authorized agent under his supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale.

"Manufacturer" means every person who manufactures.

"Marijuana" means any part of a plant of the genus Cannabis whether growing or not, its seeds or resin; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds, or its resin. Marijuana shall not include any oily extract containing one or more cannabinoids if such extract contains less than twelve percent of tetrahydrocannabinol by weight, or the mature stalks of such plant, fiber produced from such stalk, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture or preparation of such mature stalks, fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination.

"Narcotic drug" means any of the following, whether produced directly or indirectly by

extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis: (i) opium, opiates, and any salt, compound, derivative, or preparation of opium or opiates; (ii) any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (i), but not including the isoquinoline alkaloids of opium; (iii) opium poppy and poppy straw; (iv) coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extraction of coca leaves which do not contain cocaine or ecgonine.

"New drug" means: (i) any drug, except a new animal drug or an animal feed bearing or containing a new animal drug, the composition of which is such that such drug is not generally recognized, among experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, as safe and effective for use under the conditions prescribed, recommended, or suggested in the labeling, except that such a drug not so recognized shall not be deemed to be a "new drug" if at any time prior to the enactment of this chapter it was subject to the Food and Drugs Act of June 30, 1906, as amended, and if at such time its labeling contained the same representations concerning the conditions of its use; or (ii) any drug, except a new animal drug or an animal feed bearing or containing a new animal drug, the composition of which is such that such drug, as a result of investigations to determine its safety and effectiveness for use under such conditions, has become so recognized, but which has not, otherwise than in such investigations, been used to a material extent or for a material time under such conditions.

"Official compendium" means the official United States Pharmacopoeia National Formulary, official Homeopathic Pharmacopoeia of the United States, or any supplement to any of them.

"Official written order" means an order written on a form provided for that purpose by the United States Drug Enforcement Administration, under any laws of the United States making provision therefor, if such order forms are authorized and required by federal law, and if no such order form is provided then on an official form provided for that purpose by the Board of Pharmacy.

"Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled under Article 4 (§ 54.1-3437 et seq.) of this chapter, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms.

"Opium poppy" means the plant of the species Papaver somniferum L., except the seeds thereof.

"Original package" means the unbroken container or wrapping in which any drug or medicine is enclosed together with label and labeling, put up by or for the manufacturer, wholesaler, or distributor for use in the delivery or display of such article.

"Person" means both the plural and singular, as the case demands, and includes individual, partnership, corporation, association, governmental agency, trust, or other institution or entity.

"Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

"Practitioner" means a physician, dentist, *licensed nurse practitioner pursuant to § 54.1-2957.01,* veterinarian, scientific investigator, or other person licensed, registered or otherwise permitted to distribute, dispense, prescribe and administer, or conduct research with respect to, a controlled substance in the course of professional practice or research in this Commonwealth.

"Prescription" means an order for drugs or medical supplies, written or signed or transmitted by word of mouth, telephone, telegraph or other means of communication to a pharmacist by a duly licensed physician, dentist, veterinarian or other practitioner, authorized by law to prescribe and administer such drugs or medical supplies.

"Production" or "produce" includes the manufacture, planting, cultivation, growing or harvesting of a controlled substance or marijuana.

"Proprietary medicine" means a completely compounded nonprescription drug in its unbroken, original package which does not contain any controlled substance or marijuana as defined in this chapter and is not in itself poisonous, and which is sold, offered, promoted or advertised directly to the general public by or under the authority of the manufacturer or primary distributor, under a trademark, trade name or other trade symbol privately owned, and the labeling of which conforms to the requirements of this chapter

and applicable federal law. However, this definition shall not include a drug which is only advertised or promoted professionally to licensed practitioners, a narcotic or drug containing a narcotic, a drug which may be dispensed only upon prescription or the label of which bears substantially the statement "Warning - may be habit-forming," or a drug intended for injection.

"Sale" includes barter, exchange, or gift, or offer therefor, and each such transaction made by any person, whether as individual, proprietor, agent, servant or employee.

"Wholesaler" or "distributor" means every person, except a manufacturer, engaged in the business of distributing, supplying, selling or otherwise disposing of drugs, cosmetics or devices to any person who is not the ultimate user or consumer. No person shall be subject to any state or local tax as a wholesale merchant by reason of this definition.

The words "drugs" and "devices" as used in Chapter 33 (§ 54.1-3300 et seq.) of this title and in this chapter shall not include surgical or dental instruments, physical therapy equipment, X-ray apparatus or glasses or lenses for the eyes.

The terms "pharmacist," "pharmacy" and "practice of pharmacy" as used in this chapter shall be defined as provided in Chapter 33 of this title unless the context requires a different meaning.

§ 54.1-3408. Professional use by practitioners.—A. A practitioner of medicine, osteopathy, podiatry, or dentistry *or a licensed nurse practitioner pursuant to § 54.1-2957.01* shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice. The practitioner may prescribe, on a written prescription or on oral prescription as authorized by this chapter, and administer drugs and devices, or he may cause them to be administered by a nurse or intern under his direction and supervision, or a practitioner may prescribe and cause drugs and devices to be administered to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the State Mental Health, Mental Retardation and Substance Abuse Services Board by other persons who have been trained to properly administer drugs and who administer drugs only under the control and supervision of the practitioner or a pharmacist.

No written prescription order form shall include more than one prescription. This provision shall not apply, however, to the entry of any order on a patient's chart in any hospital in Virginia or to a prescription ordered through the pharmacy operated by the Department of Corrections, the central pharmacy of the Department of Health, or the central outpatient pharmacy operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Such a prescription shall be written, dated, and signed by the person prescribing on the day when issued, and shall bear the full name and address of the patient for whom the drug is prescribed, and the full name, address, and registry number under the federal laws of the person prescribing, if he is required by those laws to be so registered.

This section shall not prevent the administration of drugs by an agent authorized in writing by the physician to administer such drugs, in accordance with such physician's instructions pertaining to dosage, frequency, and manner of administration, when the drugs administered would be normally self-administered by (i) a resident of a facility licensed or certified by the State Mental Health, Mental Retardation and Substance Abuse Services Board when the authorized agent administering the drugs has satisfactorily completed a training program for this purpose approved by the Board of Nursing; (ii) a resident of any home for adults which is licensed by the Department of Social Services; or (iii) a resident of the Virginia Rehabilitation Center for the Blind when the authorized agent administering the drugs has satisfactorily completed a training program specifically designed to meet the needs of such residents and approved by the Board of Nursing.

No physician who authorizes the administration of medication for a resident of a home for adults under this section shall be civilly liable for the actions of the person administering the medication, but this provision shall not relieve such physician from liability for his own negligence.

This section shall not interfere with any practitioner issuing prescriptions in compliance with the provisions of this section to a Board agent for use pursuant to subsection G of § 18.2-258.1. Such prescriptions issued by such practitioner shall be deemed to be valid prescriptions. This section shall not prohibit a practitioner from using preprinted prescriptions for drugs classified in Schedule VI if all requirements concerning dates, signatures, and other information specified above are otherwise fulfilled.

B. The written prescription referred to in subsection A of this section shall be written with ink or individually typed and each prescription shall be manually signed by the practitioner. The prescription may be prepared by an agent for his signature. The

prescription shall contain the name, address, telephone number, and federal controlled substances registration number assigned to the prescriber. The prescriber's information shall be either preprinted upon the prescription blank, typewritten, rubber stamped, or printed by hand.

_____

President of the Senate

_____

Speaker of the House of Delegates

Approved:

_____

Governor

An Act to amend and reenact §§ 54.1-3408, 63.1-25.1, 63.1-174, 63.1-174.01, 63.1-174.1, 63.1-175, 63.1-177 and 63.1-180 of the Code of Virginia, to amend the Code of Virginia by adding sections numbered 63.1-178.1 and 63.1-179.1, and to repeal § 63.1-179, relating to the licensure of homes for adults.

[S 608]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-3408, 63.1-25.1, 63.1-174, 63.1-174.01, 63.1-174.1, 63.1-175, 63.1-177 and 63.1-180 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 63.1-178.1 and 63.1-179.1 as follows:

§ 54.1-3408. Professional use by practitioners.—A. A practitioner of medicine, osteopathy, podiatry, or dentistry shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice. The practitioner may prescribe, on a written prescription or on oral prescription as authorized by this chapter, and administer drugs and devices, or he may cause them to be administered by a nurse or intern under his direction and supervision, or a practitioner may prescribe and cause drugs and devices to be administered to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the State Mental Health, Mental Retardation and Substance Abuse Services Board by other persons who have been trained to properly administer drugs and who administer drugs only under the control and supervision of the practitioner or a pharmacist.

No written prescription order form shall include more than one prescription. This provision shall not apply, however, to the entry of any order on a patient's chart in any hospital in Virginia or to a prescription ordered through the pharmacy operated by the Department of Corrections, the central pharmacy of the Department of Health, or the central outpatient pharmacy operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Such a prescription shall be written, dated, and signed by the person prescribing on the day when issued, and shall bear the full name and address of the patient for whom the drug is prescribed, and the full name, address, and registry number under the federal laws of the person prescribing, if he is required by those laws to be so registered.

This section shall not prevent the administration of drugs by an agent authorized in writing by the physician to administer such drugs, in accordance with such physician's instructions pertaining to dosage, frequency, and manner of administration, when the drugs administered would be normally self-administered by (i) a resident of a facility licensed or certified by the State Mental Health, Mental Retardation and Substance Abuse Services Board when the authorized agent administering the drugs has satisfactorily completed a training program for this purpose approved by the Board of Nursing; (ii) a resident of any home for adults which is licensed by the Department of Social Services *when the authorized agent administering the drugs has satisfactorily completed a training program for this purpose approved by the Board of Nursing, which program may be conducted by the physician who will authorize the administration of the drugs* ; or (iii) a resident of the Virginia Rehabilitation Center for the Blind when the authorized agent administering the drugs has satisfactorily completed a training program specifically designed to meet the needs of such residents and approved by the Board of Nursing.

No physician who authorizes the administration of medication for a resident of a home for adults under this section shall be civilly liable for the actions of the person administering the medication, but this provision shall not relieve such physician from liability for his own negligence.

This section shall not interfere with any practitioner issuing prescriptions in compliance with the provisions of this section to a Board agent for use pursuant to subsection G of § 18.2-258.1. Such prescriptions issued by such practitioner shall be deemed to be valid prescriptions. This section shall not prohibit a practitioner from using preprinted prescriptions for drugs classified in Schedule VI if all requirements concerning dates, signatures, and other information specified above are otherwise fulfilled.

B. The written prescription referred to in subsection A of this section shall be written with ink or individually typed and each prescription shall be manually signed by the

practitioner. The prescription may be prepared by an agent for his signature. The prescription shall contain the name, address, telephone number, and federal controlled substances registration number assigned to the prescriber. The prescriber's information shall be either preprinted upon the prescription blank, typewritten, rubber stamped, or printed by hand.

§ 63.1-25.1. Auxiliary grants program; repeal of provisions relating to old age assistance and aid to the permanently and totally disabled; administration of program.—A. ~~Notwithstanding any other provision of law,~~ The State Board of Social Services is authorized to prepare and implement, effective with repeal of Titles I, X, and XIV of the Social Security Act, a plan for a state and local funded auxiliary grants program to provide assistance to certain individuals ineligible for benefits under Title XVI of the Social Security Act and to certain other individuals for whom benefits provided under Title XVI of the Social Security Act are not sufficient to maintain the minimum standards of need established by the Board. The plan shall be in effect in all political subdivisions in the Commonwealth and shall be administered in conformity with rules and regulations of the Board.

Insofar as any provisions of this title relate to assistance and payments under old age assistance or aid to the permanently and totally disabled, they are repealed, effective January 1, 1974. Nothing herein is to be construed to affect any such section as it relates to aid to dependent children, general relief or services to persons eligible for assistance under Public Law 92-603 enacted by the ninety-second United States Congress.

B. Those individuals who receive an auxiliary grant, as provided for in subsection A of this section, who reside in licensed homes for adults or adult family care homes shall be entitled to a personal needs allowance when computing the amount of the auxiliary grant. The amount of such personal needs allowance shall be at least thirty dollars per month.

C. The Board shall promulgate regulations for the administration of the auxiliary grants program which shall include requirements for the Department of Social Services to use in establishing auxiliary grant rates for licensed homes for adults and adult family care homes. At a minimum these requirements shall address (i) the process for the homes to use in reporting their costs, including allowable costs and resident charges, the time period for reporting costs, forms to be used, financial reviews and audits of reported costs; (ii) the process to be used in calculating the auxiliary grant rates for the homes; and (iii) the services to be provided to the auxiliary grant recipient and paid for by the auxiliary grant and not charged to the recipient's personal needs allowance.

§ 63.1-174. Regulations for construction, maintenance, operation, and enforcement.— *A.* The State Board is directed to adopt reasonable regulations governing the construction, maintenance and operation of homes for adults in conformity with this article, in order to reasonably protect the health, safety and welfare of the persons cared for therein. Such regulations shall contain minimum standards and requirements by which the Commissioner is to be guided in his determination as to what structures and facilities comply with the provisions set forth in § 63.1-173.

The minimum requirements which shall be promulgated for all homes for adults shall include standards for staffing; staff qualifications and training; facility design and equipment; services to be provided to residents; administration of medicine; allowable medical conditions for which care can be provided; and medical procedures to be followed by staff, including provisions for physicians' services, restorative care, and specialized rehabilitative services.

Regulations for medical procedures in homes for adults shall be developed in consultation with the State Board of Health and promulgated by the State Board of Social Services. and compliance with these regulations shall be determined by Department of Health or Department of Social Services inspectors as provided by an interagency agreement between the Department of Social Services and the Department of Health.

B. The Board of Social Services shall promulgate regulations authorizing the Commissioner to initiate court proceedings against homes for adults. Such proceedings may be initiated severally or in conjunction with the administrative sanctions provided in § 63.1-179.1.

The Board shall promulgate guidelines for the Commissioner to use in determining when the imposition of administrative sanctions or initiation of court proceedings, or both, are appropriate in order to ensure prompt correction of violations involving noncompliance with state law or regulation as discovered through any inspection or investigation conducted by the Department of Social Services or the Department of Health.

§ 63.1-174.01. Application fees; regulations and schedules; use of fees; certain facilities exempt.—The State Board is authorized to establish regulations and schedules for fees to be

charged for processing applications for licenses to operate homes for adults and adult day care centers. Such schedules shall specify minimum and maximum fees and, where appropriate, gradations based on the capacity for residents or participants of the facility making application. ~~It is the intent of the General Assembly that~~ Such fees *shall* be used ~~to the extent possible~~ for the development and delivery of training for operators and staff of homes for adults and adult day care centers. *Such fees shall be expended for this purpose within two fiscal years following the fiscal year in which they are collected.* These fees shall not be applicable to facilities operated by federal entities.

§ 63.1-174.1. Admission and discharge of residents.—In determining whether to deny admission to a home for adults which is licensed to accept only ambulatory residents or to discharge from such a home a person who is nonambulatory and who objects to being denied admission or being discharged, the operator of the home shall consider the opinion of a physician as to the ability of the person to exit the home in an emergency. In enforcing regulations governing the kinds of residents accepted by a home for adults, the Department shall consider any medical opinions . *including those of the Department of Health inspectors authorized to inspect homes for adults as provided in § 63.1-174,* received by the operators of such homes as to the ability of residents to exit in an emergency and shall have the option of requiring additional medical evaluations, if deemed advisable.

The Department of Social Services shall establish the method of evaluation of residents in homes for adults, in consultation with the Department of Health, in order to determine when any of those residents are in need of the professional medical and nursing care provided in licensed nursing homes.

For purposes of this section, an "ambulatory resident" is one who is either (i) independently mobile, meaning he is physically and mentally capable of exiting the particular home from the area thereof used by the resident without assistance in an emergency and can ascend or descend stairs if present in any necessary exit path, or (ii) semimobile, meaning he is able to exit the home with assistance of a wheelchair, walker, cane, prosthetic device or verbal command. A nonambulatory resident is a person who by reason of physical or mental disability or condition is unable to vacate the home in case of an emergency without the assistance of another person.

Buildings licensed for *independently mobile* ambulatory residents, semimobile *ambulatory* residents or nonambulatory residents shall be classified by and meet the specifications for the proper Use Group as required by the Virginia Uniform Statewide Building Code.

§ 63.1-175. Licenses required; expiration and renewal; maximum number of residents; restrictions on nomenclature.— ~~(a)~~ *A.* Every person who constitutes, or who operates or maintains, a home for adults shall obtain an appropriate license from the Commissioner, which he shall have renewed annually. The Commissioner or his designated agents, upon request, shall consult with, advise, and assist any person interested in securing and maintaining any such license.

~~(b)~~ *B.* The licenses shall be issued on forms prescribed by the Commissioner. Any two or more licenses may be issued for concurrent operation of more than one home for adults. Each license and renewals thereof shall expire at the end of one year from the date of its issuance or renewal, unless sooner revoked or surrendered.

~~(c) [Repealed.]~~

~~(d)~~ *C.* Each license shall stipulate the maximum number of persons who may be cared for in the home for adults for which it is issued.

D. Any facility licensed exclusively as a home for adults shall not use in its title the words "convalescent," "health," "hospital," "nursing," "sanitorium," or "sanitarium," nor shall such words be used to describe the facility in brochures, advertising, or other marketing material. Nothing in this subsection shall prohibit the facility from describing services available in the facility.

§ 63.1-177. Inspections and interviews.—A. Applicants and licensees shall at all times afford the representatives of the Commissioner reasonable opportunity to inspect all of their facilities, books and records, and to interview their agents and employees and any person living in such facilities.

B. The Commissioner and his authorized agents shall have the right to inspect and investigate all homes for adults, interview their residents and have access to their records.

C. The Commissioner or his authorized agents shall make at least ~~one unannounced inspection~~ *two inspections* of each licensed facility each year *and in every instance the annual license renewal inspection made by the Commissioner or his authorized agents shall be unannounced. The Commissioner may authorize such other announced or*

unannounced inspections as he considers appropriate .

§ 63.1-178.1. Cooperation of Department with other departments.—The Department of Social Services shall assist and cooperate with other state departments in fulfilling their respective inspection responsibilities and in coordinating the regulations involving inspections. The State Board may promulgate regulations allowing the Department of Social Services to so assist and cooperate with other state departments.

§ 63.1-179.1. Enforcement.—In accordance with applicable regulations of the State Board of Social Services, the Commissioner may impose such sanctions or take such actions as are appropriate for violation of any of the provisions of this article, § 54.1-3408, or any rule or regulation promulgated under any provision of this article which adversely impacts the health, safety or welfare of the person cared for therein, or for permitting, aiding, or abetting the commission of any illegal act in a home for adults. Such sanctions or actions may include (i) reducing the licensed capacity of any home for adults, (ii) restricting or prohibiting new admissions to any home for adults, (iii) petitioning the court to impose a civil penalty against any home for adults or to appoint a receiver for the home for adults, and (iv) revoking or denying renewal of the license for the home for adults.

§ 63.1-180. Appeal from refusal, denial of renewal or revocation of license and other sanctions.— ~~(a)~~ *A.* Whenever the Commissioner refuses to issue or to renew a license for a home for adults or whenever the Commissioner revokes a license of a home for adults, *or imposes a sanction as provided in § 63.1-179.1,* the provisions of the Administrative Process Act (§ 9-6.14:1 et seq.) shall apply *, except that all appeals from notice of imposition of administrative sanctions, pursuant to § 63.1-179.1, shall be received in writing from the home for adults operator within fifteen days of the date of receipt of the notice* . Judicial review of a final review agency decision shall be in accordance with the provisions of the Administrative Process Act. No stay may be granted upon appeal to the Virginia Supreme Court.

~~(b)~~ *B.* In every appeal to a court of record, the Commissioner shall be named defendant.

~~(c)~~ *C.* An appeal, taken as provided in this section, shall operate to stay any criminal prosecution for operation without a license.

~~(d)~~ *D.* When issuance or renewal of a license has been refused by the Commissioner, the applicant shall not thereafter for a period of ~~six months~~ *one year* apply again for such license unless the Commissioner in his sole discretion believes that there has been such a change in the conditions on account of which he refused the prior application as to justify considering the new application. When an appeal is taken by the applicant pursuant to subsection ~~(a)~~ *A* above, the ~~six-month~~ *one-year* period shall be extended until a final decision has been rendered on appeal.

2. That § 63.1-179 of the Code of Virginia is repealed.

_____

President of the Senate

_____

Speaker of the House of Delegates

Approved:

_____

Governor

1991 SESSION

VIRGINIA ACTS OF ASSEMBLY -- CHAPTER

An Act to amend and reenact §§ 2.1-342, 32.1-102.1, 32.1-102.2, 32.1-102.3:2, 32.1-102.3:3, 32.1-102.3:4, 32.1-102.4, and 32.1-102.6 of the Code of Virginia, relating to medical facilities certificate of public need; penalties.

[H 1331]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-342, 32.1-102.1, 32.1-102.2, 32.1-102.3:2, 32.1-102.3:3, 32.1-102.3:4, 32.1-102.4, and 32.1-102.6 of the Code of Virginia are amended and reenacted as follows:

§ 2.1-342. Official records to be open to inspection; procedure for requesting records and responding to request; charges; exceptions to application of chapter.—A. Except as otherwise specifically provided by law, all official records shall be open to inspection and copying by any citizens of this Commonwealth during the regular office hours of the custodian of such records. Access to such records shall not be denied to citizens of this Commonwealth, representatives of newspapers and magazines with circulation in this Commonwealth, and representatives of radio and television stations broadcasting in or into this Commonwealth. The custodian of such records shall take all necessary precautions for their preservation and safekeeping. Any public body covered under the provisions of this chapter shall make an initial response to citizens requesting records open to inspection within five work days after the receipt of the request by the public body which is the custodian of the requested records. Such citizen request shall designate the requested records with reasonable specificity. A specific reference to this chapter by the requesting citizen in his request shall not be necessary to invoke the provisions of this chapter and the time limits for response by the public body. The response by the public body within such five work days shall be one of the following responses:

1. The requested records shall be provided to the requesting citizen.

2. If the public body determines that an exemption applies to all of the requested records, it may refuse to release such records and provide to the requesting citizen a written explanation as to why the records are not available with the explanation making specific reference to the applicable Code sections which make the requested records exempt.

3. If the public body determines that an exemption applies to a portion of the requested records, it may delete or excise that portion of the records to which an exemption applies, disclose the remainder of the requested records and provide to the requesting citizen a written explanation as to why these portions of the record are not available to the requesting citizen with the explanation making specific reference to the applicable Code sections which make that portion of the requested records exempt. Any reasonably segregatable portion of an official record shall be provided to any person requesting the record after the deletion of the exempt portion.

4. If the public body determines that it is practically impossible to provide the requested records or to determine whether they are available within the five-work-day period, the public body shall so inform the requesting citizen and shall have an additional seven work days in which to provide one of the three preceding responses.

Nothing in this section shall prohibit any public body from petitioning the appropriate court for additional time to respond to a request for records when the request is for an extraordinary volume of records and a response by the public body within the time required by this chapter will prevent the public body from meeting its operational responsibilities. Before proceeding with this petition, however, the public body shall make reasonable efforts to reach an agreement with the requester concerning the production of the records requested.

The public body may make reasonable charges for the copying, search time and computer time expended in the supplying of such records; however, such charges shall not exceed the actual cost to the public body in supplying such records, except that the public body may charge, on a pro rata per acre basis, for the cost of creating topographical maps developed by the public body, for such maps or portions thereof, which encompass a contiguous area greater than fifty acres. Such charges for the supplying of requested records shall be estimated in advance at the request of the citizen. The public body may require the advance payment of charges which are subject to advance determination.

In any case where a public body determines in advance that search and copying

charges for producing the requested documents are likely to exceed $200, the public body may, before continuing to process the request, require the citizen requesting the information to agree to payment of an amount not to exceed the advance determination by five percent. The period within which the public body must respond under this section shall be tolled for the amount of time that elapses between notice of the advance determination and the response of the citizen requesting the information.

Official records maintained by a public body on a computer or other electronic data processing system which are available to the public under the provisions of this chapter shall be made reasonably accessible to the public at reasonable cost.

Public bodies shall not be required to create or prepare a particular requested record if it does not already exist. Public bodies may, but shall not be required to, abstract or summarize information from official records or convert an official record available in one form into another form at the request of the citizen. The public body shall make reasonable efforts to reach an agreement with the requester concerning the production of the records requested.

Failure to make any response to a request for records shall be a violation of this chapter and deemed a denial of the request.

B. The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. Memoranda, correspondence, evidence and complaints related to criminal investigations; reports submitted to the state and local police, to investigators authorized pursuant to § 53.1-16 and to the campus police departments of public institutions of higher education as established by Chapter 17 (§ 23-232 et seq.) of Title 23 in confidence; portions of records of local government crime commissions that would identify individuals providing information about crimes or criminal activities under a promise of anonymity; and all records of persons imprisoned in penal institutions in this Commonwealth provided such records relate to the imprisonment. Information in the custody of law-enforcement officials relative to the identity of any individual other than a juvenile who is arrested and charged, and the status of the charge or arrest, shall not be excluded from the provisions of this chapter.

Criminal incident information relating to felony offenses shall not be excluded from the provisions of this chapter; however, where the release of criminal incident information is likely to jeopardize an ongoing criminal investigation or the safety of an individual, cause a suspect to flee or evade detection, or result in the destruction of evidence, such information may be withheld until the above-referenced damage is no longer likely to occur from release of the information.

2. Confidential records of all investigations of applications for licenses and all licensees made by or submitted to the Alcoholic Beverage Control Board or the State Lottery Department.

3. State income, business, and estate tax returns, personal property tax returns, scholastic records and personnel records containing information concerning identifiable individuals, except that such access shall not be denied to the person who is the subject thereof, and medical and mental records, except that such records can be personally reviewed by the subject person or a physician of the subject person's choice; however, the subject person's mental records may not be personally reviewed by such person when the subject person's treating physician has made a part of such person's records a written statement that in his opinion a review of such records by the subject person would be injurious to the subject person's physical or mental health or well-being.

Where the person who is the subject of medical records is confined in a state or local correctional facility, the administrator or chief medical officer of such facility may assert such confined person's right of access to the medical records if the administrator or chief medical officer has reasonable cause to believe that such confined person has an infectious disease or other medical condition from which other persons so confined need to be protected. Medical records shall be reviewed only and shall not be copied by such administrator or chief medical officer. The information in the medical records of a person so confined shall continue to be confidential and shall not be disclosed to any person except the subject by the administrator or chief medical officer of the facility or except as provided by law.

For the purposes of this chapter such statistical summaries of incidents and statistical data concerning patient abuse as may be compiled by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services shall be open to inspection and releasable as provided in subsection A of this section. No such summaries

or data shall include any patient identifying information. Where the person who is the subject of scholastic or medical and mental records is under the age of eighteen, his right of access may be asserted only by his guardian or his parent, including a noncustodial parent, unless such parent's parental rights have been terminated or a court of competent jurisdiction has restricted or denied such access. In instances where the person who is the subject thereof is an emancipated minor or a student in a state-supported institution of higher education such right of access may be asserted by the subject person.

4. Memoranda, working papers and correspondence held or requested by members of the General Assembly or by the office of the Governor or Lieutenant Governor, Attorney General or the mayor or other chief executive officer of any political subdivision of the Commonwealth or the president or other chief executive officer of any state-supported institutions of higher education.

5. Written opinions of the city, county and town attorneys of the cities, counties and towns in the Commonwealth and any other writing protected by the attorney-client privilege.

6. Memoranda, working papers and records compiled specifically for use in litigation or as a part of an active administrative investigation concerning a matter which is properly the subject of an executive or closed meeting under § 2.1-344 and material furnished in confidence with respect thereto.

7. Confidential letters and statements of recommendation placed in the records of educational agencies or institutions respecting (i) admission to any educational agency or institution, (ii) an application for employment, or (iii) receipt of an honor or honorary recognition.

8. Library records which can be used to identify both (i) any library patron who has borrowed material from a library and (ii) the material such patron borrowed.

9. Any test or examination used, administered or prepared by any public body for purposes of evaluation of (i) any student or any student's performance, (ii) any employee or employment seeker's qualifications or aptitude for employment, retention, or promotion, or (iii) qualifications for any license or certificate issued by any public body.

As used in this subdivision 9, "test or examination" shall include (i) any scoring key for any such test or examination, and (ii) any other document which would jeopardize the security of such test or examination. Nothing contained in this subdivision 9 shall prohibit the release of test scores or results as provided by law, or limit access to individual records as is provided by law. However, the subject of such employment tests shall be entitled to review and inspect all documents relative to his performance on such employment tests.

When, in the reasonable opinion of such public body, any such test or examination no longer has any potential for future use, and the security of future tests or examinations will not be jeopardized, such test or examination shall be made available to the public. However, minimum competency tests administered to public school children shall be made available to the public contemporaneously with statewide release of the scores of those taking such tests, but in no event shall such tests be made available to the public later than six months after the administration of such tests.

10. Applications for admission to examinations or for licensure and scoring records maintained by the Department of Health Professions or any board in that department on individual licensees or applicants. However, such material may be made available during normal working hours for copying, at the requester's expense, by the individual who is the subject thereof, in the offices of the Department of Health Professions or in the offices of any health regulatory board, whichever may possess the material.

11. Records of active investigations being conducted by the Department of Health Professions or by any health regulatory board in the Commonwealth.

12. Memoranda, legal opinions, working papers and records recorded in or compiled exclusively for executive or closed meetings lawfully held pursuant to § 2.1-344.

13. Reports, documentary evidence and other information as specified in §§ 2.1-373.2 and 63.1-55.4.

14. Proprietary information gathered by or for the Virginia Port Authority as provided in § 62.1-132.4 or § 62.1-134.1.

15. Contract cost estimates prepared for the confidential use of the Department of Transportation in awarding contracts for construction or the purchase of goods or services and records, documents and automated systems prepared for the Department's Bid Analysis and Monitoring Program.

16. Vendor proprietary information software which may be in the official records of a public body. For the purpose of this section, "vendor proprietary software" means computer

programs acquired from a vendor for purposes of processing data for agencies or political subdivisions of this Commonwealth.

17. Data, records or information of a proprietary nature produced or collected by or for faculty or staff of state institutions of higher learning, other than the institutions' financial or administrative records, in the conduct of or as a result of study or research on medical, scientific, technical or scholarly issues, whether sponsored by the institution alone or in conjunction with a governmental body or a private concern, where such data, records or information has not been publicly released, published, copyrighted or patented.

18. Financial statements not publicly available filed with applications for industrial development financings.

19. Lists of registered owners of bonds issued by a political subdivision of the Commonwealth, whether the lists are maintained by the political subdivision itself or by a single fiduciary designated by the political subdivision.

20. Confidential proprietary records, voluntarily provided by private business to the Division of Tourism of the Department of Economic Development, used by that Division periodically to indicate to the public statistical information on tourism visitation to Virginia attractions and accommodations.

21. Information which meets the criteria for being filed as confidential under the Toxic Substances Information Act (§ 32.1-239 et seq.), regardless of how or when it is used by authorized persons in regulatory processes.

22. Documents as specified in § 58.1-3.

23. Confidential records, including victim identity, provided to or obtained by staff in a rape crisis center or a program for battered spouses.

24. Computer software developed by or for a state agency, state-supported institution of higher education or political subdivision of the Commonwealth.

25. Investigator notes, and other correspondence and information, furnished in confidence with respect to an active investigation of individual employment discrimination complaints made to the Department of Personnel and Training; however, nothing in this section shall prohibit the disclosure of information taken from inactive reports in a form which does not reveal the identity of charging parties, persons supplying the information or other individuals involved in the investigation.

26. Fisheries data which would permit identification of any person or vessel, except when required by court order as specified in § 28.1-23.2.

27. Records of active investigations being conducted by the Department of Medical Assistance Services pursuant to Chapter 10 (§ 32.1-323 et seq.) of Title 32.1.

28. Documents and writings furnished by a member of the General Assembly to a meeting of a standing committee, special committee or subcommittee of his house established solely for the purpose of reviewing members' annual disclosure statements and supporting materials filed under § 2.1-639.40 or of formulating advisory opinions to members on standards of conduct, or both.

29. Customer account information of a public utility affiliated with a political subdivision of the Commonwealth, including the customer's name and service address, but excluding the amount of utility service provided and the amount of money paid for such utility service.

30. Investigative notes and other correspondence and information furnished in confidence with respect to an investigation or conciliation process involving an alleged unlawful discriminatory practice under the Virginia Human Rights Act (§ 2.1-714 et seq.); however, nothing in this section shall prohibit the distribution of information taken from inactive reports in a form which does not reveal the identity of the parties involved or other persons supplying information.

31. Investigative notes; proprietary information not published, copyrighted or patented; information obtained from employee personnel records; personally identifiable information regarding residents, clients or other recipients of services; and other correspondence and information furnished in confidence to the Department of Social Services in connection with an active investigation of an applicant or licensee pursuant to Chapters 9 (§ 63.1-172 et seq.) and 10 (§ 63.1-195 et seq.) of Title 63.1; however, nothing in this section shall prohibit disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information, or other individuals involved in the investigation.

32. Reports, manuals, specifications, documents, minutes or recordings of staff meetings or other information or materials of the Virginia Board of Corrections, the Virginia Department of Corrections or any institution thereof to the extent, as determined by the Director of the Department of Corrections or his designee, that disclosure or public

dissemination of such materials would jeopardize the security of any correctional facility or institution, as follows:

(i) Security manuals, including emergency plans that are a part thereof;

(ii) Engineering and architectural drawings of correctional facilities, and operational specifications of security systems utilized by the Department, provided the general descriptions of such security systems, cost and quality shall be made available to the public;

(iii) Training manuals designed for correctional facilities to the extent that they address procedures for institutional security, emergency plans and security equipment;

(iv) Internal security audits of correctional facilities, but only to the extent that they specifically disclose matters described in (i), (ii), or (iii) above or other specific operational details the disclosure of which would jeopardize the security of a correctional facility or institution;

(v) Minutes or recordings of divisional, regional and institutional staff meetings or portions thereof to the extent that such minutes deal with security issues listed in (i), (ii), (iii), and (iv) of this subdivision;

(vi) Investigative case files by investigators authorized pursuant to § 53.1-16; however, nothing in this section shall prohibit the disclosure of information taken from inactive reports in a form which does not reveal the identity of complainants or charging parties, persons supplying information, confidential sources, or other individuals involved in the investigation, or other specific operational details the disclosure of which would jeopardize the security of a correctional facility or institution; nothing herein shall permit the disclosure of materials otherwise exempt as set forth in subdivision 1 of subsection B of this section;

(vii) Logs or other documents containing information on movement of inmates or employees; and

(viii) Documents disclosing contacts between inmates and law-enforcement personnel.

Notwithstanding the provisions of this subdivision, reports and information regarding the general operations of the Department, including notice that an escape has occurred, shall be open to inspection and copying as provided in this section.

33. Personal information, as defined in § 2.1-379 of the Code, (i) filed with the Virginia Housing Development Authority concerning individuals who have applied for or received loans or other housing assistance or who have applied for occupancy of or have occupied housing financed, owned or otherwise assisted by the Virginia Housing Development Authority, (ii) concerning persons participating in or persons on the waiting list for federally funded rent-assistance programs, or (iii) filed with any local redevelopment and housing authority created pursuant to § 36-4 concerning persons participating in or persons on the waiting list for housing assistance programs funded by local governments or by any such authority. However, access to one's own information shall not be denied.

34. Documents regarding the siting of hazardous waste facilities, except as provided in § 10.1-1441, if disclosure of them would have a detrimental effect upon the negotiating position of a governing body or on the establishment of the terms, conditions and provisions of the siting agreement.

35. Appraisals and cost estimates of real property subject to a proposed purchase, sale or lease, prior to the completion of such purchase, sale or lease.

36. Records containing information on the site specific location of rare, threatened, endangered or otherwise imperiled plant and animal species, natural communities, caves, and significant historic and archaeological sites if, in the opinion of the public body which has the responsibility for such information, disclosure of the information would jeopardize the continued existence or the integrity of the resource. This exemption shall not apply to requests from the owner of the land upon which the resource is located.

37. Official records, memoranda, working papers, graphics, video or audio tapes, production models, data and information of a proprietary nature produced by or for or collected by or for the State Lottery Department relating to matters of a specific lottery game design, development, production, operation, ticket price, prize structure, manner of selecting the winning ticket, manner of payment of prizes to holders of winning tickets, frequency of drawings or selections of winning tickets, odds of winning, advertising, or marketing, where such official records have not been publicly released, published, copyrighted or patented. Whether released, published or copyrighted, all game-related information shall be subject to public disclosure under this chapter upon the first day of sales for the specific lottery game to which it pertains.

38. Official records of studies and investigations by the State Lottery Department of (i) lottery agents, (ii) lottery vendors, (iii) lottery crimes under §§ 58.1-4014 through 58.1-4018,

(iv) defects in the law or regulations which cause abuses in the administration and operation of the lottery and any evasions of such provisions, or (v) use of the lottery as a subterfuge for organized crime and illegal gambling where such official records have not been publicly released, published or copyrighted. All studies and investigations referred to under subdivisions (iii), (iv) and (v) shall be subject to public disclosure under this chapter upon completion of the study or investigation.

39. Those portions of engineering and construction drawings and plans submitted for the sole purpose of complying with the building code in obtaining a building permit which would identify specific trade secrets or other information the disclosure of which would be harmful to the competitive position of the owner or lessee; however, such information shall be exempt only until the building is completed. Information relating to the safety or environmental soundness of any building shall not be exempt from disclosure.

40. Trade secret information furnished to the Board of Medical Assistance Services or the Medicaid New Drug Review Committee pursuant to Article 2 (§ 32.1-331.1 et seq.) of Chapter 10 of Title 32.1.

41. Records concerning reserves established in specific claims administered by the Department of General Services through its Division of Risk Management as provided in Article 5.1 (§ 2.1-526.1 et seq.) of Chapter 32 of Title 2.1, or by any county, city, or town.

42. Information and records collected for the designation and verification of trauma centers and other specialty care centers within the Statewide Emergency Medical Care System pursuant to § 32.1-112.

43. Reports and court documents required to be kept confidential pursuant to § 37.1-67.3.

44. (Effective July 1, 1991) Trade secret information furnished to the Board of Medical Assistance Services or the Virginia Medicaid Formulary Committee pursuant to Article 3 (§ 32.1-331.6 et seq.) of Chapter 10 of Title 32.1.

45. Data required to be submitted to the Commissioner of Health relating to the establishment of new or expansion of existing clinical health services, acquisition of major medical equipment, or certain projects requiring capital expenditures pursuant to § 32.1-102.3:4.

C. Neither any provision of this chapter nor any provision of Chapter 26 (§ 2.1-377 et seq.) of this title shall be construed as denying public access to contracts between a public official and a public body, other than contracts settling public employee employment disputes held confidential as personnel records under subdivision 3 of subsection B of this section, or to records of the position, job classification, official salary or rate of pay of, and to records of the allowances or reimbursements for expenses paid to any public officer, official or employee at any level of state, local or regional government in this Commonwealth. The provisions of this subsection, however, shall not apply to records of the official salaries or rates of pay of public employees whose annual rate of pay is $10,000 or less.

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

"Certificate" means a certificate of public need for a project required by this article.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Medical care facility," as used in this title, means any institution, place, building or agency, whether licensed or required to be licensed by the Board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately-owned or privately-operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled, or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans. For purposes of this article, only the following medical care facilities shall be subject to review:

1. General hospitals.

2. Sanitariums.
3. Nursing homes.
4. Intermediate care facilities.
5. Extended care facilities.
6. Mental hospitals.
7. Mental retardation facilities.
8. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.
9. Specialized centers or clinics developed for the provision of outpatient or ambulatory surgery.
10. Rehabilitation hospitals.

The term "medical care facility" shall not include any facility of the Department of Mental Health, Mental Retardation and Substance Abuse Services or any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services' Comprehensive Plan.

"Project" means:

1. Establishment of a medical care facility;
2. An increase in the total number of beds in an existing medical care facility;
3. Relocation of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of ten percent of its beds as nursing home beds as provided in § 32.1-132;
4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided; or
5. Introduction into an existing medical care facility of any new open heart surgery, psychiatric, medical rehabilitation, or substance abuse treatment service which the facility has never provided or has not provided in the previous twelve months.

"Regional Health Planning Agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform the health planning activities set forth in this chapter within a health planning region.

"Registration" means the recordation of the establishment of certain new or expansion of existing clinical health services, acquisition of certain major medical equipment or initiation of certain capital expenditures as required by § 32.1-102.3:4.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for medical care facility beds and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services. In developing the plan, the Board shall take into consideration the policies and recommendations contained in the State Health Plan.

"Virginia Health Planning Board" means the statewide health planning body established pursuant to § 32.1-122.02 which serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.

§ 32.1-102.2. Regulations.— *A.* The Board shall promulgate regulations which are consistent with this article and:

1. Shall establish procedures for the review of applications for certificates consistent with the provisions of this article *, which may include a structured batching process which incorporates, but is not limited to, authorization for the Commissioner to request proposals for certain projects;*
2. May classify projects and may eliminate one or more or all of the procedures prescribed in § 32.1-102.6 for different classifications *; ;*
3. May provide for exempting from the requirement of a certificate projects determined by the Commissioner, upon application for exemption, to be subject to the economic forces of a competitive market or to have no discernable impact on the cost or quality of health services *; ; and*
4. *Shall establish a schedule of fees for applications for certificates to be applied to expenses for the administration and operation of the certificate of public need program.*

Such fees shall not exceed the lesser of one-half of one percent of the proposed expenditure for the project or $5,000.

B. The Board shall promulgate regulations providing for time limitations for schedules for completion and limitations on the exceeding of the maximum capital expenditure amount for all reviewable projects. The Commissioner shall not approve any such extension or excess unless it complies with the Board's regulations.

C. The Board shall also promulgate regulations authorizing the Commissioner to condition approval of a certificate on the agreement of the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care. In addition, the Board's licensure regulations shall direct the Commissioner to consider, when issuing or renewing any license for any applicant whose certificate was approved upon such condition, whether such applicant has complied with any agreement to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care.

§ 32.1-102.3:2. Certificates of public need; moratorium; exceptions.—The Commissioner of Health shall not approve, authorize or accept applications for the issuance of any certificate of public need pursuant to this article for any project which would result in an increase in the number of beds in which nursing home or extended care services are provided through June 30, ~~1991~~ *1993* . However, the Commissioner may approve or authorize the issuance of a certificate of public need for a project for the (i) renovation or replacement on site of an existing facility or any part thereof or (ii) replacement off-site of an existing facility at a location within the same city or county and within reasonable proximity to the current site when replacement on the current site is proven infeasible, in accordance with the law, when a capital expenditure is required to comply with life safety codes, licensure, certification or accreditation standards. Under no circumstances shall the State Health Commissioner approve, authorize, or accept an application for the issuance of a certificate for any project which would result in the continued use of the facility replaced as a nursing home.

The Commissioner may also approve or authorize the issuance of a certificate of public need for any project for the conversion on site of existing licensed beds to beds certified for skilled nursing services (SNF) when (i) the total number of beds to be converted does not exceed the lesser of twenty beds or ten percent of the beds in the facility; (ii) the facility has demonstrated that the SNF beds are needed specifically to serve a specialty heavy care patient population, such as ventilator-dependent and AIDS patients and that such patients otherwise will not have reasonable access to such services in existing or approved facilities; and (iii) the facility further commits to admit such patients on a priority basis once the SNF unit is certified and operational.

The Commissioner of Health may approve or authorize the issuance of a certificate of public need for any project for the conversion on site of existing beds in a home for adults facility licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1 as of March 1, 1990, to beds certified as nursing facility beds when (i) the total number of beds to be converted does not exceed the lesser of thirty beds or twenty-five percent of the beds in the home for adults facility; (ii) the home for adults facility has demonstrated that nursing facility beds are needed specifically to serve a patient population of AIDS, or ventilator-dependent, or head and spinal cord injured patients, or any combination of the three, and that such patients otherwise will not have reasonable access to such services in existing or approved nursing facilities; (iii) the home for adults facility further commits to admit such patients once the nursing facility beds are certified and operational; and (iv) the licensed home for adults facility otherwise meets the standards for nursing facility beds as set forth in the regulations of the Board of Health. *Notwithstanding the conditions required by this exception related to serving specific patient populations, a home for adults which has obtained by January 1, 1991, a certificate of public need for a project for conversion on site of existing beds in its facility licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1 as of March 1, 1990, to beds certified as nursing facility beds may use the beds converted to nursing facility beds pursuant to this exception for patient populations requiring specialized care of at least the same intensity which meet the criteria for the establishment of a specialized care nursing facility contract with the Department of Medical Assistance Services.*

Notwithstanding the foregoing and other provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1, of the Code, the state home for aged and infirm veterans authorized by Chapter 668, 1989 Acts of Assembly, shall be exempt from all certificates of public need review requirements as a medical care facility.

§ 32.1-102.3:3. Same; general hospitals and outpatient or ambulatory surgery centers or clinics.—Notwithstanding any provision of law to the contrary, as of July 1, ~~1991~~ *1993* ,

general hospitals and specialized centers or clinics developed for the provision of outpatient or ambulatory surgery shall no longer be medical care facilities subject to review pursuant to this article except with respect to the establishment of nursing home beds in general hospitals.

§ 32.1-102.3:4. Registration of certain equipment, services, and projects required.— ~~Upon initiating~~ *A. Prior to establishing* a new *or expanding an existing* clinical health service which does not require a certificate pursuant to this article or ~~upon acquiring~~ *at the time of contractual obligation or other commitment to acquire* any ~~new~~ *major* medical equipment requiring an expenditure of $400,000 or more, any medical care facility *listed in § 32.1-102.1* , ~~licensed hospital or~~ physician's office *, or specialized center or clinic* shall register such ~~initiation of~~ services or acquisition of equipment with the Commissioner. ~~Specialized centers or clinics for the provision of~~ *Such registration shall only be required for the following: obstetrics, neonatal special care, heart, lung, kidney or other transplantation,* radiation therapy, magnetic resonance imaging, computed tomography scanning, positron emission tomography scanning, lithotripsy, cardiac catheterization, ~~open heart surgery,~~ or ~~such~~ other *specialized* treatment *or diagnostic* procedures as are designated by the Commissioner , ~~shall register with~~ . The Commissioner ~~and~~ shall ~~provide, periodically on request of the Commissioner,~~ *also require the periodic submission of* data ~~delineating~~ *including but not limited to,* patient volumes, morbidity and mortality, aggregate costs and charges for the services provided. *However, such data shall be excluded from the provisions of the Virginia Freedom of Information Act as provided in § 2.1-342 of this Code only until such time as the new or expanded clinical health service or the acquired medical equipment becomes operational.*

B. In addition, any medical care facility listed in § 32.1-102.1, specialized center or clinic, or physician's office shall register prior to establishment of a project not requiring a certificate pursuant to this article for which there will be a capital expenditure of one million dollars or more.

C. Any person willfully refusing, failing, or neglecting to register as required by subsections A and B of this section shall be subject to a civil penalty of $100 per day per violation.

§ 32.1-102.4. Conditions of certificates; monitoring; revocation of certificates.—A. A certificate shall be issued with a schedule for the completion of the project and a maximum capital expenditure amount for the project. The schedule may not be extended and the maximum capital expenditure may not be exceeded without the approval of the Commissioner *in accordance with the regulations of the Board* .

B. The Commissioner shall monitor each project for which a certificate is issued to determine its progress and compliance with the schedule and with the maximum capital expenditure.

C. A certificate may be revoked when:

1. Substantial and continuing progress towards completion of the project in accordance with the schedule has not been made;

2. The maximum capital expenditure amount set for the project is exceeded; or

3. The applicant has willfully or recklessly misrepresented intentions or facts in obtaining a certificate.

D. Notwithstanding the authority of the Commissioner to grant an extension of a schedule for completion of the project pursuant to subsection A of this section, no extension shall be granted for any nursing home bed project beyond June 30, 1992. However, the Commissioner may grant an extension of a schedule for completion for an additional six months upon determining that (i) substantial and continuing progress has been made toward completion of the project; and (ii) the project owner had agreed in writing prior to February 13, 1991, to delay the project to facilitate cost savings for the Commonwealth. The certificate for any such nursing home bed project approved prior to January 1, 1991, which has not been completed by June 30, 1992, or by the expiration date of any approved extension shall be revoked.

E. Further, the Commissioner shall not approve an extension for a schedule for completion of any project or the exceeding of the maximum capital expenditure of any project unless such extension or excess complies with the limitations provided in the regulations promulgated by the Board pursuant to § 32.1-102.2.

F. Any person willfully violating the Board's regulations establishing limitations for schedules for completion of any project or limitations on the exceeding of the maximum capital expenditure of any project shall be subject to a civil penalty of $100 per violation per day until the date of completion of the project.

G. The Commissioner may condition, pursuant to the regulations of the Board, the

approval of a certificate upon the agreement of the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care.

Any person willfully refusing, failing, or neglecting to honor such agreement shall be subject to a civil penalty of $100 per violation per day until the date of compliance.

H. For the purposes of this section, "completion" means conclusion of construction activities necessary for the substantial performance of the contract.

§ 32.1-102.6. Administrative procedures.—A. To obtain a certificate for a project, the applicant shall file a completed application for a certificate with the Department and the appropriate health systems agency. At least 30 days before any person is contractually obligated to acquire an existing medical care facility, the cost of which is $600,000 or more, that person shall notify the Commissioner and the appropriate health systems agency of the intent, the services to be offered in the facility, the bed capacity in the facility and the projected impact that the cost of the acquisition will have upon the charges for services to be provided. If clinical services or beds are proposed to be added as a result of the acquisition, the Commissioner may require the proposed new owner to obtain a certificate prior to the acquisition.

B. The appropriate health systems agency shall begin to review each complete application for a certificate within such time as the Board may prescribe by regulation. The health systems agency shall hold one public hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city. The health systems agency shall cause notice of the public hearing to be published in a newspaper of general circulation in the county or city where a project is proposed to be located at least nine days prior to the public hearing. In no case shall a health systems agency hold more than two meetings on any application, one of which shall be a public hearing conducted by the board of the health systems agency or a subcommittee of the board. The applicant shall be given the opportunity, prior to the vote, to respond to any comments made about the project by the health systems agency staff, any information in a staff report, or comments by those voting. The health systems agency shall submit its recommendations on each application and its reasons therefor to the Department within such time as may be prescribed by the Board by regulation.

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

~~D. [Repealed.]~~

~~E.~~ *D.* A determination whether a public need exists for a project shall be made by the Commissioner within 120 days of the receipt of a completed application. Such determination shall be made in accordance with the provisions of the Administrative Process Act (§ 9-6.14:1 et seq.) except that the parties to the case shall include only the applicant, any person showing good cause, any third-party payor providing health care insurance or prepaid coverage to five percent or more of the patients in the applicant's service area, or the health systems agency if its recommendation was to deny the application. For purposes of this subsection, "good cause" shall mean that (i) there is significant relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing, or (iii) there is a substantial material mistake of fact or law in the Department staff's report on the application or in the report submitted by the health systems agency.

~~F. [Repealed.]~~

E. The project review procedures shall provide for separation of the project review manager functions from the hearing officer functions. No person serving in the role of project review manager shall serve as a hearing officer.

2. That, by December 1, 1991, the Secretary of Health and Human Resources shall develop a comprehensive health care plan and submit such plan to the Committee on Health, Welfare and Institutions of the House of Delegates; to the Committee on Education and Health of the Senate; and to the Commission on Health Care for All Virginians. In developing this plan, the Secretary shall periodically confer with the Commission on Health Care for All Virginians as deemed necessary by the Commission.

3. That the Secretary of Health and Human Resources shall continue the study of

implications and effects of the application of Article 1.1 of Title 32.1 (§ 32.1-102.1 et seq.) on the accessibility, affordability and quality of health care until November 1, 1992. The Secretary shall submit an interim report by November 1, 1991, and a final report by November 1, 1992, to the Committee on Health, Welfare and Institutions of the House of Delegates; to the Committee on Education and Health of the Senate; and to the Commission on Health Care for All Virginians. In preparation of these reports, the Secretary shall continue to consult with groups and organizations representing public and private health care providers and consumers. The reports shall focus on the implications and effects of the expiration of the certificate of public need requirements for hospitals and ambulatory surgery centers pursuant to § 32.1-102.3:3, the amendments effected by Chapter 517 of the 1989 Acts of Assembly, and the revisions set forth in this act and shall include, but not be limited to, (i) an analysis of changing federal, state and third-party reimbursement of medical services and its effect on the economic viability of health care providers; (ii) an analysis of the effects of the deregulation of certain medical care facilities, clinical services and medical technology from the Medical Care Facilities Certificate of Public Need Law as set forth in such article, the effect of deregulation upon health care price competition, and the affordability of primary, acute and long-term health care; and (iii) the effect of deregulation upon the budget of the Commonwealth. The House Committee on Health, Welfare and Institutions; the Senate Committee on Education and Health; and the Commission on Health Care for All Virginians shall review the interim report of the Secretary of Health and Human Resources and shall recommend to the General Assembly by January 1, 1992, and January 1, 1993, any revisions of the law determined to be appropriate.

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President of the Senate

_____

Speaker of the House of Delegates

Approved:

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Governor

1991 SESSION

SENATE JOINT RESOLUTION NO. 178

Requesting the Virginia Health Services Cost Review Council with the Virginia Health Planning Board to study possible establishment of a patient level data base.

Agreed to by the Senate, February 4, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, the most recent analysis by the Health Care Financing Administration of the United States Department of Health and Human Services indicated that spending for health amounted to 11.1 percent of the Gross National Product in 1988, more than twice that of 1960; that hospital expenditures increased 9.3 percent from 1987 through 1988; and that spending for physician services increased 13.1 percent during that same period; and

WHEREAS, health care expenditures have continued to grow at an increasing rate so that they comprised 11.6 percent of the Gross National Product in 1989 and estimates indicate that this figure will climb to 15 percent by the year 2000; and

WHEREAS, one economic forecast estimates that, absent fundamental change, overall health care spending by the year 2000 will be six and one-half times higher than it was in 1980; and

WHEREAS, the same economic estimate projects that employers and employees will have to absorb a 529 percent increase from 1980 to 2000 for employer-based health coverage; and

WHEREAS, health care providers, health care users, third party payers, employers, the general public, and state and federal officials agree there is a need to contain these rising health care costs while simultaneously improving the quality of health care and expanding access to necessary care; and

WHEREAS, all states, including the Commonwealth, have undertaken many initiatives to deal with these critical issues; and

WHEREAS, thirty-five states, including the Commonwealth, have created health data organizations to collect and disseminate information regarding health care costs; and

WHEREAS, thirty-two states have established statewide patient level data bases to assist in the review and comparison of costs, utilization, quality, and effectiveness of health services; and

WHEREAS, the objective of a patient level data base is to improve the quality of care by providing payers and consumers, including employers and governments with information needed to make intelligent buying decisions; evaluate medical technologies and services; and establish guidelines to improve treatment and limit unnecessary procedures; and

WHEREAS, many health care providers already utilize data from patient level data bases to review internal operations, pinpoint inefficiencies, and plan future services; and other providers would benefit from such information in the future; and

WHEREAS, information from a patient level data base would provide information regarding access to care issues and provide for effective planning for future needs; and

WHEREAS, the Virginia Health Services Cost Review Council is the state-level health data organization created by legislation to collect and disseminate information concerning health care costs; and

WHEREAS, the Robert Wood Johnson Foundation has recently announced a new grant program for states to encourage the development of comprehensive health data collection at the state level; and

WHEREAS, the Virginia Health Planning Board has the statutory responsibility to supervise the development of a health data system in order to provide necessary information to support health policy recommendations; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Virginia Health Services Cost Review Council, in cooperation with the Virginia Health Planning Board, be requested to study all aspects of the possible establishment of a patient level data base in the Commonwealth, including its potential use by providers, payers, employers, state and local governments, and the general public; the need for and efficacy of establishing state agency oversight to ensure the delivery of cost-effective health care services; and to prepare a grant application for the Robert Wood Johnson Foundation on this issue.

All agencies of the Commonwealth shall provide assistance in the study as requested by the Virginia Health Services Cost Review Council.

The Council shall report its findings and recommendations to the Commission on Health Care for All Virginians by October 15, 1991, and to the Governor and 1992 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

1991 SESSION

SENATE JOINT RESOLUTION NO. 179

Requesting each district health director within the Virginia Department of Health to assess his district's primary care needs and to develop a cost effective plan to meet those needs.

Agreed to by the Senate, February 4, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, a goal of the Commonwealth is that each Virginian have access to a health care delivery system for the provision of primary care that meets his needs; and

WHEREAS, primary care is continual health care and services that include prevention, maintenance, diagnosis, treatment, and management of most illnesses; and

WHEREAS, the Commission on Health Care for All Virginians has in its history studied primary health care and recognized its provision to the citizens of the Commonwealth as critically important in the continuum of health care services; and

WHEREAS, that emphasis on strengthening and expanding primary health care has included several initiatives engendered by the Commission on Health Care for All Virginians and adopted by the General Assembly, including appropriations for $1 million to establish four primary care pilot programs in the Commonwealth as a means to enlarge access and availability to primary care; and

WHEREAS, an individual's entering the continuum of health services at the primary level of care rather than requiring tertiary or secondary care mitigates both personal suffering and personal financial expense; and

WHEREAS, the provision of primary care is also a means of cost-containment for the Commonwealth in its role as health care provider; and

WHEREAS, primary care providers include family practitioners, general internists, general pediatricians, obstetricians, and mid-level providers; and

WHEREAS, the Virginia Department of Health has local health departments that serve each locality in the Commonwealth; and

WHEREAS, the Virginia Department of Health has thirty-six health districts with physician health directors who are responsible for providing public health, preventive medicine, and environmental health services to their communities; and

WHEREAS, several local health departments directly provide primary care services, in addition to traditional public health services; and

WHEREAS, all health directors have knowledge of health care providers in their communities and health directors are able by the nature of their positions to facilitate the development of a system to improve availability and access to primary care services; and

WHEREAS, the Commission on Health Care for All Virginians has determined that further study is needed on the provision of primary care for all citizens of the Commonwealth; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That as part of his public health mission, each district health director be given the responsibility of determining the availability and accessibility of primary care services to the residents of his district and developing a community plan for addressing problems identified in the accessibility and availability of primary care services, particularly for indigent persons; and, be it

RESOLVED FURTHER, That in the determination of the availability and accessibility of primary care services to the residents of his districts and his development of a cost effective community plan to address problems of such accessibility and availability, each district health director shall:

1. Complete, by November 1, 1991, in cooperation with community representatives and health care providers including primary care providers, an assessment of the primary care needs in the district. This assessment will identify the availability of health manpower resources, identify accessibility to resources, and determine the need for specific services;

2. Develop, by July 1, 1992, a plan with the assistance of community leaders, other agencies, health care providers, and other groups to develop the capacity to provide primary care services in those areas where those services are not available through a public/private partnership; and

3. Formulate also, in conjunction with his development of a comprehensive primary care provision plan, a community plan to educate and inform citizens on the best means of accessing primary care and appropriately utilizing primary care services; and, be it

RESOLVED FURTHER, That in district health departments currently providing comprehensive primary care, the district health director shall develop a system to measure access, availability, utilization, and cost of those services; and, be it

RESOLVED FURTHER, That local medical societies, hospitals, medical training programs, community health centers, other providers of primary care, local governments, and voluntary health agencies are requested to participate with the Department of Health in providing leadership in the development of the analysis and plan for the provision of primary care services.

All agencies of the Commonwealth shall provide assistance to the Department for this study as appropriate.

The Department of Health shall report its interim findings and recommendations to the Commission on Health Care for All Virginians by December 15, 1991, and its final report to the Governor and the 1993 Session of the General Assembly. Both reports shall comply with the procedures of Legislative Automated Systems for the processing of legislative documents.

1991 SESSION

SENATE JOINT RESOLUTION NO. 180

Requesting the Joint Legislative Audit and Review Commission to study the Commonwealth's Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

Agreed to by the Senate, February 19, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, a goal of the Commission on Health Care for All Virginians is to provide access to basic health care for all Virginians; and

WHEREAS, approximately 330,000 persons in Virginia are eligible for the Medicaid program, but an estimated 300,000 additional Virginians in poverty have no health insurance; and

WHEREAS, the number of Virginians eligible for Medicaid has increased by only 10 percent during the last 10 years, but Medicaid expenditures in Virginia have tripled during that period; and

WHEREAS, costs in the 1990-92 biennium are expected to be more than 40 percent greater than the costs in the 1988-90 biennium; and

WHEREAS, the Medicaid program now represents about 12 percent of the Commonwealth's general fund budget, with an estimated $1.4 billion (general fund) cost for the 1990-92 biennium; and

WHEREAS, Medicaid costs will continue to escalate at a rapid rate as inflation in health care costs far surpasses other goods and services; and new federal mandates are likely to continue as Congress expands health insurance for the elderly, disabled, and poor through Medicare and Medicaid; and

WHEREAS, federal mandates establish the core of the Medicaid program, but states can partially shape the benefits and costs through policy adjustments in reimbursement rates for service providers; services offered to recipients; utilization review to ensure appropriate care; and eligibility for groups of persons, and to some extent, how much recipients pay for their own care; and

WHEREAS, University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads provide a significant amount of care to low-income persons and receive state support for this care through Medicaid and direct general fund appropriations; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be requested to study the Virginia Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

The study shall include, but not be limited to:

1. Assessment of the cost savings and health policy implications of limiting the scope or duration of optional services, or adjusting recipients' contributions to their care;

2. Examination of the interpretation of federal requirements to determine if they have been implemented in the most effective and least costly manner;

3. Determination of the effectiveness of current utilization review procedures in controlling costs and exploration of additional options;

4. Evaluation of reimbursement methods to determine if they adequately encourage cost effective delivery of services;

5. Determination of the sufficiency of reimbursement rates to provide quality care at the lowest required cost;

6. Review of budget and forecasting methods to ensure that they adequately identify and project the cost of policy changes, service utilization, and new mandates;

7. Determination of how the legislative branch could increase its capacity to more closely monitor Medicaid forecasts and expenditures;

8. Exploration of the costs of alternative administrative methods for implementing program requirements and options;

9. Examination of the relationship with other State programs to promote optimal utilization of State funds;

10. Identification of options for using Medicaid funds for services currently supported with general funds; and

11. Review of eligibility, scope of services, and reimbursement rates for indigent care at University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads, and a determination of the appropriateness of general fund and Medicaid allocation methodologies.

All agencies of the Commonwealth shall provide assistance upon request to the study as

appropriate.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its findings and recommendations to the Governor and to the 1993 Session of the General Assembly, and shall provide interim reports to the Commission on Health Care for All Virginians and to the 1992 Session of the General Assembly and at other times as appropriate, using the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

1991 SESSION

SENATE JOINT RESOLUTION NO. 181

Requesting the Bureau of Insurance to develop proposals to increase health insurance access for small businesses and requesting the Small Business Advisory Board to promote the low-cost insurance packages for small businesses.

Agreed to by the Senate, February 4, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, approximately 880,000 Virginians do not have health insurance, and of that uninsured population, approximately 60 percent of the households are headed by persons employed at least on a part-time basis; and

WHEREAS, many uninsured workers are employed by small businesses, and approximately 35 percent of the businesses with 50 or fewer employees do not offer health insurance, accounting for an estimated 165,000 employees; and

WHEREAS, structural changes have occurred in the economy, including a shift of jobs from larger businesses to smaller businesses; and

WHEREAS, the high cost of health insurance, volatility of insurance rates, and underwriting exclusions are among the principal impediments of small businesses' offering health insurance; and

WHEREAS, small businesses frequently lack information about insurance products and possess little negotiating power with insurance carriers; and

WHEREAS, Chapter 394 of the 1990 Acts of Assembly directed the Technical Advisory Panel of the Virginia Indigent Care Trust Fund to study the technical and operational considerations related to requiring employers who do not provide minimum health insurance benefits, as defined by the Commissioner of Insurance, to their employees or whose employees are not otherwise provided such benefits to make reasonable contributions to the Trust Fund by July 1, 1992; and

WHEREAS, the Technical Advisory Panel found that small businesses should be provided incentives so that they might voluntarily obtain health insurance for their employees prior to any mandates being enacted in the Commonwealth to require employers to provide health insurance options to their employees; and

WHEREAS, the Technical Advisory Panel suggested incentives that included the formation of a state-sponsored small business insurance pool to aggregate small businesses seeking to purchase health insurance; and the establishment of a reinsurance pool to cover losses of high-risk groups with all insurers in the small-group market participating, with possible restrictions on rate increases to small employers, prohibitions against canceling policies with adverse experience, restrictions on preexisting conditions, and requirements to accept or reject entire employer groups without excluding high risk individuals; and

WHEREAS, a tenet of the mission of the Commission on Health Care for All Virginians is to seek means to expand the availability and accessibility of health care for citizens of the Commonwealth, and a subcommittee of the Commission will continue to study business participation in the Virginia Indigent Care Trust Fund and insurance reform; and

WHEREAS, the Commission on Health Care for All Virginians has reviewed the findings of the Technical Advisory Panel and recommended measures to increase the accessibility of health insurance for small businesses; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Bureau of Insurance be requested to develop a feasible proposal to establish a small business risk-sharing pool with insurance reforms that improve access and moderate rate increases and to evaluate options for monitoring costs and rates of health insurance carriers; and, be it

RESOLVED FURTHER, That the Small Business Advisory Board be requested to promote the availability of low-cost insurance packages for small businesses, when products are offered by multiple insurance carriers.

All agencies of the Commonwealth shall provide information and assistance needed by the Bureau and the Board in their development of these proposals.

The Bureau of Insurance and the Small Business Advisory Board shall report their findings and recommendations by November 1, 1991, to the Commission on Health Care for All Virginians, the Governor and the 1992 Session of the General Assembly as provided in the procedures of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Summary of 1990 Legislation, As Adopted

Bill Number	Purpose of Bill
SB 478/HB 1106	Creates Advisory Commission on Mandated Health Insurance Benefits.
SB 479/HB 1107	Requires insurance industry reports on cost of state-mandated health insurance benefits.
SB 480/HB 1108	Authorizes low-cost health insurance products with an exemption from most state mandates.
SB 481/HB 1109	Adds three business representatives to the Technical Advisory Panel of the Virginia Indigent Health Care Trust Fund.
SB 482/HB 1110	Authorizes technical changes to the Virginia Indigent Health Care Trust Fund.
SB 483/HB 1111	Authorizes primary care program.
SB 484/HB 1112	Extends the moratorium on COPN for nursing home beds until June 30, 1991.
SB 485/HB 1113	Transfers licensing of homes for adults from Department of Social Services to Department of Health (carried over until 1991).
SJR 118	Continues study of the Joint Subcommittee on Health Care for All Virginians as the Commission on Health Care for All Virginians until 1992.

APPENDIX C

Summary of 1989 Legislation, As Adopted

Bill Number	Purpose of Bill
SB759/HB 1858	Establishes uniform eligibility criteria for the State/Local Hospitalization Program, requires all localities to participate in SLH, and moves the program's administration to the Department of Medical Assistance Services.
SB 760/ HB 1859	Creates the Virginia Indigent Health Care Trust Fund.
SB 761/ HB 1860	Requires Virginia nursing homes to submit data to the Virginia Health Services Cost Review Council.
SB 762	Implements changes to the Virginia Medical Care Facilities Certificate of Public Need Program.
SJR 214	Continues study of the Joint Subcommittee on Health Care for All Virginians.
SJR 215	Authorizes study of health insurance mandates by the Bureau of Insurance.

APPENDIX D

1990 BUDGET REDUCTIONS ON RECOMMENDATIONS OF THE JOINT SUBCOMMITTEE ON HEALTH CARE FOR ALL VIRGINIANS (SJR 99/SJR 214)

ISSUE	APPROPRIATION 1991/1992	REDUCTION PLAN 1991/1992
INDIGENT HEALTH CARE TRUST FUND	$8,900,000/$8,900,000	($500,000)/($500,000)
MEDICAL SCHOLARSHIPS	$500,000/$500,000	($320,000)/($320,000)
PHYSICIAN LOAN REPAYMENT	$50,000/$50,000	($50,000)/NO CHANGE
AREA HEALTH EDUCATION CENTER	0/$150,000	NO CHANGE
PRIMARY CARE GRANTS	$1,500,000/$1,500,000	($1,000,000)/($500,000)
CASE MANAGEMENT FOR ELDERLY	0/$3,000,000	0/($1,000,000)
STAFF FOR LONG-TERM CARE COUNCIL	$125,000/$125,000	($62,500)/($62,500)
TOTAL	$11,075,000/$14,225,000	($1,932,500)/($3,882,500)

SENATE JOINT RESOLUTION NO. 118

Continuing the Joint Subcommittee on Health Care for All Virginians as the Commission on Health Care for All Virginians.

Agreed to by the Senate, March 9, 1990
Agreed to by the House of Delegates, March 9, 1990

WHEREAS, the issues associated with health care are among the most complex and difficult issues of the 1990's, and increasing health care costs and indigent health care have been cited as among the most critical issues facing the Commonwealth; and

WHEREAS, the availability and affordability of quality medical and health care services for all Virginians regardless of economic status remain issues of major concern for the Commonwealth; and

WHEREAS, these issues require that the Commonwealth develop a balanced approach to the conflicting goals of improving the quality of health care, expanding access to necessary health care, and controlling the costs of such care; and

WHEREAS, health care issues include rapidly increasing costs in both the public and private sectors; for example, the rising costs of health insurance and the burden these costs impose on employers and employees, and the escalating expenditures for Medicare and Medicaid; and

WHEREAS, concerns have also been expressed about the substantial operating losses which have been incurred by inpatient hospitals in the Commonwealth in the last several years and the need to analyze the factors affecting hospital operating margins in order to determine whether commitment of additional public funds is warranted to address these concerns; and

WHEREAS, new federal mandates will expand eligibility for Medicaid to include pregnant women and children up to age six in families with incomes up to 133 percent of the federal poverty level in April of 1990; and

WHEREAS, although the ideal and ultimate objective for Virginia would be to ensure adequate health care for all its citizens, such an ideal by economic realities must be tempered with the pragmatic realization that limited revenues will dictate the magnitude of funding streams for health care services; and

WHEREAS, as part of the state/local cooperative budget process, the Virginia Department of Health has the responsibility to allocate its resources among the various health districts; and

WHEREAS, the current mechanism for allocation of state funds may, in some instances, result in disparities in funding levels among localities; and

WHEREAS, it would be in the best interests of localities in particular and the Commonwealth overall to study in-depth the state/local cooperative budget allocation in order that inconsistencies may be reduced and that the equitable allocation of state funds be maximized to the extent possible; and

WHEREAS, advancements in medical technology have raised the expectations of the public in terms of access to sophisticated and expensive diagnostic and treatment modalities; and

WHEREAS, the citizens of the Commonwealth have recently confronted problems in obtaining payment from medical insurers for new, expensive medical technologies and procedures because the insurers determine that such technologies and procedures are "experimental" or "investigative"; and

WHEREAS, some new medical technologies and procedures may be state-of-the-art treatment and not experimental or investigative, and such technologies and procedures may in fact represent the best means of treatment for particular patients; and

WHEREAS, the citizens of the Commonwealth are entitled to a fair, objective, and efficient means of determining whether particular new medical technologies and procedures are experimental or investigative and are therefore covered under medical insurance policies; and

WHEREAS, the Joint Subcommittee on Health Care for All Virginians was created by Senate Joint Resolution 99 and House Joint Resolution 78 of 1988 and continued by Senate Joint Resolution 214 of 1989; and

WHEREAS, the Joint Subcommittee has submitted an interim report to the 1990 General Assembly which recommends steps to increase access and affordability of health insurance and primary health care and to strengthen the coordination and delivery of long term care; and

WHEREAS, the Joint Subcommittee is required to submit a final report to the Governor and the General Assembly in 1991; however, many difficult issues remain to be resolved;

and

WHEREAS, the continuing study involving both the legislative and executive branches of government in the Commonwealth and providing opportunity for input from the provider and business communities is essential to enable Virginia to manage costs while responding to the changing health care needs of her citizens in the 1990's; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Subcommittee on Health Care for All Virginians is hereby continued until 1992 as the Commission on Health Care for All Virginians which shall consist of twenty-two members. The membership of the Commission shall remain as established in Senate Joint Resolution 214 of 1989. In order to ensure continuity, the members so appointed shall be requested to continue to serve, notwithstanding any resignation or failure to seek reelection or reappointment to the office which was the basis of such members' appointments to the Joint Subcommittee in 1989. However, in addition to the original members appointed pursuant to the enabling resolutions of 1989, the duly appointed Secretaries of Health and Human Services and Finance shall be members of the Commission. Any vacancies shall be filled as originally provided in the enabling resolutions.

In its deliberations, the Commission shall examine:

1. The feasibility of expanding the Virginia Indigent Health Care Trust Fund through adding contributors or covered services and the efficacy of consolidating the Trust Fund and the State/Local Hospitalization program.

2. The need for providing assistance to certain hospitals in order to preserve access to acute care in isolated areas of the Commonwealth and examine the current mechanism for the state/local cooperative budget allocation to determine appropriate ways to provide for the equitable allocation of state funds.

3. Health insurance issues including, but not limited to, incentives for businesses to offer health insurance to their employees, ways to assure that health insurance is provided for children by absent parents as an essential component of child support orders, the impact of mandated insurance benefits and providers and a process for evaluating the social and financial effects of these mandates, ways of determining fairly and objectively whether new medical technologies and procedures are reimbursable or are excluded from coverage as experimental and investigative under medical insurance policies applicable to citizens in the Commonwealth, and ways to encourage the availability of private long-term care insurance which covers institutional and community-based care.

4. Medicaid issues including, but not limited to, the impact of new federal mandates on reducing the numbers of uninsured Virginians and improving their health, the concept of managed care and its effects on access and costs, the relationship between recent expansions of Medicaid eligibility and initiatives to expand the role of local health departments in the delivery of primary care for families with children, and Medicaid reimbursement for physicians' services, hospitals, and nursing homes.

5. Long-term care issues including, but not limited to, services that foster independence for as long as possible, the need to recognize the family as the primary source of care for elderly Virginians and to identify methods to increase support of family care givers, the development of pilot programs to ensure appropriate types and levels of services to elderly Virginians, eligibility for and the level of auxiliary grants for residents of homes for adults, and the efficacy of making case management available to all elderly Virginians on a sliding fee basis.

6. Issues related to the Certificate of Public Need Program including, but not limited to, a review of the current methodology for projecting the need for new nursing facility beds, recommendations for this methodology, and the future of the COPN program in Virginia.

Staff support shall be provided to the Commission jointly by the personnel of the Senate Committee on Finance, the House Committee on Appropriations, the Department of Health and the Division of Legislative Services.

The Commission shall submit its interim findings and recommendations to the Governor and the 1991 Session of the General Assembly and shall submit its final report to the 1992 Session of the General Assembly. Both reports shall comply with the procedures of the Division of Legislative Automated Systems for processing legislative documents.

The indirect costs of this study are estimated to be $23,950; the direct costs shall not exceed $34,200.