1995 ANNUAL REPORT OF

THE JOINT COMMISSION ON HEALTH CARE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 9

COMMONWEALTH OF VIRGINIA
RICHMOND
1997

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

Senator Stanley C. Walker
Chairman

Jane Norwood Kusiak
Executive Director

August 2, 1996

Suite 115
Old City Hall
1001 East Broad Street
Richmond, Virginia 23219
(804) 786-5445
FAX (804) 786-5538

TO: The Honorable George F. Allen, Governor of Virginia
and Members of the General Assembly

Pursuant to the provisions of the Code of Virginia (Title 9, Chapter 38, §§9-311 through 9-316) establishing the Joint Commission on Health Care and setting forth its purpose, I am submitting the Annual Report for the calendar year ending December 31, 1995.

This 1995 annual report includes a summary of the Joint Commission's 1995 activities and legislative recommendations to the 1996 General Assembly, and an overview of health care issues facing Virginia and the nation. Copies of the legislation sponsored by the Joint Commission and passed by the 1996 General Assembly also are included.

In addition to this annual report, a separate report was published as a House or Senate document for each study the Joint Commission conducted pursuant to a joint study resolution. The document numbers of the individual study reports we published in 1995 are identified on page 4 of this document.

The membership and staff identified in the following two pages reflects our status as of December, 1995. As many changes have occurred since that time, we have provided a current listing of our membership and staff in Appendix C. As of July 1, 1996, the chairmanship of the Joint Commission rotated to the Senate and the vice chairmanship rotated to the House of Delegates. Senate President pro tempore Stanley C. Walker from

Norfolk and founding Chairman of the Joint Commission resumed the chairmanship for a two-year term. Delegate Kenneth R. Melvin from Portsmouth was elected to serve a two-year term as Vice Chairman.

Sincerely,

Jane N. Kusiak
Executive Director

JOINT COMMISSION ON HEALTH CARE

Chairman
The Honorable Jay W. DeBoer

Vice Chairman
The Honorable Elliot S. Schewel

The Honorable Hunter B. Andrews
The Honorable Clarence A. Holland
The Honorable Edward M. Holland
The Honorable Benjamin J. Lambert, III
The Honorable Stanley C. Walker
The Honorable Jane H. Woods
The Honorable Thomas G. Baker, Jr.
The Honorable Robert B. Ball, Sr.
The Honorable David G. Brickley
The Honorable Julia A. Connally
The Honorable George H. Heilig, Jr.
The Honorable Kenneth R. Melvin
The Honorable Harvey B. Morgan
The Honorable Thomas W. Moss, Jr.

Secretary of Health and Human Resources
The Honorable Kay Coles James

JOINT COMMISSION ON HEALTH CARE

Staff

Director
Jane Norwood Kusiak

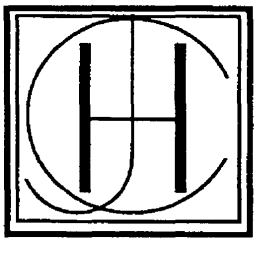
Senior Health Policy Analysts
Patrick W. Finnerty

Stephen A. Horan, Ph.D.

Office Manager
Mamie V. White

Acknowledgements

The Joint Commission extends its sincere appreciation to the Office of the Clerk of the Senate, the Office of the Clerk of the House of Delegates, the Division of Legislative Services, and the Division of Legislative Automated Systems for their assistance and support throughout 1995.



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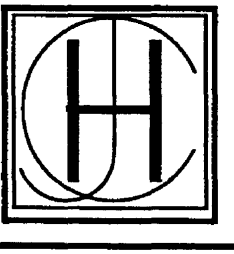
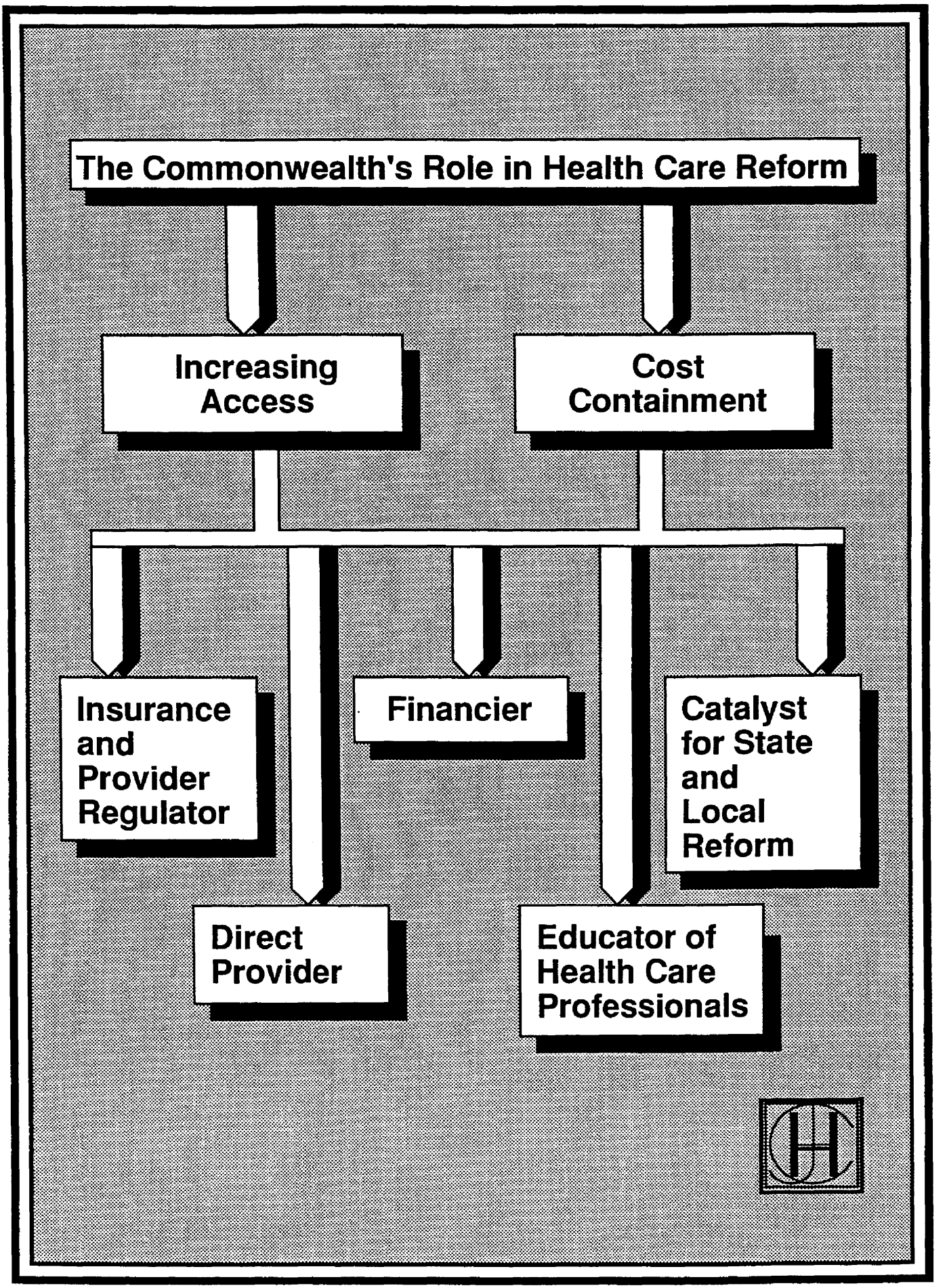



The Commonwealth's Role in Health Care Reform
Increasing Access
Cost Containment
Insurance and Provider Regulator
Financier
Catalyst for State and Local Reform
Direct Provider
Educator of Health Care Professionals

I. EXECUTIVE SUMMARY

AUTHORITY FOR STUDY

The Joint Commission on Health Care was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032. This sixteen-member legislative commission, with a separately staffed agency, continues the work of the Commission on Health Care for All Virginians (Senate Joint Resolution 118, 1990 Session).

1995 COMMISSION ACTIVITIES

The Joint Commission held eight meetings in 1995, as well as one additional meeting in January, 1996, prior to the 1996 Session of the General Assembly. All meetings were held at the General Assembly Building in Richmond. In addition to the agenda items identified below, monthly staff reports were presented at each meeting.

At the March 27th meeting, the final status of the Joint Commission's 1995 legislation, as well as the current status of Joint Commission on Health Care initiatives were reviewed. Additionally, the workplan for 1995 was presented and reviewed.

The April 24th meeting included a presentation by Steven T. Foster, Commissioner of Insurance, on the status of a settlement between the State Corporation Commission and Trigon BlueCross BlueShield to resolve allegations that Trigon had violated state insurance law.

Also at the April 24th meeting, a workplan for the Joint Commission's study on the value and utility of Virginia's cost and quality data initiatives was presented. A panel of experts reacted to the work plan and provided testimony regarding health care data initiatives. The panelists were Robert E. Hurley, Ph.D., Associate Professor, Department of Health Administration, Virginia Commonwealth University (VCU); Louis F. Rossiter, Ph.D., Director, Medical College of Virginia (MCV) Office of

Health Care Policy and Research; Ramesh K. Shukla, Ph.D., Director, MCV's Williamson Institute for Health Studies; and Wally R. Smith, M.D., Assistant Professor and Health Administrator, MCV Division of General Medicine.

During the May 22nd meeting, a staff report on telemedicine was presented. In addition, Karen S. Rheuban, M.D., Associate Dean for Continuing Medical Education and Associate Professor of Pediatric Cardiology at the University of Virginia (UVA), presented an example of a telemedicine consultation. Laura Adams, Director of Operations, Telemedicine Center Medical College of Georgia, gave an overview of Georgia's telemedicine program. Following these presentations, a panel of experts provided testimony and answered questions regarding telemedicine. The panelists were Laura Adams, Hudnall R. Croasdale, Director, Council on Information Management, Charles C. Livingston, Director, Department of Information Technology, and Karen S. Rheuban, M.D.

The May 22nd meeting also included a staff report on organizing and funding poison control services in the Commonwealth. The meeting concluded with a presentation by Toby Litovitz, M.D., Director, National Capital Poison Center.

The July 24th meeting included presentations on the organization and effectiveness of health workforce initiatives and the value and utility of current health care cost and quality data initiatives. A summary of the public comments received on the two studies presented at the May 22nd meeting was provided.

During the August 28th meeting, Jack O. Lanier, DR.P.H., FACHE, Chairman and Professor, Department of Preventive Medicine, Medical College of Virginia/VCU, gave an overview of Virginia's Area Health Education Centers Program. The August 28th meeting also included reports on obstetrical care in rural areas and long-term care pharmacy operations. Lastly, a summary of public comments received on the reports presented at the previous meeting was provided.

The October 2nd meeting was attended by members of the Health and Human Resources Subcommittee of Senate Finance and House Appropriations and the Joint Subcommittee on Deinstitutionalization. A status report was presented by Robert C. Metcalf, Director, Department of Medical Assistance Services on Federal Medicaid Block Grant Proposals and the Department's proposed Medicaid Managed Care Implementation

Plan. Timothy A. Kelly, Ph.D., Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services, presented an update on the mental health component of the Medallion II project. The executive directors of the Virginia Association of Community Services Boards and the Virginia Alliance for the Mentally Ill commented on his report.

Staff reports on: (i) the impact of third party reimbursement on pharmacies; and (ii) pharmaceutical care delivery programs also were presented at the October 2nd meeting.

The November 20th meeting included a presentation by Katharine M. Webb, Senior Vice President of the Virginia Hospital and Healthcare Association (VHHA) and Richard G. Steele, Executive Vice President of Southeastern Institute of Research, Inc. on a study commissioned by the VHHA regarding Virginia's consumer and business interests in cost and quality information. A brief follow-up on the cost and quality study also was presented.

Commissioner of Insurance, Steven T. Foster, reported on the Bureau of Insurance's study of individual insurance market reforms and other related insurance issues. Additionally, a staff report was presented on the pre-hospital and inter-hospital triage of trauma patients in Virginia. Lastly, summaries of public comments on the obstetrical care and long-term care pharmacy operations studies were provided.

Secretary Kay Coles James presented a report on her proposal for a Medicaid block grant planning process at the December 4th meeting. A decision matrix which summarized each issue studied by the Joint Commission during 1995, along with a recap of the options presented for addressing each issue, was presented and discussed.

Recommendations regarding each of the various issues studied by the Joint Commission throughout 1995, as well as potential legislation to be introduced during the 1996 Session of the General Assembly were presented at the meeting on January 11, 1996. Final decisions regarding potential 1996 legislation were made.

INDIVIDUAL STUDY REPORTS PUBLISHED BY THE JOINT COMMISSION ON HEALTH CARE

The Joint Commission conducted numerous studies throughout 1995. Prior to 1994, the Joint Commission incorporated the written reports from each study into the annual report. However, since 1994, the Joint Commission has prepared a separate report on each study that was conducted pursuant to a study resolution. This practice was continued in 1995. These reports, called "issue briefs," were presented to the Joint Commission at its monthly meetings.

Copies of each issue brief were distributed to persons attending the meeting at which the study was presented to the Joint Commission, as well as other interested parties who requested a copy. Public comments were received on each issue brief and presented to the Joint Commission at the next monthly meeting. Following the public comment period, each issue brief was finalized and printed as either a House or Senate Document. Figure 1 identifies each of the Joint Commission's studies which were printed as separate documents.

Figure 1
Individual Study Reports Published by the Joint Commission on Health Care: 1995

Name of Study	House/Senate Joint Resolution	House/Senate Document
Health Workforce Initiatives	SJR 308	Senate Document 5
Access to Obstetrical Care for the Women of Rural Virginia	SJR 331	Senate Document 13
Need for and Efficacy of a Statewide Trauma Triage Plan	SJR 353	Senate Document 23
Telemedicine	HJR 159	House Document 6
Health Care Cost and Quality Data Initiatives	HJR 513	House Document 11
Long-Term Care Pharmacy Operations	HJR 642	House Document 12

NOTE: All joint resolution numbers are from the 1995 General Assembly Session. All House/Senate Document numbers are 1996 document numbers.

1996 LEGISLATIVE PROPOSALS

As a result of the work completed by the Joint Commission during 1995, a series of legislative proposals was introduced during the 1996 Session of the General Assembly. The following paragraphs identify each legislative proposal. For each legislative proposal, the parenthetical expression indicates the 1996 General Assembly's actions on the recommendation. A copy of each bill and resolution approved by the General Assembly is provided in Appendix A.

Health Workforce

Proposed Legislation

1. A joint study resolution (SJR 72) requesting Virginia's academic health centers to evaluate their programs for obstetrical training of family medicine residents. This resolution emanated from a study of this issue published as Senate Document 13.

   (Resolution adopted by General Assembly.)

2. A joint resolution (HJR 110) requesting the Commissioner of Health to create a task force of the Department of Health and various medical associations and societies to establish standards and protocols as professional guidelines for obstetrical care. This resolution emanated from a study of this issue published as Senate Document 13.

   (Resolution adopted by General Assembly.)

Health Insurance/Access to the Uninsured

Proposed Legislation

1. Legislation (HB 700) which extends the small group insurance reforms (limits on pre-existing conditions, portability, guaranteed renewability, and no exclusions from the group) to groups up to 99 employees.

   (Legislation approved by General Assembly.)

2. Legislation (HB 835) which clarifies that Medicare, Medicaid, CHAMPUS, other publicly funded health care programs and HMOs are included in the types of coverage for which small group enrollees receive credit for serving waiting periods.

   (Legislation approved by General Assembly.)

3. Legislation (HB 1026) which requires guaranteed renewability of individual health insurance policies. Second enactment clause directs Joint Commission and Bureau of Insurance to study additional individual reforms.

   (Legislation approved by General Assembly.)

Health Care Cost and Quality

Proposed Legislation

1. Legislation (HB 1302) which replaces the current Certificate of Public Need (COPN) process for nursing home beds with a "Request for Applications" process.

   (Legislation approved by General Assembly.)

2. Legislation (HB 1307) which improves the Commonwealth's health care cost and quality data functions by eliminating little-used data projects, and consolidating data functions in Virginia Health Information, Inc. (VHI). This bill emanated from a study of this issue published as House Document 11.

   (Legislation approved by General Assembly.)

3. Legislation (SB 367) which would transfer the licensing and regulatory functions of adult care residencies, district homes of the aged and adult day care centers from the Department of Social Services to the Department of Health.

   (Legislation not approved by General Assembly.)

4. A joint study resolution (SJR 58) requesting the Commissioner of Health to convene a task force to develop a draft statewide hospital

and inter-hospital trauma triage plan. This resolution emanated from a study of this issue published as Senate Document 23.

(Resolution adopted by General Assembly.)

5. A joint resolution (HJR 109) requesting the Secretaries of Administration and Health and Human Resources to develop a policy for considering reimbursement for telemedicine services by state health programs. This resolution emanated from a study of this issue published as House Document 6.

(Resolution adopted by General Assembly.)

Other Proposed Legislation

1. Legislation (HB 1306) to continue the Joint Commission on Health Care until June 30, 2002.

(Legislation approved by General Assembly.)

STATUS OF PAST INITIATIVES

Since its inception, the Joint Commission on Health Care has implemented or coordinated the implementation of numerous health care reform initiatives. In addition, other health care initiatives related to the work of the Joint Commission have been instituted. Each year, a report on the status of these initiatives is presented to the Joint Commission. The most recent status report, which was completed in April, 1996, is provided in Appendix B.

II. HEALTH CARE ISSUES FACING VIRGINIA AND THE NATION

NATIONAL AND STATE HEALTH CARE REFORM STRATEGIES

The prospect of comprehensive national health care reform that began in 1993, and wilted in 1994, barely was discussed at all during 1995. While there are still efforts underway in Washington to implement incremental health insurance reforms, comprehensive reform of the health care system is no longer on the national agenda.

Moreover, of the handful of states which had taken bold initial steps to set the groundwork for comprehensive reforms, few have been able to sustain their momentum long enough to take the next steps toward actually implementing these reforms. In fact, some of these states have passed legislation which significantly scaled back their reform strategies.

Despite the "retreat" from system wide reform, the same complex set of health care issues continues to perplex and frustrate federal and state government policy makers, providers, insurers, employers, and consumers. This is not to say, however, that no progress has been made. Many states have moved to a more incremental approach in addressing these issues, and, like Virginia, have found this approach to be more manageable, and the objectives more attainable.

The following list of state actions evidences the incremental reforms taking place across the nation:

* forty-four states, including Virginia, have enacted small-group market reforms to guarantee access to health insurance for groups with individuals who have pre-existing medical conditions;

* eleven states now require that insurers guarantee the issuance of insurance policies in their individual insurance markets to

broaden access to coverage for individuals with high risk medical conditions;

* twenty states, including Virginia, have enacted some form of community rating for certain segments of their health insurance markets to spread the cost of high risk persons across a broader pool of insureds;

* at least 20 states are encouraging managed competition experiments, such as purchasing alliances that allow small groups to purchase collectively and command more choice and better prices on health insurance; and

* a number of states, including Virginia, have instituted managed care programs for their Medicaid populations to help curb cost increases; some states have used these savings to expand coverage to new populations.

This chapter describes the changing health care market and the status of health care costs, quality and access in the nation and the Commonwealth. It is against this backdrop that Virginia must navigate its way through further improvements in the health care system during 1996 and beyond.

TRANSFORMATION OF THE HEALTH CARE MARKETPLACE

During 1995, the transformation of the health care marketplace continued at an even faster pace. While federal and state health care policies have prompted some of this transformation, the market itself is responsible for much of the dramatic change that is occurring.

Change is evident in virtually every aspect of the health care marketplace. However, some of the most significant changes have been in the health care delivery system. Specifically, the health care delivery system has seen tremendous shifts in who provides care, how care is delivered, and how providers are compensated for their services.

Consolidation And Integration Of Health Care Providers Is Increasing

As public and private purchasers continue to look for ways to trim costs from their employee benefit plans, and other health care consumers become increasingly cost-conscious, providers have had to find ways of trimming their own costs to remain competitive.

Excess capacity in hospitals and in the number of specialist physicians has led many providers (i.e., physicians and hospitals) to consolidate and merge operations, facilities and resources with other providers. Physicians are forming cooperative arrangements and merging with other physicians and hospitals. Hospitals are merging with each other while creating networks of affiliated physicians in record numbers. In addition, health plans are forming increasingly integrated networks of physicians and hospitals. Mergers and acquisitions of hospitals, physician group practices, medical laboratories and other patient care organizations increased from $6 billion in 1992 to about $20 billion in 1994. (Eckholm, 1994.)

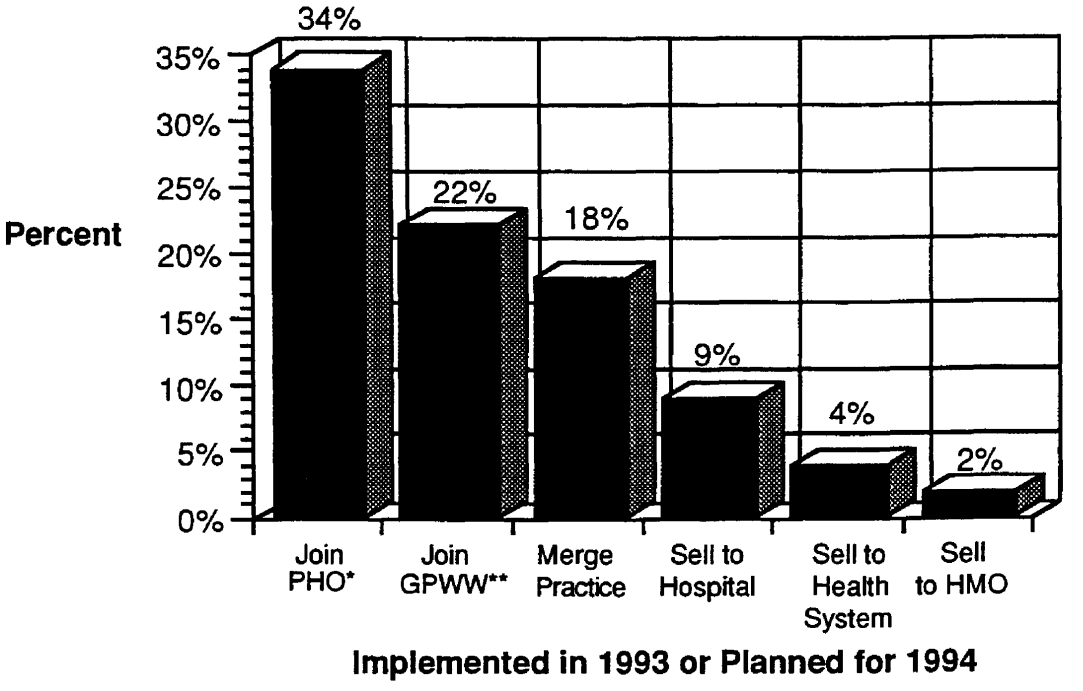
Eighty-one percent of 1,200 acute care hospital executives surveyed in 1994 stated that their hospitals would not be free-standing within five years. To remain competitive, these executives said they would join a network to share services and facilities. In another study of 400 large hospitals, 45% of the hospitals had formed an integrated delivery system within the last year. Another 58 integrated delivery systems were expected to be formed by these hospitals in the coming year. (Kenkel, 1995.)

The consolidation and integration of providers also applies to physicians. Figure 1 illustrates the extent to which office-based physician practice changes occurred across the country in 1993 or were planned for 1994. This information is just one indication of how providers are reacting to the changing health care marketplace. Indications are that this trend continued throughout 1995 and into 1996.

Providers are also forming integrated systems as well, with some adding managed care products; thus, entering the health insurance business. For example, market change is evident here in Virginia with the development and implementation of QualChoice, a Health Maintenance Organization (HMO) initiated by the University of Virginia (UVA) Medical Center. As part of its efforts to make the UVA Medical Center more competitive in today's managed care market, QualChoice provides a means of directing managed care patients to the hospital and its physicians rather than having other insurers and HMOs potentially direct patients away from the hospital and other associated providers.

Figure 1

Office-Based Physician Practice Changes Implemented in 1993 and Planned for 1994



* PHO: Physician - Hospital Organization

** GPPW: Group Practice Without Walls is a network of physicians who practice in independent locations but are merged for administrative purposes; assets are purchased by the network, separate offices are maintained.

Source: Terry, Ken, "Grabbing the Bandwagon of Change, " Medical Economics, 10/94

In response to the competitive pressures of the health care marketplace, both the University of Virginia Medical Center and Virginia Commonwealth University's Medical College of Virginia had legislation introduced during the 1996 General Assembly Session to give their respective hospitals more autonomy in their operations. In passing this legislation, the General Assembly recognized the need for these teaching institutions to be constrained less by government requirements and be able to respond more quickly to changing market dynamics.

The Changing Marketplace Raises Key Public Policy Issues For The Commonwealth

As the marketplace continues its transformation, it will be important for the Commonwealth to allow the market to adapt itself to changing demands and at the same time ensure that the market responds to its citizens' health care needs. It also will be important for the Commonwealth's health care purchasing programs (i.e., the Medicaid and state employee health benefits programs) to recognize these market changes and adjust their purchasing strategies accordingly. Finally, in its role as a health care provider, the Commonwealth must not only react to market developments but anticipate market changes to make certain that its academic medical centers remain viable, competitive and financially sound.

MANAGED CARE HAS BECOME THE DOMINANT DELIVERY SYSTEM

Perhaps more than any other change, the rapid expansion of managed care delivery systems is the most pervasive change in the health care marketplace today. Without question, managed care has become the dominant health care delivery system in the United States and has implications for providers, insurers, purchasers and consumers.

Managed care can be defined in many ways and can involve different levels of care management. In its simplest form, managed care may include pre-certification of hospital stays or utilization review to ensure services are medically necessary. However, more and more of the marketplace is moving to the more advanced form of managed care in which patients have limited choices of providers and access to care is coordinated and managed by a primary care provider.

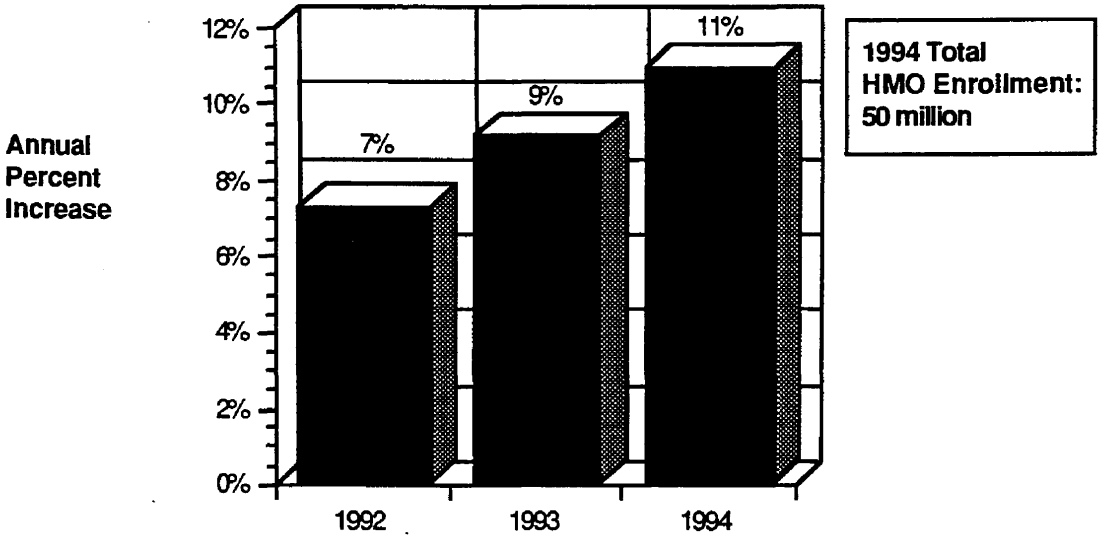
Dramatic Growth Is Seen In Managed Care Plans

Evidence of the move to managed care abounds and can be measured in numerous ways. In 1994, 65 percent of the nation's workers employed by large companies (200 or more employees) were enrolled in managed care plans, including HMOs, preferred provider organizations (PPOs), or point-of-service (POS) plans. In 1990, this percentage was less than 50 percent. According to the Group Health Association of America (GHAA), nationwide enrollment in HMOs increased by 5.3 million people (11%) in 1994, representing the single largest one year jump ever recorded by the

industry trade group. Figure 2 illustrates the increases recorded over the past few years.

Figure 2

Annual Increases in National HMO Enrollments 1992 - 1994

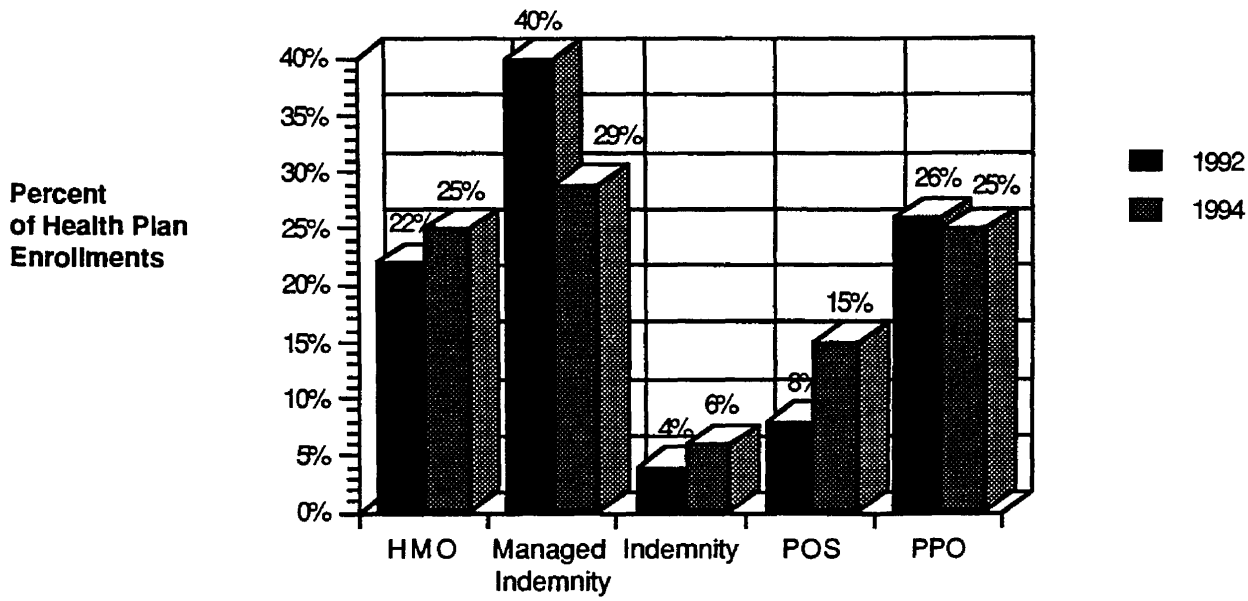


Source: Dimmit, Barbara; "Managed Care Organizations," The State of Health Care in America, Business and Health Magazine, 1995

The growth in managed care enrollment across the country has not been limited to HMOs. Point-of -service (POS) plans, which provide benefits to HMO enrollees who receive care outside the provider network, also have seen significant growth while most indemnity plans have seen marked declines in enrollments. Figure 3 illustrates these shifts in enrollment.

Figure 3

Trends In National Health Plan Enrollments
1992 - 1994



Source: KMPG, Peat Marwick, National Survey of Employer-Sponsored Health Plans, 1992, 1994.

The American Managed Care & Review Association reports that total enrollment in managed care plans has increased from 93 million persons in 1992 to 157 million in 1995, a 69% increase in just three years.

State Benefit Programs Have Moved To Managed Care

While Virginia's move to managed care has not been at the pace seen in some parts of the country, it nonetheless has been significant. In 1992, the state employee benefits program implemented a statewide PPO/primary care physician managed care program (Key Advantage) for all employees. With Key Advantage and the existing HMO offerings, all state employees have been enrolled in a managed care program since 1992.

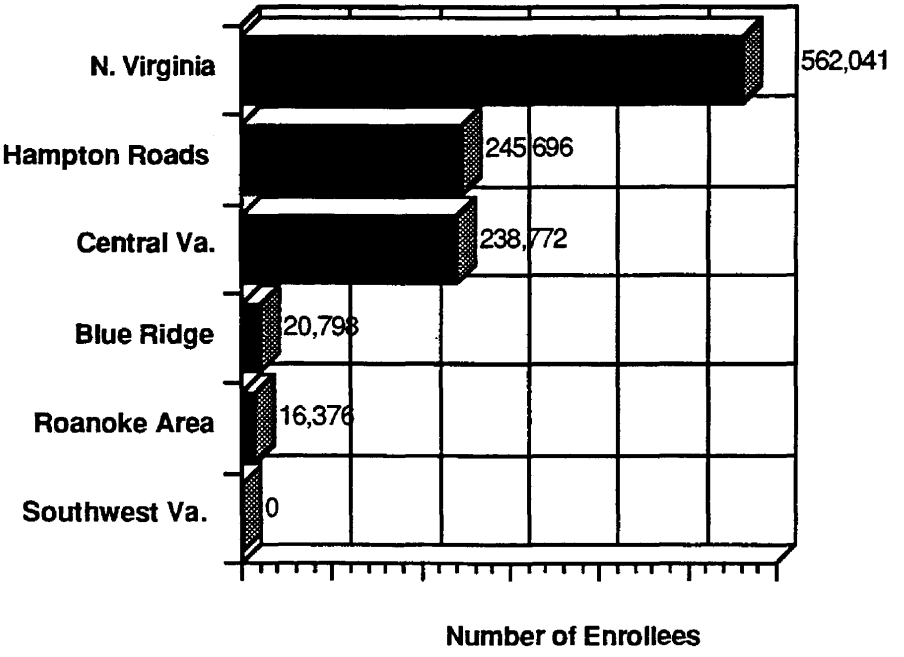
The state Medicaid program also has moved much of the Medicaid population into managed care. As of April, 1996, 372,818 Medicaid clients

were eligible for managed care. Of this number, 201,402 recipients were enrolled in the Medallion program (primary case management program). Another 36,203 were enrolled in the Options HMO program (voluntary capitated managed care program), while 93,835 were enrolled in the Medallion II program (mandatory HMO coverage) that was implemented January 1, 1996, in Tidewater. The remaining 41,378 were in the process of being enrolled in one of these three programs. Additional Medicaid recipients will be enrolled in Medallion II as the program is implemented in other parts of the Commonwealth.

HMO Enrollments In Virginia Have More Than Doubled In The Past Six Years

The number of Virginians enrolled in HMOs has increased 140% since 1990. HMOs enrolled more than 1 million persons in 1995 providing coverage to one out of every six Virginians. As seen in Figure 4, much of Virginia's HMO enrollees live in Northern Virginia, the Hampton Roads

Figure 4
HMO Enrollments in Virginia: 1995
Total Enrollment: 1,083,683



Note: Hampton Roads enrollment does not include 93,835 Medallion II enrollees.
Source: Virginia Association of HMOs

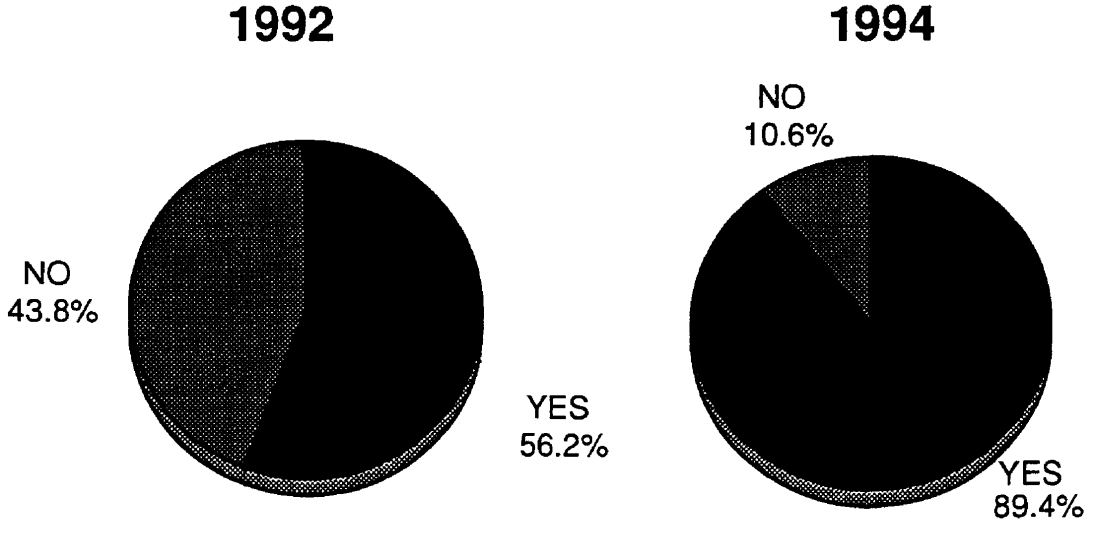
area and Central Virginia. However, new managed care plans are developing in the Blue Ridge, Roanoke and Southwest Virginia areas which will increase further managed care's penetration in the Commonwealth.

Managed Care Has Significant Impact On Provider Practices

The growth of managed care has had a rapid and profound impact on physicians, hospitals and other providers as they have had to adapt their clinical and business practices to function in a managed care environment. The impact of managed care on providers is clearly illustrated in Figures 5 and 6. Figure 5 indicates that in just three years, the number of medical group practices with HMO and PPO contracts has increased from 56% in 1992 to 89% in 1994 indicating that nearly all providers are contracting with managed care organizations for some portion of their patient populations.

Figure 5

Medical Group Practices With HMO/PPO Contracts

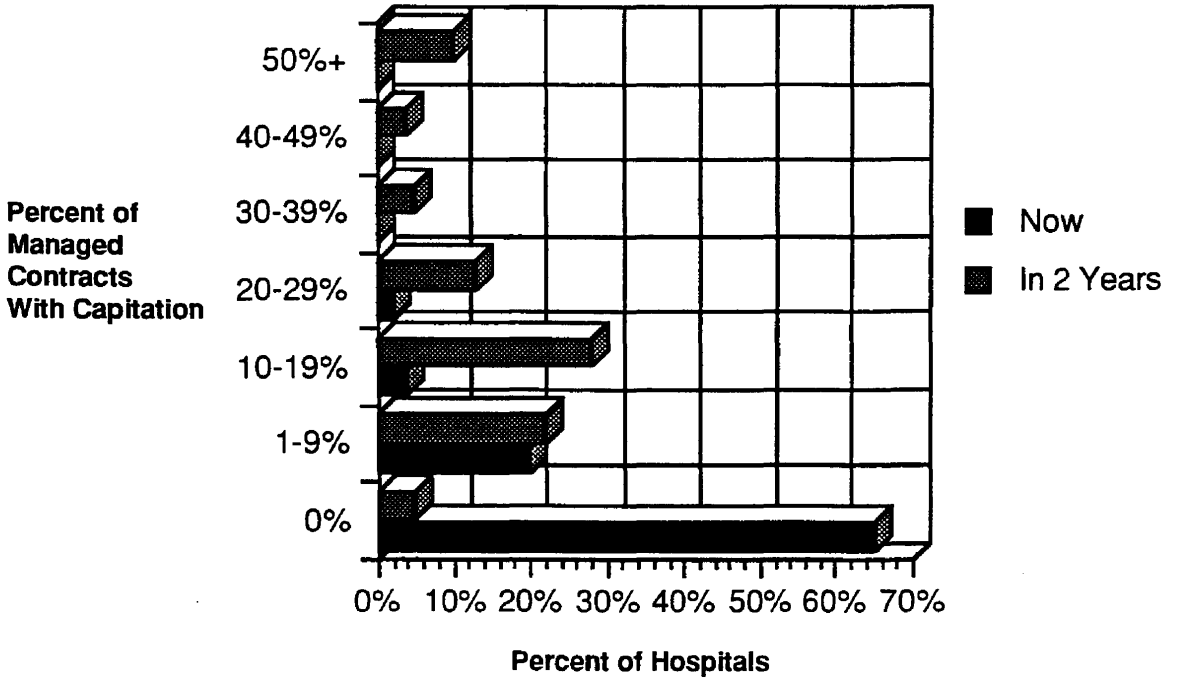


Source: Marion Merrell Dow, Inc., *Managed Care Digest*, Medical Group Practice Edition, 1994; *Activities and Trends Survey*, Medical Group Management Association, 1994

Managed care has affected hospital operations as well. Fewer hospitalizations and shorter lengths of stay have pushed hospitals to retool their operations and become more efficient. Hospitals are being pressed by purchasers to be more efficient, and, at the same time, to improve patient outcomes. However, hospitals expect the impact to be even more pronounced in the next two years. As illustrated in Figure 6, approximately 65% of the nation's hospitals currently have no capitated managed care contracts; however, within two years only about 5% of hospitals believe they will continue to have no capitated managed care contracts. Similarly, while only about 4% of hospitals now have 10-19% of their managed care contracts on a capitated basis, nearly 28% of hospitals believe these capitated contracts will comprise 10-19% of their managed care business in two years.

Figure 6

Percentage of Hospitals Reporting Capitated Managed Care Contracts



Source: Hospitals and Health Networks, 1994; Nichols, Len; Urban Institute

Balancing Effective Managed Care Strategies With Patient/Provider Concerns Poses Difficult Public Policy Issues

As managed care continues to expand, and providers and patients increasingly become affected by its clinical and financial influences, there likely will be increased legislative debate over the degree to which the Commonwealth should monitor and regulate managed care. Legislation passed in the 1996 General Assembly (e.g., patient protection provisions, minimum maternity length of stay, and direct access to obstetricians/gynecologists) is evidence of this growing concern. Moreover, the Joint Commission on Health Care has been directed to study several managed care issues during 1996.

Without question, managed care, in some form, is here to stay. A critical health care issue facing Virginia in the coming years will be to develop and adapt a statutory framework that enables managed care organizations and programs to meet their objectives of managing care and controlling costs, and ensures access to quality care for patients and a fair and competitive market for providers.

HEALTH CARE COSTS, ACCESS AND QUALITY

For Virginia's health care system to be truly effective, all Virginians must have access to affordable, high quality health care services. While health care cost trends have subsided somewhat during the past few years, health care spending continues to be a major concern of all purchasers, including governments, businesses, families, and individuals. As cost controls remain in the forefront, efforts to improve the quality of care also must continue. Many Virginians are still without health insurance coverage, and as a result are more likely to go without primary care services, and develop conditions which could have been prevented or more successfully treated with early intervention. In some areas of the state, even those with coverage still lack access to certain health care services due to provider shortages.

While The Most Recent Data Indicate Only Minimal Increases, Health Care Spending Still Outpaced Spending In Other Categories

National health expenditures (NHE) approached $1 trillion in 1994 totaling $949.4 billion. After five years of double-digit and near-double-digit growth in aggregate health care spending from 1988 to 1992, growth slowed to 7 percent in 1993 and 6.4 percent in 1994. The 6.4 percent increase in 1994 marked the slowest growth rate in more than three

decades. Slower than average growth in health spending, combined with healthy growth in the gross domestic product (GDP) led to only a small increase in health care spending as a share of the GDP; from 13.6 percent in 1993 to 13.7 percent in 1994. (Levit, et al, 1996.) This increase in the share of the GDP shows that although health care spending for 1994 had the slowest growth in many years, it still continued to grow faster than the overall economy.

In terms of per capita spending, the NHE data indicated that spending per person rose 5.4 percent from $3,331 in 1993 to $3,510 in 1994.

Figure 7 identifies the various sources of the nation's health care dollar and how these monies were spent in 1994. As seen in these charts, 45 percent of the nation's health dollar in 1994 came from public financing (i.e. Medicare, Medicaid, Other Government Programs). Private health insurance contributed 33 percent of the nation's health dollar, while out-of-pocket dollars and other private funds contributed 18 percent and 4 percent respectively.

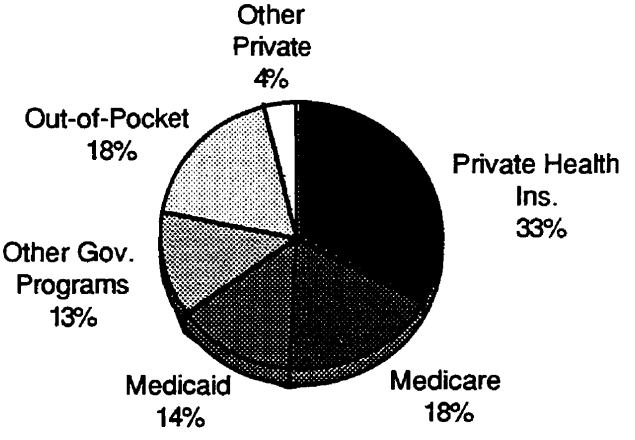
In terms of how the nation's health dollar was spent, hospital care continued to be the largest single component totaling 36 percent of expenditures. Other personal health care (dental, professional services, home health care, drugs and other non-durable medical products) was the next largest component (24%), followed by physician services (20%), other spending (12%) and nursing home care (8%).

While increases in health care spending have subsided somewhat in recent years, it is important to recognize that inflation in medical prices and insurance premiums still outgained general inflation. In the absence of continued health care reform, health care spending will exact even greater financial burdens on governments, businesses and individuals. Moreover, the opportunity costs associated with increasing health care expenditures prohibit government from spending additional dollars on other important programs such as education, economic development and public safety.

Figure 7

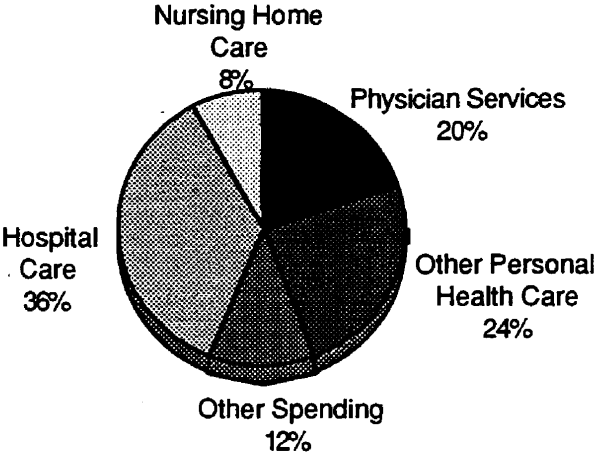
The Nation's Health Care Dollar: 1994

Where it Came From



Notes: "Other Private" includes industrial in-plant health services, non-patient revenues, and privately financed construction.

Where it Went



Notes: "Other Personal Health Care" includes dental, other professional services, home health care, drugs and other non-durable medical products, vision products and other durable medical products, and other miscellaneous health services. "Other Spending" covers program administration and the net cost of private health insurance, government public health, and research and construction.

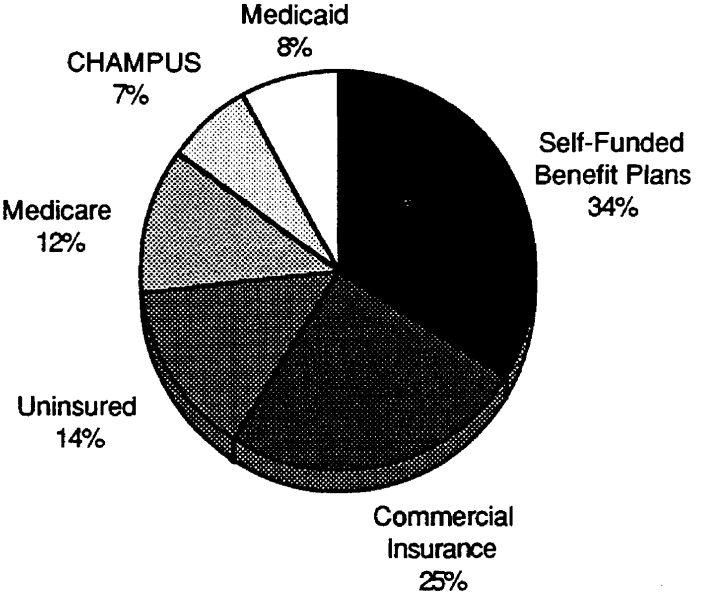
Source: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics; Health Care Financing Review, Spring, 1996.

Access To Insurance And Health Care Services Remains An Issue Of Concern In Virginia

One of the consequences of increasing health care costs is the impact these costs have on the ability of Virginians to afford health insurance. The most recent data (1992) on the uninsured in Virginia indicate that approximately 1 million persons are without health insurance coverage of any kind. A 1993 survey by the Survey Research Laboratory at Virginia Commonwealth University showed that while lack of insurance is a statewide problem (14% uninsured), it is more pronounced in the Central and Eastern regions where the uninsured rate is 16 and 15 percent respectively.

Figure 8

Health Insurance Status of Virginians: 1992



Source: Virginia Commonwealth University Survey Research Laboratory, U.S. Health Care Financing Administration, CHAMPUS, Joint Commission on Health Care Staff.

Research indicates that persons without health insurance are less likely than those with insurance to receive needed medical services such as immunizations and routine check-ups. As a result, they are more likely to develop conditions which could have been prevented or more successfully treated with early intervention and primary care.

Insurance Market Reforms Have Helped Make Coverage More Available, But Further Reforms Are Needed

Historically, small groups and individuals have had the most difficulty obtaining affordable comprehensive coverage. It is for this reason that Virginia has adopted insurance reforms in the small group and individual markets to expand access to coverage. However, initial results of the small group market reforms indicate they have had little impact thus far in expanding the number of small groups purchasing coverage. While the small group reforms were implemented only recently, it appears that further work will be needed to refine the Essential and Standard benefits plans (the guaranteed issue products) to make them more attractive to small groups. Other refinements to the reform legislation also may be needed to increase the number of small groups purchasing coverage.

In the individual market, some progress in expanding access to coverage has been made by reducing waiting periods for pre-existing conditions, requiring carriers to provide credit for waiting periods served in previous coverage, and requiring guaranteed renewability of coverage. However, guaranteed issue and modified community rating of at least the Essential and Standard plans likely would reduce further the number of uninsured persons in this market. These reforms should be considered in 1996.

Consumer Information Assessing The Quality Of Health Care Services, Providers, And Health Plans Is Still Needed

One of the more difficult problems in the health care system is the continued lack of clear, valid, comparable data on the cost and quality of health care services, providers and health plans. For the health care market to function more effectively, consumers and purchasers of health care services need understandable data that accurately assesses the cost and quality of key components of the market.

Demands by government and business purchasers as well as individual consumers have led to the development of internal data systems by providers and health plans that have helped these entities track and improve the cost and quality of their services and operations. However, most of this information is for internal use and not generally available to the public.

There are a number of cost and quality data initiatives ongoing at the national and state level to provide information to consumers. The

National Committee on Quality Assurance (NCQA) has continued to develop its capabilities in measuring the quality of health plans. NCQA's primary involvement over the past several years has been the development and refinement of an accreditation process for health plans and the Health Employer Data and Information Set (HEDIS) which is a standard measure for health plan performance.

NCQA recently announced the creation of a national database - *Quality Compass* - which will provide data on HMO quality. Expected to be operational in August, 1996, *Quality Compass* will integrate and make accessible summary accreditation information and HEDIS data. This project will, for the first time, make available national and regional benchmarks to which individual HMOs' performance and quality can be compared. The information will help purchasers and consumers make comparisons among plans on quality and performance.

There are also health data activities underway in Virginia, both in the private and public sectors. The Richmond Area Business Group on Health and the Commonwealth Health Care Coalition have been working with several HMOs and the Williamson Institute at Virginia Commonwealth University to have the HMOs submit HEDIS data to be included in a comparative report.

The Commonwealth Has Implemented A New Strategy For Producing Health Care Cost And Quality Data; Data Initiatives Must Produce Useful Information For Purchasers, Providers, And The Consumer

The Commonwealth recently has moved in a new direction to develop and disseminate health care cost and quality information. For a number of years, the Virginia Health Services Cost Review Council (VHSCRC) issued several annual reports on the cost of hospital and nursing home services, including a methodology for measuring the efficiency and productivity of these institutions. However, a study conducted last year by the Joint Commission on Health Care found that most of these reports had limited use and value in the marketplace. As a result of this study, the General Assembly passed legislation sponsored by the Joint Commission to eliminate the VHSCRC and those reports found to have little value. The legislation places responsibility for administering health care data functions with Virginia Health Information (VHI), a private, non-profit corporation. (Since 1993, VHI has been administering the patient level data base as part of the Commonwealth's overall data initiatives.)

VHI's Board of Directors, which includes business, consumer, state government, provider and insurer representatives, has been tasked with developing a strategic plan aimed at identifying data projects that will generate information to help purchasers and consumers make better-informed decisions about their health care purchases. VHI will be including in its recommendations ways to measure the quality of providers and health plans. In developing the strategic plan, VHI is required to take into account the resources and expertise for measuring and analyzing health care costs and quality that exist elsewhere in the Commonwealth and at the national level (e.g., NCQA).

While there have been some significant developments aimed at improving the usefulness and availability of cost and quality data for purchasers and consumers, in Virginia, there still exists precious little information that purchasers and consumers are able to obtain and use in making their health care purchasing decisions. Of particular importance is the lack of data projects that measure the quality of health care services, providers, and health plans. The Commonwealth must continue to foster the development of useful data for this purpose, while, at the same time, ensuring that resources spent on data initiatives are producing valuable products in the marketplace.

VIRGINIA'S CONTINUING HEALTH CARE CHALLENGE

Virginia faces a myriad of health care issues that continue to challenge the abilities and resources of the Commonwealth and its citizenry. It is clear that, for at least the foreseeable future, it will be the states and not the federal government that attempt to address these difficult issues. Issues of controlling costs, improving the quality of care and expanding access to insurance and health care services are exacerbated by a health care marketplace that can best be characterized as a "moving target." In this environment, simply reacting to the present holds little promise for material improvement in Virginia's health care system. Improvement and sustained progress will require continued analysis of future trends and market shifts and reasoned policy decisions that improve the quality and efficiency of Virginia's health care system.

The issues presented in this report represent only a fraction of those which must be addressed if there are to be improvements in the affordability, quality and accessibility of our health care system. Providing, managing and financing acute and long-term care services for low-income persons; financing medical education; educating, recruiting and retaining primary

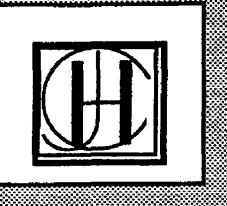
care providers, with particular emphasis on providers in medically underserved areas; ensuring access to care for the medically indigent; maintaining the viability of the state's academic medical centers; and managing the excess capacity in the health care marketplace are just some of the other issues that require continuing attention. Appendix B contains information on the status of many of these other initiatives. The status of efforts to improve and expand primary care services throughout the Commonwealth is provided in pages 6 through 26 of Appendix B; the status of long-term care initiatives is discussed on pages 59 through 64.

Unprecedented changes in the delivery and financing of care, particularly the move to managed care systems, have had a widespread impact on providers, patients and purchasers alike. The Joint Commission on Health Care will focus much of its attention on managed care issues during 1996. However, the long-term challenge ahead encompasses many aspects of Virginia's health care system and will require a cooperative effort by the Commonwealth, its citizens and other stakeholders to meet the challenge.

APPENDICES

APPENDIX A:

1996 Legislation



Joint Commission on Health Care
1996 Legislation
(As Approved)

House Bills:	Description
HB 700	Expands the size of small groups (from 49 to 99 employees) which are subject to small group insurance reforms including guaranteed renewability of coverage, reduced waiting periods for pre-existing conditions, and credit for waiting periods served in previous coverage.
HB 835	Adds Medicare, Medicaid, other similar publicly sponsored programs and HMO's to the types of coverage for which small group employees receive credit for serving waiting periods due to a pre-existing condition.
HB 1026	Requires individual health insurance policies, contracts and plans to provide for the renewability of coverage at the sole option of the insured; and requests the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to study additional reforms in the individual health insurance market.
HB 1302	Establishes a "Request for Applications" process for reviewing nursing home bed needs under COPN; directs Department of Health to study whether higher level adult care residences should be subject to COPN; does not extend nursing home moratorium.
HB 1306	Continues the Joint Commission on Health Care for an additional five-year period.
HB 1307	Eliminates the Virginia Health Services Cost Review Council; merges the efficiency and productivity methodology for health care institutions into the activities of Virginia Health Information, Inc. (VHI); and transfers responsibility for contracting with VHI to the Department of Health.

Joint Commission on Health Care
1996 Legislation
(As Approved)

Senate Joint Resolutions:	Description
SJR 58	Requests the Office of Emergency Medical Services to develop a draft statewide pre-hospital and inter-hospital trauma triage plan.
SJR 72	Requests Virginia's academic health centers to evaluate their programs for obstetrical training for family medicine residents.

House Joint Resolutions:	Description
HJR 109	Requests the Secretaries of Administration and Health and Human Resources to develop a policy for considering reimbursement for telemedicine services by state health programs.
HJR 110	Requests the Virginia Academy of Family Practice, the Virginia Obstetrical and Gynecological Society, and the Virginia Department of Health to form a joint task force for the purpose of establishing standards and protocols for obstetrical care.

CHAPTER 262

An Act to amend and reenact § 38.2-3431 of the Code of Virginia, relating to health insurance; small employer market.

[H 700]

Approved March 19, 1996

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3431 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3431. Small employer market.

A. Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers coverage to the small employer or primary small employer market shall be subject to the provisions of this article if any of the following conditions are met:

1. Any portion of the premiums or benefits is paid by or on behalf of the small employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

3. The small employer has permitted payroll deduction for the covered individual or any portion of the premium is paid by the small employer; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of §§ 106, 125, or 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a small employer carrier is in compliance with the provisions of this article based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

"Carrier" means any person that provides one or more health benefit plans or insurance in this Commonwealth, including an insurer, a health services plan, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, a third party administrator or any other person providing a plan of health insurance subject to the authority of the Commission.

"Community rate" means the average rate charged for the same or similar coverage to all primary small employer groups with the same area, age and gender characteristics. This rate shall be based on the carrier's combined claims experience for all groups within its primary small employer market.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of thirty or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee.

"Essential and standard health benefit plans" means health benefit plans developed pursuant to subsection D of this section.

"Established geographic service area" means a broad geographic area of the Commonwealth in which a carrier sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. Health benefit plan does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance

arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Initial enrollment period" means a period of at least thirty days.

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer after the initial enrollment period provided under the terms of the health benefit plan.

"Preexisting conditions provision" means a policy provision that limits, denies, or excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care, or treatment was recommended or received within twelve months of the effective date of coverage.

"Premium" means all moneys paid by a small employer and eligible employees as a condition of coverage from a carrier, including fees and other contributions associated with the health benefit plan.

"Primary small employer," a subset of "small employer," means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed no more than twenty-five eligible employees and not less than two unrelated eligible employees, except as provided in subdivision A 2 of § 38.2-3523, the majority of whom are enrolled within this Commonwealth. Primary small employer includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a primary small employer shall apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this subsection.

"Rating period" means the twelve-month period for which premium rates are determined by a small employer carrier and are assumed to be in effect.

"Small employer" or "small employer market" means any person actively engaged in business that, on at least fifty percent of its working days during the preceding year, employed less than ~~fifty~~ *100* eligible employees and not less than two unrelated eligible employees, the majority of whom are employed within this Commonwealth. A small employer market group includes companies that are affiliated companies or that are eligible to file a combined tax return. Except as otherwise provided, the provisions of this article that apply to a small employer shall continue to apply until the earlier of the plan anniversary or one year following the date the employer no longer meets the requirements of this section.

"Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers or one or more primary small employers.

C. A late enrollee may be excluded from coverage for up to eighteen months or may have a preexisting condition limitation apply for up to twelve months; however, in no case shall a late enrollee be excluded from some or all coverage for more than eighteen months. An eligible employee or dependent shall not be considered a late enrollee if all of the conditions set forth below in subdivisions 1 through 4 are met or one of the conditions set forth below in subdivision 5 or 6 is met:

1. The individual was covered under a public or private health benefit plan at the time the individual was eligible to enroll.

2. The individual certified at the time of initial enrollment that coverage under another health benefit plan was the reason for declining enrollment.

3. The individual has lost coverage under a public or private health benefit plan as a result of termination of employment or employment status eligibility, the termination of the other plan's entire group coverage, death of a spouse, or divorce.

4. The individual requests enrollment within thirty days after termination of coverage provided under a public or private health benefit plan.

5. The individual is employed by a small employer that offers multiple health benefit plans and the individual elects a different plan offered by that small employer during an open enrollment period.

6. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan, the minor is eligible for coverage and is a dependent, and the request

for enrollment is made within thirty days after issuance of such court order.

However, such individual may be considered a late enrollee for benefit riders or enhanced coverage levels not covered under the enrollee's prior plan.

D. The Commission shall adopt regulations establishing the essential and standard plans. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. Every small employer carrier shall, as a condition of transacting business in Virginia with primary small employers, offer to primary small employers at least the essential and standard plans. However, any regulation adopted by the Commission shall contain a provision requiring all small employer carriers to offer an option permitting a primary small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a primary small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 of this title. All small employer carriers shall issue the plans to every primary small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and shall satisfy the following provisions:

1. Such plan may include cost containment features such as, but not limited to, utilization review of health care services including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians and other health care providers, subject to the limitations set forth in §§ 38.2-3407 and 38.2-4209 and Chapter 43 (§ 38.2-4300 et seq.) of this title; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; or other managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost-sharing levels which are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations, if a health maintenance organization is federally qualified, and of nonfederally qualified health maintenance organizations, if a health maintenance organization is not federally qualified. The essential and standard plans of coverage for health maintenance organizations shall be actuarial equivalents of these plans for small employer carriers.

2. No law requiring the coverage or offering of coverage of a benefit shall apply to the essential or standard health care plan or riders thereof.

3. Within 180 days after the Commission's approval of essential and standard health benefit plans, every small employer carrier shall, as a condition of transacting business in Virginia with primary small employers, offer and make available to primary small employers an essential and a standard health benefit plan.

4. Within 180 days after the Commission's approval of essential and standard health benefit plans, every primary small employer that elects to be covered under either an essential or standard health benefit plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier to become effective upon renewal or termination of any group health benefit plan which the small employer may be party to.

5. All essential and standard benefit plans issued to primary small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than and in addition to the essential and standard plans may be provided by rider, separate policy or plan provided that no rider, separate policy or plan shall reduce benefit or premium. A small employer carrier shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by § 38.2-316. Each rider, separate policy or plan providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, separate policy or plan. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a small employer carrier, disapprove the continued use by the small employer carrier of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.

6. No small employer carrier is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection:

a. From a primary small employer already covered under a health benefit plan except for coverage that is to commence on the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a small employer carrier from issuing coverage to a group prior to its anniversary date; or

b. If the Commission determines that acceptance of an application or applications would result in the carrier being declared an impaired insurer.

A small employer carrier that does not offer coverage pursuant to subdivision 6 b of this subsection may not offer coverage to small employers until the Commission determines that the carrier is no longer impaired.

7. Every small employer carrier shall uniformly apply the provisions of subdivision D 6 of this section and shall fairly market the essential and standard health benefit plans to all primary small employers in their established geographic service area of the Commonwealth. A small employer carrier that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the carrier submits and the Commission approves a plan to fairly market to their established geographic service area.

8. No health maintenance organization is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection in the case of any of the following:

a. To small employers, where the policy would not be delivered or issued for delivery in the health maintenance organization's approved service areas;

b. To an employee, where the employee does not reside or work within the health maintenance organization's approved service areas;

c. To primary small employers if the health maintenance organization is a federally qualified health maintenance organization and it demonstrates to the satisfaction of the Commission that the federally qualified health maintenance organization is prevented from doing so by federal requirement; however, any such exemption under this subdivision would be limited to the essential plan; or

d. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than ~~fifty~~ *ninety-nine* eligible employees until the later of 180 days after closure to new applications or the date on which the carrier notifies the Commission that it has regained capacity to deliver services to small employers.

In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision 7 of this subsection apply.

9. In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for carriers, agents and third-party administrators, including requirements relating to the following:

a. Registration by each carrier with the Commission of its intention to be a small employer carrier under this article;

b. Publication by the Commission of a list of all small employer carriers, including a potential requirement applicable to agents, third-party administrators, and carriers that no health benefit plan may be sold to a small employer by a carrier not so identified as a small employer carrier;

c. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by small employers to information concerning this article;

d. To the extent deemed to be necessary to ensure the fair distribution of primary small employers among carriers, periodic reports by carriers about plans issued to primary small employers; provided that reporting requirements shall be limited to information concerning case characteristics and

numbers of health benefit plans in various categories marketed or issued to primary small employers. Carriers shall maintain data relating to the essential and standard benefit plans separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section; and

e. Methods concerning periodic demonstration by small employer carriers that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.

CHAPTER 269

An Act to amend and reenact § 38.2-3432 of the Code of Virginia, relating to accident and sickness insurance; small employer market; preexisting conditions.

[H 835]

Approved March 19, 1996

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3432 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3432. Small employer market subject to certain provisions.

A. Every individual or group policy, subscription contract or plan delivered, issued for delivery or renewal in this Commonwealth or providing benefits to or on behalf of a small employer pursuant to this article is subject to the following provisions:

1. Except in the case of a late enrollee, any preexisting-conditions provision may not limit, deny or exclude coverage for a period beyond twelve months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage or as to a pregnancy existing on the effective date of coverage.

2. A condition which would otherwise be covered pursuant to subdivision A 1 may not be excluded from coverage.

3. In determining whether a preexisting-conditions provision applies to an insured, all coverage shall credit the time the person was covered under previous ~~individual or group policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis~~ *coverage provided under: (i) Medicare, Medicaid, CHAMPUS, the Indian Health Service Program or any other similar publicly sponsored program, (ii) a group health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the essential health benefit plan, or (iii) an individual health insurance policy, including coverage issued by a health maintenance organization, health services plan or fraternal benefit society, that provides benefits similar to or exceeding the benefits provided under the essential health benefit plan* if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, whether or not the new coverage is provided by a different employer, exclusive of any applicable waiting period under such coverage.

B. Coverage shall be renewable with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, contract holder or enrollee;

2. For abuse or misuse of a provider network provision;

3. For fraud or misrepresentation of the policyholder, contract holder or enrollee, with respect to their coverage;

4. When the employer is no longer actively engaged in the business in which it was engaged on the effective date of the coverage;

5. For failure to comply with contribution and participation requirements defined by the health benefit plan;

6. For failure to comply with health benefit plan provisions that have been approved by the Commission;

7. When primary small employer new business ceases to be written by an insurer in the small employer market, provided that the following conditions are satisfied:

a. Notice of the decision to cease writing new business in the primary small employer market is provided to the Commission and to either the policyholder, contract holder, enrollee or employer;

b. Writing new business in the primary small employer market in this Commonwealth shall be prohibited for a period of three years from the date of notice to the Commission pursuant to this subdivision. In the case of a health maintenance organization which ceases to do new business in the small employer market in one service area of the Commonwealth, the rules set forth in this

subdivision shall apply to the health maintenance organization's operations in that service area;

c. When a small employer carrier ceases to write new business and renew business in the primary small employer market, it may continue to participate in the market of small employers which are not primary small employers if it complies with the provisions of this article applicable to the small employer market. Nothing in this provision shall prohibit a small employer carrier from writing and renewing business in the primary small employer market if it has ceased writing and renewing business to small employers which are not primary small employers; and

d. Health benefit plans subject to this article shall not be canceled for 180 days after the date of the notice required under subdivision 7 a of this subsection and for that business of a small employer carrier which remains in force, any small employer carrier that ceases to write new business in the small employer market shall continue to be governed by this article with respect to business conducted under this article; or

8. Benefits and premiums which have been added by rider to the essential or standard benefit plans issued to primary small employers shall be renewable at the sole option of the small employer carrier.

C. If coverage is offered under this article, such coverage shall be offered and made available to all of the eligible employees of a small employer and their dependents. No coverage may be offered to only certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status; provided that small employer groups having policies, contracts or plans in effect prior to July 1, 1994, which charge different premiums to their employees or dependents because of health status, may, upon written request to the small employer carrier at the time of any renewal of such policy, contract or plan, continue to have different premiums charged to their employees and dependents because of health status; however, this ability to charge different premiums because of health status shall expire on July 1, 1997.

D. If coverage to the small employer market pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

E. No coverage offered under this article shall exclude an employer based solely on the nature of the employer's business.

CHAPTER 550

An Act to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3514.2, relating to individual accident and sickness insurance policies.

[H 1026]

Approved April 3, 1996

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3514.2 as follows:

§ 38.2-3514.2. Renewability of coverage.

A. Every individual policy, subscription contract or plan delivered, issued for delivery or renewal in this Commonwealth providing benefits to or on behalf of an individual shall provide for the renewability of such coverage at the sole option of the insured, policyholder, subscriber, or enrollee. The insurer, health services plan or health maintenance organization issuing such policy, subscription contract or plan shall be permitted to refuse to renew the policy, subscription contract or plan only for one or more of the following reasons:

1. Nonpayment of the required premiums by the insured, policyholder, subscriber, or enrollee, or such individual's representative;

2. In the event that the policy, subscription contract or plan contains a provision requiring the use of network providers, a documented pattern of abuse or misuse of such provision by the insured, policyholder, subscriber, or enrollee, continuing for a period of no less than two years;

3. Subject to the time limits contained in § 38.2-3503.2 or in regulations adopted by the Commission governing the practices of health maintenance organizations, for fraud or material misrepresentation by the individual, with respect to his application for coverage;

4. Eligibility of an individual insured for Medicare, provided that such coverage may not terminate with respect to other individuals insured under the same policy, subscription contract or plan and who are not eligible for Medicare; and

5. The insured, subscriber, or enrollee has not maintained a legal residence in the service area of the insurer, health services plan or health maintenance organization for a period of at least six months.

B. This section shall not apply to the following insurance policies, subscription contracts or plans:

1. Short-term travel;

2. Accident-only;

3. Disability income;

4. Limited or specified disease contracts;

5. Long-term care insurance; and

6. Short term nonrenewable policies or contracts of not more than six months' duration which are subject to no medical underwriting or minimal underwriting.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3425 through 38.2-3429, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3514.1, *38.2-3514.2*, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, *38.2-3514.2,* 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

2. That the Joint Commission on Health Care, in cooperation with the State Corporation Commission's Bureau of Insurance, shall study additional reforms in the individual health insurance market including, but not limited to, guaranteed issue and modified community rating for the essential and standard health benefit plans as defined in § 38.2-3431. The Joint Commission also shall evaluate: (i) whether the Commonwealth has the authority to apply individual health insurance reforms to fully insured and not fully insured multiple employer welfare arrangements and out-of-state group trusts and associations; and (ii) the impact of guaranteed issue reforms on the taxation of open enrollment carriers. The Joint Commission shall report its findings and recommendations to the Governor and the 1997 Session of the General Assembly by October 1, 1996.

CHAPTER 901

An Act to amend and reenact § 32.1-102.3:2 of the Code of Virginia, relating to certificates of public need for nursing home beds.

[H 1302]

Approved April 10, 1996

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-102.3:2 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-102.3:2. Certificates of public need; applications for increases in nursing home bed supplies to be filed in response to Requests For Applications (RFAs).

A. Except for applications for continuing care retirement community nursing home bed projects filed by continuing care providers registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2, the Commissioner of Health shall ~~not~~ *only* 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 facility or extended care services are provided ~~through June 30, 1996~~ *when such applications are filed in response to Requests For Applications (RFAs).*

B. The Board of Health shall adopt regulations establishing standards for the approval and issuance of Requests for Applications by the Commissioner of Health. The standards shall include, but shall not be limited to, a requirement that determinations of need take into account any limitations on access to existing nursing home beds in the planning districts. The RFAs, which shall be published at least annually, shall be jointly developed by the Department of Health and the Department of Medical Assistance Services and based on analyses of the need, or lack thereof, for increases in the nursing home bed supply in each of the Commonwealth's planning districts in accordance with standards adopted by the Board of Health by regulation. The Commissioner shall only accept for review applications in response to such RFAs which conform with the geographic and bed need determinations of the specific RFA.

C. Sixty days prior to the Commissioner's approval and issuance of any Request For Applications, the Board of Health shall publish the proposed RFA in the Virginia Register for public comment together with an explanation of (i) the regulatory basis for the planning district bed needs set forth in the RFA and (ii) the rationale for the RFA's planning district designations. Any person objecting to the contents of the proposed RFA may notify, within fourteen days of the publication, the Board and the Commissioner of his objection and the objection's regulatory basis. The Commissioner shall prepare, and deliver by registered mail, a written response to each such objection within two weeks of the date of receiving the objection. The objector may file a rebuttal to the Commissioner's response in writing within five days of receiving the Commissioner's response. If objections are received, the Board shall, after considering the provisions of the RFA, any objections, the Commissioner's responses, and if filed, any written rebuttals of the Commissioner's responses, hold a public hearing to receive comments on the specific RFA. Prior to making a decision on the Request for Applications, the Commissioner shall consider any recommendations made by the Board. ~~However, the Commissioner may approve or authorize:~~

~~1. 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 facility.~~

~~2. 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.

3. The issuance of a certificate of public need for any project for the conversion on site of existing beds in an adult care residence 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 adult care residence; (ii) the adult care residence 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 adult care residence further commits to admit such patients once the nursing facility beds are certified and operational; and (iv) the licensed adult care residence 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, an adult care residence 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 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.

4. The issuance of a certificate of public need for a project in an existing nursing facility owned and operated by the governing body of a county when (i) the total number of new beds to be added by construction does not exceed the lesser of thirty beds or twenty-five percent of the existing nursing facility beds in the facility; (ii) the facility has demonstrated that the nursing facility beds are needed specifically to serve a specialty heavy care patient population, such as dementia, ventilator-dependent, and AIDS patients; and (iii) the facility has executed an agreement with a state-supported medical college to provide training in geriatric nursing.

5. The issuance of a certificate of public need for a nursing facility project located in the City of Staunton when (i) the total number of new beds to be constructed does not exceed thirty beds; (ii) the facility is owned by and will be operated as a nonprofit entity; and (iii) the project is proposed as part of a retirement community that is a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2.

6. The issuance of a certificate of public need for any project for an increase in the number of beds in which nursing home or extended care services are provided, or the creation of new beds in which such services are to be provided, by any continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 of Title 38.2, if (i) the total number of new or additional nursing home beds plus any existing nursing home beds operated by the provider does not exceed twenty percent of the continuing care provider's total existing or planned independent living and adult care residence population when the beds are to be added by new construction, or twenty-five beds when the beds are to be added by conversion on site of existing beds in an adult care residence licensed pursuant to Chapter 9 of Title 63.1; (ii) such beds are necessary to meet existing or reasonably anticipated obligations to provide care to present or prospective residents of the continuing care facility pursuant to continuing care contracts meeting the requirements of § 38.2-4905; (iii) the provider agrees in writing not to seek certification for the use of such new or additional beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act; (iv) the provider agrees in writing to obtain, prior to admission of every resident of the continuing care facility, the resident's written acknowledgement that the provider does not serve recipients of medical assistance services and that, in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement, such resident shall not be eligible for placement in the provider's nursing facility unit; and (v) the provider agrees in writing that only continuing care contract holders will be admitted to the nursing home beds after the first

three years of operation.

Further, if a certificate is approved pursuant to this subdivision, admissions to such new or additional beds shall be restricted for the first three years of operation to patients for whose care, pursuant to an agreement between the facility and the individual financially responsible for the patient, private payment will be made or persons who have entered into an agreement with the facility for continuing care contracts meeting the requirements of § 38.2-4905.

7. The issuance of a certificate of public need for a nursing facility project associated with a continuing care provider which did not operate a nursing home on January 1, 1993, and was registered as of January 1, 1993, with the State Corporation Commission pursuant to Chapter 49 of Title 38.2, if (i) the total number of new beds to be constructed does not exceed sixty beds; (ii) the facility is owned by and will be operated as a nonprofit entity; (iii) after the first three years of operation, the facility will admit only retired officers of the United States uniformed forces and their surviving spouses; (iv) the provider agrees in writing not to seek certification for the use of such beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act; and (v) the provider agrees in writing to obtain, prior to admission of every resident of the continuing care facility, the written acknowledgement that the provider does not serve recipients of medical assistance services and that, in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement, such resident shall not be eligible for placement in the provider's nursing facility unit. Further, if a certificate is approved, pursuant to this subdivision, admissions to such beds shall be restricted to persons for whose care, pursuant to an agreement with the facility, private payment will be made or persons who have entered into an agreement with the facility for continuing care contracts meeting the requirements of § 38.2-4905.

8. The issuance of a certificate of public need for a nursing facility project located in the City of Norfolk if (i) the total number of beds to be constructed does not exceed 120 beds; (ii) the facility will replace an existing facility in the City of Chesapeake; (iii) the construction of the facility has been delayed by environmental contamination caused by leaking underground storage tanks; and (iv) the total capital costs of the facility will not exceed $4,387,000.

9. The issuance of a certificate of public need for a project in an existing nonprofit nursing facility located in the City of Lynchburg if (i) the current facility consists of four nursing units, with the two nursing units constructed in 1969 to be retained; (ii) forty of the newly constructed beds will replace existing eighteen two-bed and twenty two-bed units, built before 1915; (iii) the total number of beds to be constructed does not exceed sixty beds, including forty existing and twenty new beds; (iv) the area around the construction site has been identified by the local governing body for major renovation and revitalization; and (v) the project is the subject of a memorandum of agreement between the local governing body and the applicant, pursuant to which, the local governing body agrees to make certain improvements to the area of the project's location.

10. The issuance of a certificate of public need for an increase in the number of beds in which nursing facility or extended care services are provided or the creation of new beds in which such services are to be provided in the City of Virginia Beach by an association described in § 55-458 created in connection with a real estate cooperative for which an application for registration was filed as required by § 55-497 prior to January 1, 1994, which offers a level of nursing services to its residents consistent with the definition of continuing care in § 38.2-4900 if (i) the total number of new or additional nursing care beds plus any existing nursing care beds operated by the association does not exceed twenty percent of the number of total existing or planned cooperative units when beds are to be added by new construction or by conversion on site of existing beds in a licensed adult care residence; (ii) such beds are necessary to meet existing or reasonably anticipated obligations to provide nursing care to present or prospective residents of the cooperative units pursuant to a written agreement with the association; (iii) the association agrees in writing not to seek certification for the use of any such beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act; (iv) the association agrees in writing to obtain, prior to each resident's occupancy of a cooperative unit, the resident's written acknowledgment that the association does not serve recipients of medical assistance services and that in the event such resident becomes a medical assistance services recipient who is eligible for nursing facility placement such resident shall

not be eligible for placement in the association's nursing facility unit; (v) the association agrees in writing that only residents of cooperative units will be admitted to the nursing care beds after the first three years of operation as a nursing care facility; and (vi) the association complies with the disclosure requirements for continuing care providers pursuant to Chapter 49 of Title 38.2.

11. The issuance of a certificate of public need for a nursing facility project located in the City of Charlottesville if (i) the total number of beds to be converted from hospital to nursing facility use does not exceed thirty beds; (ii) the facility will provide nursing services to patients committed to, transferred to, or discharged from facilities owned by the Department of Mental Health, Mental Retardation and Substance Abuse Services and from any psychiatric hospital located in the City of Charlottesville or Albemarle County; and (iii) the facility has executed an agreement with the Department of Mental Health, Mental Retardation and Substance Abuse Services to provide such services.

12. The issuance of a certificate of public need for a nursing facility project located in Montgomery County if (i) the total number of beds to be constructed does not exceed sixty beds; (ii) the facility has entered into a partnership with several public institutions of higher education to establish a gerontology center for the conduct of research and the education of professionals; and (iii) the nursing facility beds will be an integral part of an existing health care institution which has a mission of providing a continuum of care as recorded in its 100-year plan.

13. The issuance of a certificate of public need for a nursing facility project located in the Town of Colonial Beach if (i) the total number of beds to be converted from adult care residence to nursing facility use does not exceed seven; (ii) the facility is owned by a nonprofit health care center located in Fredericksburg; and (iii) the total number of new or additional beds plus existing nursing facility beds operated by the facility will not exceed sixty.

14. The issuance of a certificate of public need to a nursing facility in Ashland, Virginia, currently operating at ninety-nine percent occupancy to convert ten private rooms to semiprivate, thereby adding ten beds to an existing fifty-bed wing to promote efficiency of operations and improve access for area residents if the total capital expenditures will not exceed $15,000.

15. The issuance of a certificate of public need for a nursing facility project located in an existing facility which currently contains 325 "independent living" units with home health services available, seventy-five assisted living units, and thirty-one nursing facility beds, only five of which are certified for use by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act if (i) the total number of beds to be constructed does not exceed thirty beds, (ii) the facility agrees in writing not to seek certification for the use of any such beds by persons eligible to receive medical assistance services pursuant to Title XIX of the United States Social Security Act, (iii) such beds are necessary to meet existing or reasonably anticipated obligations to provide nursing care to present or prospective residents of this retirement community, and (iv) the retirement community agrees in writing that only residents of the retirement community will be admitted to such nursing facility beds after the first three years of operation.

16. The issuance of a certificate of public need for a project in an existing facility located in Scott County for the conversion on site of existing beds in an adult care residence licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1 as of October 1, 1994, 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 adult care residence; (ii) the adult care residence has demonstrated that nursing facility beds are needed specifically to serve a population of patients having Alzheimer's Disease or related disorders and that such patients will not otherwise have reasonable access to such services in existing or approved nursing facilities; (iii) the adult care residence will restrict admissions to such patients once the nursing facility beds are certified and operational; and (iv) the licensed adult care residence otherwise meets the standards for nursing facility beds as set forth in the regulations of the Board of Health.

17. The issuance of a certificate of public need in an existing nursing facility project if (i) the facility's total number of beds will not exceed sixty beds, including existing beds and those proposed; (ii) the space in the existing nursing facility in which the proposed additional beds will be located has never been occupied by any licensed beds; and (iii) the total direct capital costs associated with the proposed project will not exceed $10,000.

~~18. The issuance of a certificate of public need to a nonprofit nursing facility project located in Henrico County that is designed to provide a continuum of care for patients with Alzheimer's Disease and related disorders if (i) the project was under construction January 1, 1995, and will be ready for occupancy no later than June 1, 1996; (ii) not less than thirty of the newly constructed beds will be designated and retained as private-pay beds; and (iii) the total number of beds to be constructed does not exceed sixty beds.~~

~~Notwithstanding the foregoing and other provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title, the state home for aged and infirm veterans authorized by Chapter 668, 1989 Acts of Assembly, shall be exempt from all the 1993 certificates of public need review requirements as a medical care facility.~~

2. That the Commissioner of Health, in cooperation with the Director of the Department of Medical Assistance Services and other affected public and private stakeholders, shall evaluate the need for and appropriateness of requiring adult care residences providing assisted living and intensive assisted living levels of care to be subject to the Commonwealth's Certificate of Public Need regulations and the requirements established pursuant to this article or a similar and parallel program for determining need and preventing redundant capitalization. The Commissioner shall provide to the Secretary of Health and Human Resources and the Joint Commission on Health Care an interim report by October 1, 1996, and a final report of his findings and recommendations by June 1, 1997.

3. That the Joint Commission on Health Care shall study the appropriateness of the Commonwealth's Certificate of Public Need regulations and requirements, including, but not limited to, the need for and appropriateness of requiring outpatient or ambulatory surgical centers to be subject to the Commonwealth's Certificate of Public Need regulations and requirements pursuant to this act. The Department of Health and the health-system agencies shall provide staff support and technical assistance for the study. The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the 1997 Session of the General Assembly.

CHAPTER 772

An Act to amend and reenact § 9-316 of the Code of Virginia, relating to the Joint Commission on Health Care.

[H 1306]

Approved April 6, 1996

Be it enacted by the General Assembly of Virginia:

1. That § 9-316 of the Code of Virginia is amended and reenacted as follows:

§ 9-316. Sunset.

The provisions of this chapter shall expire on July 1, ~~1997~~ *2002*.

CHAPTER 902

An Act to amend and reenact §§ 2.1-1.7, 2.1-51.15, 2.1-342, 2.1-344, 9-6.25:2, 11-45, 32.1-122.02, 32.1-335, 32.1-336, and 32.1-337 of the Code of Virginia; to amend the Code of Virginia by adding in Title 32.1 a chapter number 7.2, consisting of sections numbered 32.1-276.2 through 32.1-276.11; and to repeal Chapter 26 (§§ 9-156 through 9-166.7) of Title 9 of the Code of Virginia, relating to health care data reporting and the Virginia Health Services Cost Review Council.

[H 1307]

Approved April 10, 1996

Whereas, the objective of health care data initiatives is to improve the quality of care by providing the information needed to assist consumers in choosing appropriate health care and long-term care services; to evaluate medical technologies; and to improve treatment and eliminate unnecessary procedures; and

Whereas, a study conducted by the Joint Commission on Health Care regarding the Commonwealth's current health care cost and quality data initiatives found that most of the existing reports do not produce useful information for the marketplace; and

Whereas, although the patient level data base system and the efficiency and productivity methodology for hospitals and nursing homes were found to provide useful information, the current organizational structure for administering these initiatives is duplicative and should be streamlined; and

Whereas, a partnership between the Commonwealth and a private, nonprofit organization representing purchasers, consumers, providers, and third party payers offers the best means of providing accurate and helpful health care cost and quality data in the marketplace; now, therefore,

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-1.7, 2.1-51.15, 2.1-342, 2.1-344, 9-6.25:2, 11-45, 32.1-122.02, 32.1-335, 32.1-336, and 32.1-337 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 32.1 a chapter number 7.2, consisting of sections numbered 32.1-276.2 through 32.1-276.11, as follows:

§ 2.1-1.7. State councils.

A. There shall be, in addition to such others as may be established by law, the following permanent collegial bodies either affiliated with more than one agency or independent of an agency within the executive branch:

Adult Education and Literacy, Virginia Advisory Council for
Agricultural Council, Virginia
Alcohol and Drug Abuse Problems, Governor's Council on
Apprenticeship Council
Blue Ridge Regional Education and Training Council
Child Day Care and Early Childhood Programs, Virginia Council on
Child Day-Care Council
Citizens' Advisory Council on Furnishing and Interpreting the Executive Mansion
Commonwealth Competition Council
Commonwealth's Attorneys' Services Council
Developmental Disabilities Planning Council, Virginia
Disability Services Council
Equal Employment Opportunity Council, Virginia
~~Health Services Cost Review Council, Virginia~~
Housing for the Disabled, Interagency Coordinating Council on
Human Rights, Council on
Human Services Information and Referral Advisory Council
Indians, Council on
Interagency Coordinating Council, Virginia

Job Training Coordinating Council, Governor's
Land Evaluation Advisory Council
Local Debt, State Council on
Maternal and Child Health Council
Military Advisory Council, Virginia
Needs of Handicapped Persons, Overall Advisory Council on the
Prevention, Virginia Council on Coordinating
Public Records Advisory Council, State
Rate-setting for Children's Facilities, Interdepartmental Council on
Revenue Estimates, Advisory Council on
Southside Virginia Marketing Council
Specialized Transportation Council
State Health Benefits Advisory Council
Status of Women, Council on the
Technology Council, Virginia
Virginia Business-Education Partnership Program, Advisory Council on the
Virginia Recycling Markets Development Council.

B. Notwithstanding the definition for "council" as provided in § 2.1-1.2, the following entities shall be referred to as councils:

Council on Information Management
Higher Education, State Council of
Independent Living Council, Statewide
Rehabilitation Advisory Council, Statewide
Rehabilitation Advisory Council for the Blind, Statewide
World Trade Council, Virginia.

§ 2.1-51.15. Agencies for which responsible.

The Secretary of Health and Human Resources shall be responsible to the Governor for the following agencies: Department of Health, Department for the Visually Handicapped, Department of Health Professions, Department for the Aging, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, Department of Social Services, ~~Virginia Health Services Cost Review Council,~~ Department for Rights of Virginians With Disabilities, Department of Medical Assistance Services, the Council on Indians, Governor's Employment and Training Department, Child Day-Care Council, Virginia Department for the Deaf and Hard-of-Hearing, the Virginia Council on Coordinating Prevention and the Virginia Council on Child Day Care and Early Childhood Programs. The Governor may, by executive order, assign any other state executive agency to the Secretary of Health and Human Resources, or reassign any agency listed above to another secretary.

§ 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 the Commonwealth during the regular office hours of the custodian of such records. Access to such records shall not be denied to citizens of the Commonwealth, representatives of newspapers and magazines with circulation in the Commonwealth, and representatives of radio and television stations broadcasting in or into the 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, but shall 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. The public body may also make a reasonable charge for preparing documents produced from a geographic information system at the request of anyone other than the owner of the land that is the subject of the request. However, such charges shall not exceed the actual cost to the public body in supplying such records or documents, 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; adult arrestee photographs when necessary to avoid jeopardizing an investigation in felony cases until such time as the release of such photograph will no longer jeopardize the investigation; 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; records of local police departments relating to neighborhood watch programs that include the names, addresses, and operating schedules of individual participants in the program that are provided to such departments under a promise of confidentiality; and all records of persons imprisoned in penal institutions in the 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. (Effective until July 1, 1996) Confidential records of all investigations of applications for licenses and permits, and all licensees and permittees made by or submitted to the Alcoholic Beverage Control Board, the State Lottery Department or the Virginia Racing Commission.

2. (Effective July 1, 1996) Confidential records of all investigations of applications for licenses and permits, and all licensees and permittees made by or submitted to the Alcoholic Beverage Control Board, the State Lottery Department, the Virginia Racing Commission, or the Charitable Gaming Commission.

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 (i) held by or requested from members of the General Assembly or the Division of Legislative Services or (ii) held or requested 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 institution of higher education. This exclusion shall not apply to memoranda, studies or other papers held or requested by the mayor or other chief executive officer of any political subdivision which are specifically concerned with the evaluation of performance of the duties and

functions of any locally elected official and were prepared after June 30, 1992, nor shall this exclusion apply to agenda packets prepared and distributed to public bodies for use at a meeting.

Except as provided in § 30-28.18, memoranda, working papers and correspondence of a member of the General Assembly held by the Division of Legislative Services shall not be released by the Division without the prior consent of the member.

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 the 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 pursuant to a promise of confidentiality from the Department of Economic Development, the Virginia Economic Development Partnership, or local or regional industrial or economic development authorities or organizations, used by the Department, the Partnership, or such entities for business, trade and tourism development; and memoranda, working papers or other records related to businesses that are considering locating or expanding in Virginia, prepared by the Partnership, where competition or bargaining is involved and where, if such records are made public, the financial interest of the governmental unit would be adversely affected.

21. Information which was filed as confidential under the Toxic Substances Information Act (§ 32.1-239 et seq.), as such Act existed prior to July 1, 1992.

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 § 28.2-204.

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 or of the Virginia Board of Youth and Family Services, the Virginia Department of Youth and Family Services or any facility thereof to the extent as determined by the Director of the Department of Youth and Family Services, or his designee, that disclosure or public dissemination of such materials would jeopardize the security of any correctional or juvenile facility or institution, as follows:

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

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

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

(iv) Internal security audits of correctional and juvenile 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 or juvenile 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 or juvenile 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, juvenile clients or employees; and

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

Notwithstanding the provisions of this subdivision, reports and information regarding the general operations of the Departments, 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, (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. [Repealed.]

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 this title, 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. [Repealed.]

45. Investigative notes; correspondence and information furnished in confidence with respect to an investigation; and official records otherwise exempted by this chapter or any Virginia statute, provided to or produced by or for the Auditor of Public Accounts and the Joint Legislative Audit and Review Commission; or investigative notes, correspondence, documentation and information furnished and provided to or produced by or for the Department of the State Internal Auditor with respect to an investigation initiated through the State Employee Fraud, Waste and Abuse Hotline. Nothing in this chapter 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; however, disclosure, unless such disclosure is prohibited by this section, of information from the records of completed investigations shall include, but is not limited to, the agency involved, the identity of the person who is the subject of the complaint, the nature of the complaint, and the actions taken to resolve the complaint. In the event an investigation does not lead to corrective action, the identity of the person who is the subject of the complaint may be released only with the consent of the subject person.

46. Data formerly 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 former § 32.1-102.3:4.

47. Documentation or other information which describes the design, function, operation or access control features of any security system, whether manual or automated, which is used to control access to or use of any automated data processing or telecommunications system.

48. Confidential financial statements, balance sheets, trade secrets, and revenue and cost projections provided to the Department of Rail and Public Transportation, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Interstate Commerce Commission or the Federal Rail Administration

with respect to data provided in confidence to the Interstate Commerce Commission and the Federal Railroad Administration.

49. In the case of corporations organized by the Virginia Retirement System, RF&P Corporation and its wholly owned subsidiaries, (i) proprietary information provided by, and financial information concerning, coventurers, partners, lessors, lessees, or investors, and (ii) records concerning the condition, acquisition, disposition, use, leasing, development, coventuring, or management of real estate the disclosure of which would have a substantial adverse impact on the value of such real estate or result in a competitive disadvantage to the corporation or subsidiary.

50. Confidential proprietary records related to inventory and sales, voluntarily provided by private energy suppliers to the Department of Mines, Minerals and Energy, used by that Department for energy contingency planning purposes or for developing consolidated statistical information on energy supplies.

51. Confidential proprietary information furnished to the Board of Medical Assistance Services or the Medicaid Prior Authorization Advisory Committee pursuant to Article 4 (§ 32.1-331.12 et seq.) of Chapter 10 of Title 32.1.

52. ~~Patient level data collected by the Virginia Health Services Cost Review Council and not yet processed, verified, and released, pursuant to § 9-166.7, to the Council by the nonprofit organization with which the Executive Director has contracted pursuant to § 9-166.4.~~

53. Proprietary, commercial or financial information, balance sheets, trade secrets, and revenue and cost projections provided by a private transportation business to the Virginia Department of Transportation and the Department of Rail and Public Transportation for the purpose of conducting transportation studies needed to obtain grants or other financial assistance under the Intermodal Surface Transportation Efficiency Act of 1991 (P.L. 102-240) for transportation projects, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Interstate Commerce Commission or the Federal Rail Administration with respect to data provided in confidence to the Interstate Commerce Commission and the Federal Railroad Administration. However, the exemption provided by this subdivision shall not apply to any wholly owned subsidiary of a public body.

54. Names and addresses of subscribers to Virginia Wildlife magazine, published by the Department of Game and Inland Fisheries, provided the individual subscriber has requested in writing that the Department not release such information.

55. Reports, documents, memoranda or other information or materials which describe any aspect of security used by the Virginia Museum of Fine Arts to the extent that disclosure or public dissemination of such materials would jeopardize the security of the Museum or any warehouse controlled by the Museum, as follows:

a. Operational, procedural or tactical planning documents, including any training manuals to the extent they discuss security measures;

b. Surveillance techniques;

c. Installation, operation, or utilization of any alarm technology;

d. Engineering and architectural drawings of the Museum or any warehouse;

e. Transportation of the Museum's collections, including routes and schedules; or

f. Operation of the Museum or any warehouse used by the Museum involving the:

(1) Number of employees, including security guards, present at any time; or

(2) Busiest hours, with the maximum number of visitors in the Museum.

56. Reports, documents, memoranda or other information or materials which describe any aspect of security used by the Virginia Department of Alcoholic Beverage Control to the extent that disclosure or public dissemination of such materials would jeopardize the security of any government store as defined in Title 4.1, or warehouse controlled by the Department of Alcoholic Beverage Control, as follows:

(i) Operational, procedural or tactical planning documents, including any training manuals to the extent they discuss security measures;

(ii) Surveillance techniques;

(iii) The installation, operation, or utilization of any alarm technology;

(iv) Engineering and architectural drawings of such government stores or warehouses;

(v) The transportation of merchandise, including routes and schedules; and

(vi) The operation of any government store or the central warehouse used by the Department of Alcoholic Beverage Control involving the:

a. Number of employees present during each shift;

b. Busiest hours, with the maximum number of customers in such government store; and

c. Banking system used, including time and place of deposits.

57. Information required to be provided pursuant to § 54.1-2506.1.

58. Confidential information designated as provided in subsection D of § 11-52 as trade secrets or proprietary information by any person who has submitted to a public body an application for prequalification to bid on public construction projects in accordance with subsection B of § 11-46.

59. All information and records acquired during a review of any child death by the State Child Fatality Review Team established pursuant to § 32.1-283.1.

60. Investigative notes, correspondence, documentation and information provided to or produced by or for the committee or the auditor with respect to an investigation or audit conducted pursuant to § 15.1-765.2. Nothing in this section shall prohibit disclosure of information from the records of completed investigations or audits in a form that does not reveal the identity of complainants or persons supplying information.

61. Financial, medical, rehabilitative and other personal information concerning applicants for or recipients of loan funds submitted to or maintained by the Assistive Technology Loan Fund Authority under Chapter 11 (§ 51.5-53 et seq.) of Title 51.5.

62. Patient level data collected by the Board of Health and not yet processed, verified, and released, pursuant to § 32.1-276.9, to the Board by the nonprofit organization with which the Commissioner of Health has contracted pursuant to § 32.1-276.4.

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 the Commonwealth or to the compensation or benefits paid by any corporation organized by the Virginia Retirement System, RF&P Corporation and its wholly owned subsidiaries, to their officers or employees. 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.

§ 2.1-344. Executive or closed meetings.

A. Public bodies are not required to conduct executive or closed meetings. However, should a public body determine that an executive or closed meeting is desirable, such meeting shall be held only for the following purposes:

1. Discussion, consideration or interviews of prospective candidates for employment; assignment, appointment, promotion, performance, demotion, salaries, disciplining or resignation of specific public officers, appointees or employees of any public body; and evaluation of performance of departments or schools of state institutions of higher education where such matters regarding such specific individuals might be affected by such evaluation. Any teacher shall be permitted to be present during an executive session or closed meeting in which there is a discussion or consideration of a disciplinary matter which involves the teacher and some student or students and the student or students involved in the matter are present, provided the teacher makes a written request to be present to the presiding officer of the appropriate board.

2. Discussion or consideration of admission or disciplinary matters concerning any student or students of any state institution of higher education or any state school system. However, any such student, legal counsel and, if the student is a minor, the student's parents or legal guardians shall be permitted to be present during the taking of testimony or presentation of evidence at an executive or closed meeting, if such student, parents or guardians so request in writing and such request is submitted to the presiding officer of the appropriate board.

3. Discussion or consideration of the condition, acquisition or use of real property for public

purpose, or of the disposition of publicly held property, or of plans for the future of a state institution of higher education which could affect the value of property owned or desirable for ownership by such institution.

4. The protection of the privacy of individuals in personal matters not related to public business.

5. Discussion concerning a prospective business or industry or expansion of an existing business or industry where no previous announcement has been made of the business' or industry's interest in locating or expanding its facilities in the community.

6. The investing of public funds where competition or bargaining is involved, where, if made public initially, the financial interest of the governmental unit would be adversely affected.

7. Consultation with legal counsel and briefings by staff members, consultants or attorneys, pertaining to actual or probable litigation, or other specific legal matters requiring the provision of legal advice by counsel.

8. In the case of boards of visitors of state institutions of higher education, discussion or consideration of matters relating to gifts, bequests and fund-raising activities, and grants and contracts for services or work to be performed by such institution. However, the terms and conditions of any such gifts, bequests, grants and contracts made by a foreign government, a foreign legal entity or a foreign person and accepted by a state institution of higher education shall be subject to public disclosure upon written request to the appropriate board of visitors. For the purpose of this subdivision, (i) "foreign government" means any government other than the United States government or the government of a state or a political subdivision thereof; (ii) "foreign legal entity" means any legal entity created under the laws of the United States or of any state thereof if a majority of the ownership of the stock of such legal entity is owned by foreign governments or foreign persons or if a majority of the membership of any such entity is composed of foreign persons or foreign legal entities, or any legal entity created under the laws of a foreign government; and (iii) "foreign person" means any individual who is not a citizen or national of the United States or a trust territory or protectorate thereof.

9. In the case of the boards of trustees of the Virginia Museum of Fine Arts and The Science Museum of Virginia, discussion or consideration of matters relating to specific gifts, bequests, and grants.

10. Discussion or consideration of honorary degrees or special awards.

11. Discussion or consideration of tests or examinations or other documents excluded from this chapter pursuant to § 2.1-342 B 9.

12. Discussion, consideration or review by the appropriate House or Senate committees of possible disciplinary action against a member arising out of the possible inadequacy of the disclosure statement filed by the member, provided the member may request in writing that the committee meeting not be conducted in executive session.

13. Discussion of strategy with respect to the negotiation of a siting agreement or to consider the terms, conditions, and provisions of a siting agreement if the governing body in open meeting finds that an open meeting will have a detrimental effect upon the negotiating position of the governing body or the establishment of the terms, conditions and provisions of the siting agreement, or both. All discussions with the applicant or its representatives may be conducted in a closed meeting or executive session.

14. Discussion by the Governor and any economic advisory board reviewing forecasts of economic activity and estimating general and nongeneral fund revenues.

15. Discussion or consideration of medical and mental records excluded from this chapter pursuant to § 2.1-342 B 3, and those portions of disciplinary proceedings by any regulatory board within the Department of Professional and Occupational Regulation or Department of Health Professions conducted pursuant to § 9-6.14:11 or § 9-6.14:12 during which the board deliberates to reach a decision.

16. Discussion, consideration or review of State Lottery Department matters related to proprietary lottery game information and studies or investigations exempted from disclosure under subdivisions 37 and 38 of subsection B of § 2.1-342.

17. Those portions of meetings by local government crime commissions where the identity of, or information tending to identify, individuals providing information about crimes or criminal activities

under a promise of anonymity is discussed or disclosed.

18. Discussion, consideration, review and deliberations by local community corrections resources boards regarding the placement in community diversion programs of individuals previously sentenced to state correctional facilities.

19. ~~Those portions of meetings of the Virginia Health Services Cost Review Council in which the Council discusses filings of individual health care institutions which are confidential pursuant to subsection B of § 9-159.~~

20. Those portions of meetings in which the Board of Corrections discusses or discloses the identity of, or information tending to identify, any prisoner who (i) provides information about crimes or criminal activities, (ii) renders assistance in preventing the escape of another prisoner or in the apprehension of an escaped prisoner, or (iii) voluntarily or at the instance of a prison official renders other extraordinary services, the disclosure of which is likely to jeopardize the prisoner's life or safety.

21. Discussion of plans to protect public safety as it relates to terrorist activity.

22. In the case of corporations organized by the Virginia Retirement System, RF&P Corporation and its wholly owned subsidiaries, discussion or consideration of (i) proprietary information provided by, and financial information concerning, coventurers, partners, lessors, lessees, or investors, and (ii) the condition, acquisition, disposition, use, leasing, development, coventuring, or management of real estate the disclosure of which would have a substantial adverse impact on the value of such real estate or result in a competitive disadvantage to the corporation or subsidiary.

23. Those portions of meetings in which individual child death cases are discussed by the State Child Fatality Review Team established pursuant to § 32.1-283.1.

B. No resolution, ordinance, rule, contract, regulation or motion adopted, passed or agreed to in an executive or closed meeting shall become effective unless the public body, following the meeting, reconvenes in open meeting and takes a vote of the membership on such resolution, ordinance, rule, contract, regulation or motion which shall have its substance reasonably identified in the open meeting. Nothing in this section shall be construed to require the board of directors of any authority created pursuant to the Industrial Development and Revenue Bond Act (§ 15.1-1373 et seq.), or any public body empowered to issue industrial revenue bonds by general or special law, to identify a business or industry to which subdivision A 5 of this section applies. However, such business or industry must be identified as a matter of public record at least thirty days prior to the actual date of the board's authorization of the sale or issuance of such bonds.

C. Public officers improperly selected due to the failure of the public body to comply with the other provisions of this section shall be de facto officers and, as such, their official actions are valid until they obtain notice of the legal defect in their election.

D. Nothing in this section shall be construed to prevent the holding of conferences between two or more public bodies, or their representatives, but these conferences shall be subject to the same regulations for holding executive or closed sessions as are applicable to any other public body.

§ 9-6.25:2. Policy boards, commissions and councils.

There shall be, in addition to such others as may be designated in accordance with § 9-6.25, the following policy boards, commissions and councils:

Apprenticeship Council
Athletic Board
Auctioneers Board
Blue Ridge Regional Education and Training Council
Board for Accountancy
Board for Architects, Professional Engineers, Land Surveyors and Landscape Architects
Board for Barbers
Board for Contractors
Board for Cosmetology
Board for Geology
Board for Hearing Aid Specialists
Board for Opticians
Board for Professional and Occupational Regulation

Board for Professional Soil Scientists
Board for Waterworks and Wastewater Works Operators
Board of Agriculture and Consumer Services
Board of Audiology and Speech-Language Pathology
Board of Coal Mining Examiners
Board of Conservation and Recreation
Board of Correctional Education
Board of Dentistry
Board of Directors, Virginia Student Assistance Authorities
Board of Funeral Directors and Embalmers
Board of Health Professions
Board of Historic Resources
Board of Housing and Community Development
Board of Medical Assistance Services
Board of Medicine
Board of Mineral Mining Examiners
Board of Nursing
Board of Nursing Home Administrators
Board of Optometry
Board of Pharmacy
Board of Professional Counselors
Board of Psychology
Board of Recreation Specialists
Board of Social Services
Board of Social Work
Board of Surface Mining Review
Board of Veterinary Medicine
Board on Conservation and Development of Public Beaches
Chesapeake Bay Local Assistance Board
Child Day Care and Early Childhood Programs, Virginia Council on
Child Day-Care Council
Commission on Local Government
Commonwealth Transportation Board
Council on Human Rights
Council on Information Management
Criminal Justice Services Board
Disability Services Council
Farmers Market Board, Virginia
Immigrant and Refugee Policy Council
Interdepartmental Council on Rate-setting for Children's Facilities
Library Board, The Library of Virginia
Marine Resources Commission
Milk Commission
Pesticide Control Board
Real Estate Appraiser Board
Real Estate Board
Reciprocity Board, Department of Motor Vehicles
Safety and Health Codes Board
Seed Potato Board
Southside Virginia Marketing Council
Specialized Transportation Council
State Air Pollution Control Board
State Board of Corrections
State Board of Elections

State Board of Health
State Board of Youth and Family Services
State Health Department, Sewage Handling and Disposal Appeal Review Board
State Library Board
State Mental Health, Mental Retardation and Substance Abuse Services Board
State Water Control Board
Substance Abuse Certification Board
Treasury Board, The, Department of the Treasury
Virginia Aviation Board
Virginia Board for Asbestos Licensing
Virginia Fire Services Board
Virginia Gas and Oil Board
Virginia Health Planning Board
~~Virginia Health Services Cost Review Council~~
Virginia Manufactured Housing Board
Virginia Parole Board
Virginia Public Telecommunications Board
Virginia Soil and Water Conservation Board
Virginia Voluntary Formulary Board
Virginia Waste Management Board
Virginia World Trade Council.
(Contingently repealed) Waste Management Facility Operators, Board for.

§ 11-45. Exceptions to requirement for competitive procurement.

A. Any public body may enter into contracts without competition for the purchase of goods or services (i) which are performed or produced by persons, or in schools or workshops, under the supervision of the Virginia Department for the Visually Handicapped; or (ii) which are performed or produced by nonprofit sheltered workshops or other nonprofit organizations which offer transitional or supported employment services serving the handicapped.

B. Any public body may enter into contracts without competition for (i) legal services, provided that the pertinent provisions of Chapter 11 (§ 2.1-117 et seq.) of Title 2.1 remain applicable; or (ii) expert witnesses and other services associated with litigation or regulatory proceedings.

C. Any public body may extend the term of an existing contract for services to allow completion of any work undertaken but not completed during the original term of the contract.

D. An industrial development authority may enter into contracts without competition with respect to any item of cost of "authority facilities" or "facilities" as defined in § 15.1-1374 (d).

E. The Department of Alcoholic Beverage Control may procure alcoholic beverages without competitive sealed bidding or competitive negotiation.

F. Any public body administering public assistance programs as defined in § 63.1-87, the fuel assistance program, community services boards as defined in § 37.1-1, or any public body purchasing services under the Comprehensive Services Act for At-Risk Youth and Families (§ 2.1-745 et seq.) may procure goods or personal services for direct use by the recipients of such programs without competitive sealed bidding or competitive negotiations if the procurement is made for an individual recipient. Contracts for the bulk procurement of goods or services for the use of recipients shall not be exempted from the requirements of § 11-41.

G. Any public body may enter into contracts without competitive sealed bidding or competitive negotiation for insurance if purchased through an association of which it is a member if the association was formed and is maintained for the purpose of promoting the interest and welfare of and developing close relationships with similar public bodies, provided such association has procured the insurance by use of competitive principles and provided that the public body has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding and competitive negotiation are not fiscally advantageous to the public. The writing shall document the basis for this determination.

H. The Department of Health may enter into contracts with laboratories providing cytology and related services without competitive sealed bidding or competitive negotiation if competitive sealed

bidding and competitive negotiations are not fiscally advantageous to the public to provide quality control as prescribed in writing by the Commissioner of Health.

I. The Director of the Department of Medical Assistance Services may enter into contracts without competitive sealed bidding or competitive negotiation for special services provided for eligible recipients pursuant to § 32.1-325 E, provided that the Director has made a determination in advance after reasonable notice to the public and set forth in writing that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public, or would constitute an imminent threat to the health or welfare of such recipients. The writing shall document the basis for this determination.

J. The Virginia Code Commission may enter into contracts without competitive sealed bidding or competitive negotiation when procuring the services of a publisher, pursuant to §§ 9-77.7 and 9-77.8, to publish the Code of Virginia or the Virginia Administrative Code.

K. ~~The Executive Director of the Virginia Health Services Cost Review Council may enter into agreements or contracts without competitive sealed bidding or competitive negotiation for the compilation, storage, analysis, and evaluation of patient level data pursuant to Article 2 (§ 9-166.1 et seq.) of Chapter 26 of Title 9, if the Executive Director has made a determination in advance, after reasonable notice to the public and set forth in writing, that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public. The writing shall document the basis for this determination.~~ *The State Health Commissioner may enter into agreements or contracts without competitive sealed bidding or competitive negotiation for the compilation, storage, analysis, evaluation, and publication of certain data submitted by health care providers and for the development of a methodology to measure the efficiency and productivity of health care providers pursuant to Chapter 7.2 (§ 32.1-276.2 et seq.) of Title 32.1, if the Commissioner has made a determination in advance, after reasonable notice to the public and set forth in writing, that competitive sealed bidding or competitive negotiation for such services is not fiscally advantageous to the public. The writing shall document the basis for this determination. Such agreements and contracts shall be based on competitive principles.*

§ 32.1-122.02. Virginia Health Planning Board created; membership; terms; duties and responsibilities.

A. There is hereby created in the executive branch of the state government, in the secretariat of Health and Human Resources, the Virginia Health Planning Board, hereinafter referred to as the "Planning Board." The Planning Board shall be appointed by the Governor and shall consist of ~~nineteen~~ *eighteen* members who are domiciliaries of the Commonwealth to be appointed as follows: eight members shall be consumers with each regional health planning board being represented by at least one such consumer; four members shall be providers, one of whom shall represent the hospital industry and one of whom shall represent the nursing home industry; the Commissioner of Health; the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services; the Commissioner of the Department for the Aging; the Director of the Department of Medical Assistance Services; the Commissioner of the Department of Social Services; ~~the Executive Director of the Virginia Health Services Cost Review Council~~ and the Secretary of Health and Human Resources, who shall serve as the chairman. The initial appointments to the Planning Board shall be as follows: of the eight members who are consumers, three shall be appointed for terms of two years, three shall be appointed for terms of three years and two shall be appointed for terms of four years. Of the four members who are providers, one shall be appointed for a term of two years, one shall be appointed for a term of three years and two shall be appointed for terms of four years. Thereafter, all members shall serve terms of four years. Members shall serve at the pleasure of the Governor and may serve for two consecutive terms. The Planning Board shall meet at least four times a year at such times and in such locations as shall be designated by the chairman.

B. The Planning Board shall have the following duties and responsibilities:

1. To supervise and provide leadership for the statewide health planning system.

2. To provide technical expertise in the development of state health policy.

3. To receive data and information from the regional health planning agencies and consider regional health planning interests in its deliberations.

4. To review and assess critical health care issues.

5. To make recommendations to the Secretary, the Governor and the General Assembly concerning health policy, legislation and resource allocation.

6. To supervise the development of a health data system in order to provide necessary information to support health policy recommendations.

7. To promote the delivery of high quality and cost-effective health care throughout the Commonwealth.

8. To promote the development and maintenance of a coordinated and integrated health planning system on the state and local levels.

9. To perform such other duties relating to health planning as may be requested by the Secretary.

10. To adopt and revise as necessary bylaws for its operation.

11. To make recommendations to the Secretary, the Governor, and the General Assembly concerning statewide data collection systems for health care manpower distribution and for mortality and morbidity rates for citizens of the Commonwealth.

C. In addition to the duties and responsibilities enumerated in subsection B, the Planning Board shall promulgate such regulations as may be necessary to effectuate the purposes of this article including, but not limited to: (i) the designation of health planning regions, (ii) the designation of the regional health planning agencies, and (iii) the composition and method of appointment of members of the regional health planning boards.

D. Personnel of the Department shall serve as staff to the Planning Board. Other agencies of the Commonwealth within the Secretary's office shall cooperate and provide assistance as directed by the chairman of the Planning Board.

CHAPTER 7.2.

HEALTH CARE DATA REPORTING.

§ 32.1-276.2. Health care data reporting; purpose. The General Assembly finds that the establishment of effective health care data analysis and reporting initiatives is essential to the improvement of the quality and cost of health care in the Commonwealth, and that accurate and valuable health care data can best be identified by representatives of state government and the consumer, hospital, nursing home, physician, insurance, and business communities. For this reason, the State Board of Health and the State Health Commissioner, assisted by the State Department of Health, shall administer the health care data reporting initiatives established by this chapter.

§ 32.1-276.3. Definitions.

As used in this chapter:

"Board" means the Board of Health.

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

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1; (ii) a mental or psychiatric hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1; (iii) a hospital operated by the University of Virginia or Virginia Commonwealth University; (iv) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; or (v) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1, a hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1, or a hospital operated by the University of Virginia or Virginia Commonwealth University.

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the

characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.

"System" means the Virginia Patient Level Data System.

§ 32.1-276.4. Agreements for certain data services.

A. The Commissioner shall negotiate and enter into contracts or agreements with a nonprofit organization for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to this chapter and for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Such nonprofit organization shall be governed by a board of directors composed of representatives of state government, including the Commissioner, and the consumer, health care provider, and business communities. Of the health care provider representatives, there shall be an equal number of hospital, nursing home, physician and health plan representatives. The articles of incorporation of such nonprofit organization shall require the nomination of such board members by organizations and associations representing those categories of persons specified for representation on the board of directors.

B. In addition to providing for the compilation, storage, analysis, and evaluation services described in subsection A, any contract or agreement with a nonprofit, tax-exempt health data organization made pursuant to this section shall require the board of directors of such organization to:

1. Develop and disseminate other health care cost and quality information designed to assist businesses and consumers in purchasing health care and long-term care services;

2. Prepare and make public summaries, compilations, or other supplementary reports based on the data provided by health care providers pursuant to this chapter;

3. Collect, compile, and publish Health Employer Data and Information Set (HEDIS) information or reports voluntarily submitted by health maintenance organizations or other health care plans;

4. Maintain the confidentiality of data as set forth in § 32.1-276.9;

5. Submit a report to the Board, the Governor, and the General Assembly no later than October 1 of each year for the preceding fiscal year. Such report shall include a certified audit and provide information on the accomplishments, priorities, and current and planned activities of the nonprofit organization;

6. Submit, as appropriate, strategic plans to the Board, the Governor, and the General Assembly recommending specific data projects to be undertaken and specifying data elements that will be required from health care providers. In developing strategic plans, the nonprofit organization shall incorporate similar activities of other public and private entities to maximize the quality of data projects and to minimize the cost and duplication of data projects. In its strategic plans, the nonprofit organization shall also evaluate the continued need for and efficacy of current data initiatives, including the use of patient level data for public health purposes. The nonprofit organization shall submit the first such strategic plan to the Board, the Governor, and the General Assembly by October 1, 1996. Such initial plan shall include recommendations for measuring quality of care for all health care providers and for funding all data projects undertaken pursuant to this chapter. The approval of the General Assembly shall be required prior to the implementation of any recommendations set forth in a strategic plan submitted pursuant to this section;

7. Competitively bid or competitively negotiate all aspects of all data projects, if feasible.

C. Except as provided in subsection K of § 11-45, the provisions of the Virginia Public Procurement Act (§ 11-35 et seq.) shall not apply to the activities of the Commissioner authorized by this section. Funding for services provided pursuant to any such contract or agreement shall come from general appropriations and from fees determined pursuant to § 32.1-276.8.

§ 32.1-276.5. Providers to submit data.

Every health care provider shall submit data as required pursuant to regulations of the Board, consistent with the recommendations of the nonprofit organization in its strategic plans submitted and approved pursuant to § 32.1-276.4. Notwithstanding the provisions of Chapter 26 (§ 2.1-377 et seq.) of Title 2.1, it shall be lawful to provide information in compliance with the provisions of this chapter.

§ 32.1-276.6. Patient level data system continued; reporting requirements.

A. The Virginia Patient Level Data System is hereby continued, hereinafter referred to as the "System." Its purpose shall be to establish and administer an integrated system for collection and analysis of data which shall be used by consumers, employers, providers, and purchasers of health care and by state government to continuously assess and improve the quality, appropriateness, and accessibility of health care in the Commonwealth and to enhance their ability to make effective health care decisions.

B. Every inpatient hospital shall submit to the Board patient level data as set forth in this subsection. Any such hospital may report the required data directly to the nonprofit organization cited in § 32.1-276.4. Patient level data elements for hospital inpatients shall include:

1. Hospital identifier;

2. Attending physician identifier;

3. Operating physician identifier;

4. Payor identifier;

5. Employer identifier;

6. Patient identifier;

7. Patient sex, race, date of birth (including century indicator), zip code, patient relationship to insured, employment status code, status at discharge, and birth weight for infants;

8. Admission type, source, date and hour, and diagnosis;

9. Discharge date and status;

10. Principal and secondary diagnoses;

11. External cause of injury;

12. Co-morbid conditions existing but not treated;

13. Procedures and procedure dates;

14. Revenue center codes, units, and charges; and

15. Total charges.

C. State agencies providing coverage for outpatient services shall submit to the Board patient level data regarding paid outpatient claims. Information to be submitted shall be extracted from standard claims forms and, where available, shall include:

1. Provider identifier;

2. Patient identifier;

3. Physician identifier;

4. Dates of service and diagnostic, procedural, demographic, pharmaceutical, and financial information; and

5. Other related information.

The Board shall promulgate regulations specifying the format for submission of such outpatient data. State agencies may submit this data directly to the nonprofit organization cited in § 32.1-276.4.

§ 32.1-276.7. Methodology to review and measure the efficiency and productivity of health care providers.

A. Pursuant to the contract identified in § 32.1-276.4, and consistent with recommendations set forth in strategic plans submitted and approved pursuant to § 32.1-276.4, the nonprofit organization shall administer and modify, as appropriate, the methodology to review and measure the efficiency and productivity of health care providers. The methodology shall provide for, but not be limited to, comparisons of a health care provider's performance to national and regional data, where available, and may include different methodologies and reporting requirements for the assessment of the various types of health care providers which report to it. Health care providers shall submit the data necessary for implementation of the requirements of this section pursuant to regulations of the Board. Individual health care provider filings shall be open to public inspection once they have been received pursuant to the methodology adopted by the Board as required by this section.

B. The data reporting requirements of this section shall not apply to those health care providers enumerated in (iv) and (v) of the definition of health care providers set forth in § 32.1-276.3 until a strategic plan submitted pursuant to § 32.1-276.4 is approved requiring such reporting and any implementing laws and regulations take effect.

§ 32.1-276.8. Fees for processing, verification, and dissemination of data.

A. The Board shall prescribe a reasonable fee, not to exceed one dollar per discharge, for each

health care provider submitting patient level data pursuant to this chapter to cover the costs of the reasonable expenses in processing and verifying such data. The Board shall also prescribe a reasonable fee for each affected health care provider to cover the costs of the reasonable expenses of establishing and administering the methodology developed pursuant to § 32.1-276.7. The payment of such fees shall be at such time as the Board designates. The Board may assess a late charge on any fees paid after their due date.

The Board shall (i) maintain records of its activities; (ii) collect and account for all fees and deposit the moneys so collected into a special fund from which the expenses attributed to this chapter shall be paid; and (iii) enforce all regulations promulgated by it pursuant to this chapter.

B. The nonprofit organization providing services pursuant to an agreement or contract as provided in § 32.1-276.4 shall be authorized to charge and collect the fees prescribed by the Board in subsection A of this section when the data are provided directly to the nonprofit organization. Such fees shall not exceed the amount authorized by the Board as provided in subsection A of this section. The nonprofit organization, at its discretion, may grant a reduction or waiver of the patient level data submission fees upon a determination by the nonprofit organization that the health care provider has submitted processed, verified data.

C. State agencies shall not be assessed fees for the submission of patient level data required by subsection C of § 32.1-276.6. Individual employers, insurers, and other organizations may voluntarily provide the nonprofit organization with outpatient data for processing, storage, and comparative analysis and shall be subject to fees negotiated with and charged by the nonprofit organization for services provided.

D. The nonprofit organization providing services pursuant to an agreement or contract with the Commissioner shall be authorized to charge and collect reasonable fees for the dissemination of patient level data; however, the Commissioner shall be entitled to receive publicly available data from the nonprofit organization at no charge.

§ 32.1-276.9. Confidentiality, subsequent release of data and relief from liability for reporting; penalty for wrongful disclosure; individual action for damages.

A. Patient level data collected pursuant to this chapter shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.1-340 et seq.), shall be considered confidential, and shall not be disclosed other than as specifically authorized by this chapter; however, upon processing and verification by the nonprofit organization, all patient level data shall be publicly available, except patient, physician, and employer identifier elements, which may be released solely for research purposes if otherwise permitted by law and only if such identifier is encrypted and cannot be reasonably expected to reveal patient identities. No report published by the nonprofit organization, the Commissioner, or other person may present information that reasonably could be expected to reveal the identity of any patient. Publicly available information shall be designed to prevent persons from being able to gain access to combinations of patient characteristic data elements that reasonably could be expected to reveal the identity of any patient. The nonprofit organization, in its discretion, may release physician and employer identifier information.

B. No person or entity, including the nonprofit organization contracting with the Commissioner, shall be held liable in any civil action with respect to any report or disclosure of information made under this article unless such person or entity has knowledge of any falsity of the information reported or disclosed.

C. Any disclosure of information made in violation of this chapter shall be subject to a civil penalty of not more than $5,000 per violation. This provision shall be enforceable upon petition to the appropriate circuit court by the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred. Any penalty imposed shall be payable to the Literary Fund. In addition, any person or entity who is the subject of any disclosure in violation of this article shall be entitled to initiate an action to recover actual damages, if any, or $500, whichever is greater, together with reasonable attorney's fees and court costs.

§ 32.1-276.10. Chapter and actions thereunder not to be construed as approval of charges or costs.

Nothing in this chapter or the actions taken by the Board pursuant to any of its provisions shall be construed as constituting approval by the Commonwealth or any of its agencies or officers of the

reasonableness of any charges made or costs incurred by any health care provider.

§ 32.1-276.11. Violations.

Any person violating the provisions of this chapter may be enjoined from continuing such violation by application by the Board for relief to a circuit court having jurisdiction over the offending party.

§ 32.1-335. Technical Advisory Panel.

The Board shall annually appoint a Technical Advisory Panel whose duties shall include recommending to the Board (i) policy and procedures for administration of the fund, (ii) methodology relating to creation of charity care standards, eligibility and service verification, and (iii) contribution rates and distribution of payments. The Panel shall also advise the Board on any matters relating to the governance or administration of the fund as may from time to time be appropriate and on the establishment of pilot health care projects for the uninsured. In addition to these duties, the Panel shall, in accordance with Board regulations, establish pilot health care projects for the uninsured and shall administer any money voluntarily contributed or donated to the fund by private or public sources, including local governments, for the purpose of subsidizing pilot health care projects for the uninsured.

The Panel shall consist of fifteen members as follows: the Chairman of the Board, the Director of the Department of Medical Assistance Services, ~~the Executive Director of the Virginia Health Services Cost Review Council,~~ *the Commissioner of Health,* the Commissioner of the Bureau of Insurance or his designee, the chairman of the Virginia Health Care Foundation or his designee, two additional members of the Board, one of whom shall be the representative of the hospital industry, and two chief executive officers of hospitals as nominated by the Virginia Hospital Association.

In addition, there shall be three representatives of private enterprise, who shall be executives serving in business or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the business and industry community in Virginia including, but not limited to, the Virginia Manufacturers Association, the Virginia Chamber of Commerce, the Virginia Retail Merchants Association, and the Virginia Small Business Advisory Board. There shall be two representatives from the insurance industry who shall be executives serving in insurance companies or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the insurance industry in Virginia including, but not limited to, Blue Cross/Blue Shield of Virginia, Health Insurance Association of America and the Virginia Association of Health Maintenance Organizations. There shall be one physician member. Nominations for this appointment may be submitted to the Board by associations representing medical professionals, including, but not limited to, the Medical Society of Virginia and the Old Dominion Medical Society.

§ 32.1-336. Annual charity care data submission.

No later than 120 days following the end of each of its fiscal years, each hospital shall file with the Department a statement of charity care and such other data as may be required by the Department. The Department may grant one 30-day extension of the filing date to hospitals unable to meet the 120-day requirement. Data required for carrying out the purposes of this chapter may be supplied to the Department by the ~~Virginia Health Services Cost Review Council~~ *Board of Health.* The Board shall prescribe a procedure for alternative data gathering in cases of extreme hardship or impossibility of compliance by a hospital.

§ 32.1-337. Hospital contributions; calculations.

Hospitals shall make contributions to the fund in accordance with the following:

A. A charity care standard shall be established annually as follows: For each hospital, a percentage shall be calculated of which the numerator shall be the charity care charges and the denominator shall be the gross patient revenues as reported by that hospital. This percentage shall be the charity care percent. The median of the percentages of all such hospitals shall be the standard.

B. Based upon the general fund appropriation to the fund and the contribution, a disproportionate share level shall be established as a percentage above the standard not to exceed three percent above the standard.

C. The cost of charity care shall be each hospital's charity care charges multiplied by each hospital's cost-to-charge ratio as determined in accordance with the Medicare cost finding principles. For those hospitals whose mean Medicare patient days are greater than two standard deviations below

the Medicare statewide mean, the hospital's individual cost-to-charge ratio shall be used.

D. An annual contribution shall be established which shall be equal to the total sum required to support charity care costs of hospitals between the standard and the disproportionate share level. This sum shall be equally funded by hospital contributions and general fund appropriations.

E. A charity care and corporate tax credit shall be calculated, the numerator of which shall be each hospital's cost of charity care plus state corporate taxes and the denominator of which shall be each hospital's net patient revenues as defined by the ~~Virginia Health Services Cost Review Council~~ *Board of Medical Assistance Services*.

F. An annual hospital contribution rate shall be calculated, the numerator of which shall be the sum of one-half the contribution plus the sum of the product of the contributing hospitals' credits multiplied by the contributing hospitals' positive operating margins and the denominator of which shall be the sum of the positive operating margins for the contributing hospitals. The annual hospital contribution rate shall not exceed 6.25 percent of a hospital's positive operating margin.

G. For each hospital, the contribution dollar amount shall be calculated as the difference between the rate and the credit multiplied by each hospital's operating margin. In addition to the required contribution, hospitals may make voluntary contributions or donations to the fund for the purpose of subsidizing pilot health care projects for the uninsured.

H. The fund shall be established on the books of the Comptroller so as to segregate the amounts appropriated and contributed thereto and the amounts earned or accumulated therein and any amounts voluntarily contributed or donated for the purpose of subsidizing pilot health care projects for the uninsured. No portion of the fund shall be used for a purpose other than that described in this chapter. Any money remaining in the fund at the end of a biennium shall not revert to the general fund but shall remain in the fund to be used only for the purpose described in this chapter, including any money voluntarily contributed or donated for the purpose of subsidizing pilot health care projects for the uninsured, whether from private or public sources.

2. That Chapter 26 (§§ 9-156 through 9-166.7) of Title 9 of the Code of Virginia is repealed.

3. That the regulations of the Virginia Health Services Cost Review Council shall remain in effect until superseded by regulations promulgated by the Board of Health.

4. That any contracts entered into by the Executive Director of the Virginia Health Services Cost Review Council and any nonprofit health data organization pursuant to § 9-166.4 shall continue, and that the State Health Commissioner shall assume the rights, duties and responsibilities of the Executive Director under any such contracts.

5. That Chapter 7.2 of Title 32.1 and subsection K of § 11-45 of the Code of Virginia shall expire on July 1, 1999.

6. That the data submission requirements for implementation of programs pursuant §§ 9-161.1 and 9-166.3 shall remain in effect until such modifications are approved and any implementing laws and regulations take effect.

GLOBAL REFORMS

Primary Care Workforce Reform

Primary Care Needs Assessment (cont'd)

Status: DHP has been unable to implement this legislation because the Attorney General has advised that separate funding would be needed to avoid violating a legal requirement that licensure fees only be used to support activities directly related to administration of the licensure process. The Department of Health, through its Center for Primary Care Resource Development, is building a physician provider data base from existing commercial and public data bases. The Center expects to have the database in place by late summer of 1996.

GLOBAL REFORMS

Primary Care Workforce Reform

Generalist Initiative/Medical Education Funding

Generalist Initiative

Contact Person: R. Michael Morse, M.D. Center for the Advancement of Generalist Medicine ((804) 982-4472)

1991 Requested Virginia medical schools to develop a plan to encourage medical students to pursue careers in primary care.

1992 Requested the state academic medical centers to develop plans for emphasizing the education of primary care physicians. The institutions committed themselves to ensuring that 50 percent of their graduates would enter generalist practice.

1993 Appropriated $100,000 to match grant funding from the Robert Wood Johnson Foundation in support of the planning phase of the Generalist Initiative. The goal of the Generalist Initiative is to increase the pool of primary care physicians trained in Virginia's medical schools and residency programs.

PROGRAMS FOR THE UNINSURED

Virginia Health Care Foundation (cont'd)

1995 (cont'd) Passed a resolution encouraging continued private sector support of the Foundation.

1996 Passed a resolution (SJR 105) commending the Foundation and encouraging the private sector to support innovative efforts by the Foundation to enhance access to primary and preventive care for Virginia's uninsured and medically underserved citizens.

Maintained appropriation of $2.23 million GF in each year of the new biennium.

Status: The Foundation has granted $6.7 million in support of 60 projects across the Commonwealth. Over 42,000 uninsured Virginians were served in these projects during 1995. In FY 95, the Foundation projects generated over $5.6 million from private and local government sources. In addition, the Foundation has established the "Healthy Communities Loan Fund." Under this $4.2 million low interest loan fund made possible through First Virginia Banks, Inc. and the Virginia Practice Sights Initiative of the Robert Wood Johnson Foundation, providers can obtain loans

PROGRAMS FOR THE UNINSURED

Virginia Health Care Foundation (cont'd)

Status: (cont'd) at the prime interest rate. The loans range from $50,000 to $250,000 and must result in an increase in the number of primary care providers in one of Virginia's Health Professional Shortage Areas.

SENATE JOINT RESOLUTION NO. 72

Requesting the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia Health Sciences Center, and the Eastern Virginia Medical School to evaluate their programs for obstetrical training of family medicine residents.

Agreed to by the Senate, February 9, 1996
Agreed to by the House of Delegates, February 23, 1996

WHEREAS, measures such as infant mortality rates and low-weight birth rates indicate that Virginia needs to improve its maternal and child health care system; and

WHEREAS, quality obstetrical care is an essential element of an effective maternal and child health care system; and

WHEREAS, many rural areas are experiencing a shortage of obstetricians; and

WHEREAS, family physicians who provide obstetrical care are a vital resource for rural Virginia; and

WHEREAS, rural family physicians who practice obstetrics must be supported by appropriate referral and consultative arrangements with obstetricians; and

WHEREAS, obstetricians must be assured that referring family physicians are able to provide state-of-the-art prenatal care, detect high-risk pregnancies, and make appropriate referrals and requests for consultation; and

WHEREAS, family physicians and obstetricians must have a clear and mutually supportive relationship if Virginia is to make progress in assuring adequate access to obstetrical care in rural areas; and

WHEREAS, such supportive relationships should be formed during the obstetrical training of family physicians; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia Health Sciences Center, and the Eastern Virginia Medical School be requested to evaluate their programs for obstetrical training of family medicine residents to ensure that graduates are adequately trained to meet the demands of rural obstetrical practice within a collaborative environment with obstetricians. Each institution shall consult with representatives of community-based residency programs in conducting the study.

Each institution shall provide staff support for its study.

Each institution shall report on its progress to the Governor and the General Assembly by October 1, 1996, as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

SENATE JOINT RESOLUTION NO. 58

Requesting the Commissioner of Health to convene a task force to develop a draft statewide pre-hospital and inter-hospital trauma triage plan.

Agreed to by the Senate, February 28, 1996
Agreed to by the House of Delegates, February 26, 1996

WHEREAS, trauma is the leading cause of death in Virginia and across the country for persons under age 45, and is the fifth leading cause of death in Virginia for all ages; and

WHEREAS, trauma is the leading cause of disability for all ages; and

WHEREAS, research has shown that trauma systems in which critically injured patients are transported and admitted to specially designated trauma centers for medical care can reduce the number of preventable trauma deaths; and

WHEREAS, appropriate trauma triage protocols assess the extent of a patient's injuries and direct more seriously injured patients to designated trauma centers for specialized care; and

WHEREAS, Virginia has established a statewide trauma system with 11 designated trauma centers and a trauma registry, but has not established statewide trauma triage protocols for adults or children; and

WHEREAS, pursuant to Senate Joint Resolution No. 353 (1995), the Joint Commission on Health Care studied the feasibility of establishing a statewide pre-hospital and inter-hospital trauma triage plan; and

WHEREAS, in its study, the Joint Commission on Health Care found that there is significant variation in the triage of trauma patients across the state; and

WHEREAS, an analysis of the statewide trauma registry data indicated that approximately 24 percent of the more seriously injured patients across the state were not admitted to a designated trauma center and that, in some areas of the state, approximately 32 percent of the more seriously injured patients were not admitted to a trauma center; and

WHEREAS, on a statewide basis only 11 percent of the more seriously injured patients admitted to a non-designated hospital were transferred to a trauma center; and

WHEREAS, trauma research in both adult and pediatric patients has proven that critically injured patients not admitted to a designated trauma center often experience less than optimal outcomes; and

WHEREAS, a statewide pre-hospital and inter-hospital trauma triage plan would enhance the effectiveness of Virginia's trauma system; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Commissioner of Health be requested to convene a task force to develop a draft statewide pre-hospital and inter-hospital trauma triage plan. The task force shall consist of representatives of the State Emergency Medical Services Advisory Board, the State Health Department's Office of Emergency Medical Services, the Critical Care Committee, the regional emergency medical services (EMS) councils, the designated trauma centers, the Virginia Hospital and Healthcare Association, the Virginia Chapter of the American College of Surgeons, the Virginia Chapter of the American College of Emergency Physicians, the Virginia Chapter of the American Academy of Pediatrics, the emergency medical services community, pre-hospital care providers, and other appropriate organizations.

The State Health Department's Office of Emergency Medical Services shall provide staff support to the task force. All agencies of the Commonwealth shall provide assistance to the Department's task force, upon request.

The Commissioner of Health shall submit the draft statewide pre-hospital and inter-hospital trauma triage plan to the Joint Commission on Health Care by October 15, 1996, and the Commissioner shall report the findings and recommendations of the task force to the Governor and the 1997 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

GENERAL ASSEMBLY OF VIRGINIA -- 1996 SESSION

HOUSE JOINT RESOLUTION NO. 109

Requesting the Secretary of Administration and the Secretary of Health and Human Resources to develop a policy for considering reimbursement for telemedicine services by state health programs.

Agreed to by the House of Delegates, February 8, 1996
Agreed to by the Senate, February 29, 1996

WHEREAS, rural communities often lack adequate access to health care services; and

WHEREAS, many rural Virginians must travel long distances to receive specialized medical services, numerous rural areas are experiencing a shortage of primary care providers, and a number of rural hospitals are under financial stress due to declining utilization; and

WHEREAS, telemedicine is the use of telecommunications technology to deliver health care services and health professions education from a central site to distant areas; and

WHEREAS, telemedicine has been used to deliver high quality, specialized health care services and education programs from urban medical centers to distant rural areas; and

WHEREAS, telemedicine could allow more rural Virginians to receive care in their home community instead of traveling to a distant site; and

WHEREAS, telemedicine could allow rural hospitals to continue serving certain patients who would otherwise travel to a distant hospital for care; and

WHEREAS, telemedicine could support efforts to recruit and retain primary care providers in underserved rural areas by supplying convenient access to specialty consultation and continuing education programs; and

WHEREAS, telemedicine demonstration projects are now in progress in at least 35 states including Virginia; and

WHEREAS, third-party reimbursement of telemedicine services is essential for expanding the availability of telemedicine services in rural areas of the Commonwealth, particularly those services involving long-distance consultation via two-way interactive television; and

WHEREAS, the Commonwealth, through the State Employee Health Benefit Program and the Virginia Medicaid program, provides third-party reimbursement for some but not all available telemedicine services; and

WHEREAS, the Virginia Medicaid program has recently initiated third-party reimbursement for selected interactive television telemedicine services, while the State Employee Health Benefits Program does not provide reimbursement for such services; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Administration and the Secretary of Health and Human Resources be requested to develop a policy for considering reimbursement for telemedicine services by state health programs, including, but not limited to, interactive television telemedicine services, subject to appropriate standards of cost-effectiveness and quality assurance.

The Secretaries of Administration and Health and Human Resources shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the Secretaries, upon request.

The Secretaries shall submit a progress report to the Governor and the General Assembly by September 1, 1996, and shall complete their work in time to submit their findings and recommendations to the Governor and the 1997 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

GENERAL ASSEMBLY OF VIRGINIA -- 1996 SESSION

HOUSE JOINT RESOLUTION NO. 110

Requesting the Commissioner of Health to appoint a task force for the purpose of establishing professional guidelines for obstetrical care.

Agreed to by the House of Delegates, March 4, 1996
Agreed to by the Senate, February 29, 1996

WHEREAS, measures such as infant mortality rates and low birth-weight rates indicate that Virginia needs to improve its maternal and child health care system; and

WHEREAS, quality obstetrical care is an essential element of an effective maternal and child health care system; and

WHEREAS, many rural areas are experiencing a shortage of obstetricians; and

WHEREAS, family physicians who provide obstetrical care are a vital resource for rural Virginia; and

WHEREAS, rural family physicians and certified nurse midwives who practice obstetrics must be supported by appropriate referral and consultative arrangements with obstetricians; and

WHEREAS, obstetricians must be assured that referring family physicians and certified nurse midwives are able to provide state-of-the-art prenatal care, detect high-risk pregnancies, and make appropriate referrals and requests for consultation; and

WHEREAS, family physicians, nurse practitioners, certified nurse midwives, pediatricians, and obstetricians must have a clear and mutually supportive relationship if Virginia is to make progress in assuring adequate access to obstetrical care in rural areas; and

WHEREAS, the State Department of Health conducts maternal and child health programs for the Commonwealth; now, therefore, be it

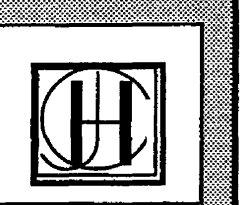
RESOLVED by the House of Delegates, the Senate concurring, That the Commissioner of Health be requested to appoint a task force for the purpose of establishing professional guidelines for obstetrical care. In appointing the task force, the Commissioner shall include representatives of the Virginia Academy of Family Physicians, the Virginia Obstetrical and Gynecological Society, the Virginia Chapter of the American College of Nurse Midwives, the Virginia Chapter of the American College of Pediatrics, nurse practitioners, and the State Department of Health. Such professional guidelines as may be established shall include, but not be limited to, prenatal care, detection of high-risk cases, and obstetrical consultation and referral.

The State Department of Health shall provide staff support for the study.

The Commissioner of Health shall submit a progress report on the work of the task force to the Governor and the General Assembly by October 1, 1996, and the task force shall complete its work in time to enable the Commissioner to submit his findings and recommendations to the Governor and the 1997 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B:

Status of Past Initiatives



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GLOBAL REFORMS

Identification of Efficient/Effective Providers

Contact Person: Michael Lundberg, Executive Director of Virginia Health Information, Inc. (643-5573)

1992 Directed the Virginia Health Services Cost Review Council (VHSCRC) to develop a new methodology for ranking hospitals and nursing homes on measures of efficiency and productivity.

1993 Established patient level data base to facilitate study of health care utilization and cost patterns for inpatient hospital services. The data is maintained by Virginia Health Information, Inc. (VHI).

1994 Expanded the patient level data base to include outpatient services for state-sponsored patients.

1995 Directed the Joint Commission on Health Care to study the value of various cost and quality initiatives.

GLOBAL REFORMS

Identification of Efficient/Effective Providers (cont'd)

1995 Passed legislation which:
(i) requires the Virginia Health Services Cost Review Council (VHSCRC) to establish an inter-agency committee with industry representatives to eliminate duplicative and unnecessary reporting;
(ii) exempts nursing homes and certified nursing facilities from the Commercial Diversification Survey and the budget filing requirements; and
(iii) requires VHSCRC to use existing data available from other state agencies to the greatest extent possible.

Passed budget language directing VHSCRC to review its current methodology for assessing fees to ensure the fees paid by health care institutions are appropriate and equitable.

GLOBAL REFORMS

Identification of Efficient/Effective Providers (cont'd)

1996 Passed legislation (HB 1307) which eliminates the VHSCRC and merges the efficiency and productivity methodology into the activities of Virginia Health Information, Inc. (VHI). Transfers responsibility for contracting with VHI to the Department of Health. Expands composition of the VHI Board to include nursing home representatives, and requires parity among health care provider representatives. Legislation requires VHI to submit a strategic plan to the Board of Health, the Governor and the General Assembly recommending data projects to be undertaken.

Status: VHSCRC, VHI and the Department of Health are working to facilitate the transition of the cost and quality data responsibilities as provided in HB 1307. The VHI Board has taken steps to revise its by-laws to reflect nursing home representatives, and has held initial discussions on developing the strategic plan.

GLOBAL REFORMS

Primary Care Workforce Reform

Primary Care Needs Assessment

Contact Person: Eula Moore, Department of Health (786-4891)

1991 Requested local health directors to assess primary care needs within their districts.

1993 Requested the Department of Health Professions (DHP) to study the supply and distribution of Virginia's physicians by specialty and location.

Requested the Virginia Statewide Area Health Education Centers Program to: (i) assess Virginia's primary care dental needs and develop a plan for addressing those needs in future years, and (ii) develop a plan by which nurses could assume a more significant role in meeting the primary care needs of the Commonwealth.

1994: Authorized DHP to require health professionals to submit data on practice profiles as part of the licensing process.

GLOBAL REFORMS

Primary Care Workforce Reform

Generalist Initiative (cont'd)

1994 Appropriated $2.65 million for FY 1995 and $1 million for FY 1996 to support implementation of the Generalist Initiative.

1995 Appropriated an additional $1.33 million for FY 1996 to bring the total to $2.33 million.

1996 Increased the general fund appropriation for the Generalist Initiative to a total of $2,995,549 in FY 1997, and $2,845,549 in FY 1998. The FY 1997 appropriation includes $150,000 in start-up funds for a family practice residency program in Southwest Virginia; accompanying language directs the Statewide Center for the Advancement of Generalist Medicine to submit a proposal for further development of the residency program to the money committees prior to the 1997 Session.

GLOBAL REFORMS

Primary Care Workforce Reform

Generalist Initiative (cont'd)

Status: The medical schools have made major strides in restructuring their medical school admissions programs and curricula, and the schools and the AHEC program have established a statewide task force on medical student recruitment and admissions. The academic health centers have taken some incremental steps to restructure their graduate medical education programs to reflect a generalist orientation, but have been hesitant to propose a more global plan due to uncertainty about the health care market and Medicare and Medicaid reform. The funding increases for FY 1997 and FY 1998 are less than requested, and the institutions are deciding how to prioritize among their programs. They will apply to the RWJ Foundation for a three-year, $2.1 million continuation grant in the Spring of 1997.

GLOBAL REFORMS

Primary Care Workforce Reform

Generalist Initiative/Medical Education Funding

Medical Education Funding

Contact Person: J. Michael Mullen, State Council of Higher Education in Virginia (SCHEV) (225-2610)

1993 Requested the State Council of Higher Education to study possible fiscal policies and other incentives to stimulate the production and utilization of primary care physicians at the three academic medical centers.

1994 Passed budget language linking medical education funding levels to the goal of 50 percent of graduates choosing generalist residencies. Directed SCHEV to develop specific guidelines and phasing-in procedures for each school.

Directed Virginia's three academic health centers to develop plans for restructuring graduate medical education programs to reflect a generalist orientation. Preliminary plans were

GLOBAL REFORMS

Primary Care Workforce Reform

Medical Education Funding (cont'd)

1994 (cont'd)	submitted by each institution in the Fall of 1994. A joint plan containing proposals for future graduate medical education planning and funding is due from the institutions in July of 1995.
1996	Appropriated an increase of $750,000 for medical education funding at the schools of medicine at UVA and MCV for FY 1998. Accompanying language directs SCHEV and the Secretary of Education to recommend to the Governor and the General Assembly a funding methodology for medical education, including the Generalist Initiative, for FY 1998.
Status:	The schools will be working with SCHEV and the Secretary of Education to complete the study. The Department of Medical Assistance Services is developing a study group to address GME issues for the Medicaid program.

GLOBAL REFORMS

Primary Care Workforce Reform

Practice Sights Initiative

Contact Person: Eula Moore, Department of Health (786-4891)

1992 Virginia won a $100,000 Practice Sights planning grant from the Robert Wood Johnson Foundation.

1993 Practice Sights implementation plan developed with four major objectives:

(I) Continuous refinement of primary care needs assessment
(ii) Establishment of a single office for health professions recruitment and retention
(iii) Development of practice support for primary care office settings in underserved areas
(iv) Development of reimbursement policies to enhance primary care payment rates in underserved areas.

GLOBAL REFORMS

Primary Care Workforce Reform

Practice Sights Initiative (cont'd)

1994 Requested the Department of Health to reallocate resources for purpose of establishing a Center of Health Professions Recruitment and Retention.

Received a three-year, $798,000 Robert Wood Johnson Foundation Practice Sights Initiative implementation grant.

Status: The Department of Health has established a new Center for Primary Care Resource Development which encompasses the former Center for Health Professions Recruitment and Retention and other primary-care related functions of the Department. The Center is engaged in marketing/ administering Virginia's primary care provider incentive programs, building a primary care management information system, refining methods for identifying primary care shortage areas, and providing technical assistance through the Office of Rural Health. Also, the Virginia Health Care Foundation has recently implemented the Health

GLOBAL REFORMS

Primary Care Workforce Reform

Practice Sights Initiative (cont'd)

Status: (cont'd) Communities Loan Fund in cooperation with RWJ and First Virginia Bank, Inc. This $4.2 million pool of funds will be used to support primary care projects in Virginia's health professional shortage areas.

GLOBAL REFORMS

Primary Care Workforce Reform

Medical Scholarships

Contact Person: Eula Moore, Department of Health (786-4891)

Virginia Medical Scholarship Program

	1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998
State Approp.	$180,000	$180,000	$360,000	$400,000	$445,000	$445,000	$445,000	$445,000
School Match	-	-	-	-	$135,000	$225,000	$225,000	$225,000
Total $	$180,000	$180,000	$360,000	$400,000	$580,000	$670,000	$670,000	$670,000
#Schol-arships	18	18	36	40	58	67	67	67

Status: The appropriation has remained at $445,000 per year since FY 95. The number of scholarships was increased to 67 per year in FY 96 to reflect the addition of matching funds from the medical schools.

GLOBAL REFORMS

Primary Care Workforce Reform

Medical Scholarships (cont'd)

Status: (cont'd) Twenty-one scholarships per year are allotted to each of the Virginia medical schools, and 4 are allotted to East Tennessee State University. DOH reports that 9 of 27 (33%) match-funded scholarships were awarded in FY 95. Thus far in FY 96, 33 of the 45 (73%) match-funded scholarships have been awarded.

DOH reports that of the 118 current Virginia Medical Scholarship recipients, 89 are fully funded, and 29 are match-funded. Of the 33 current recipients eligible to practice, 15 are practicing in medically underserved areas; the other 18 recipients are in a pay-back status. Fourteen additional scholarship recipients will be completing their residency between 1996 and 1997 and will be available to practice in medically underserved areas.

GLOBAL REFORMS

Primary Care Workforce Reform

Physician Loan Repayment

Contact Person: Eula Moore, Department of Health (786-4891))

1990 Established state/federal physician loan repayment program. Appropriated $50,000 in state matching funds. Funds were not spent because federal approval of the program was not obtained until 1993.

1994 Established state-sponsored physician loan repayment program. No funds appropriated.

Status: *Federal/State Program:* A total of $100,000 ($50,000 state & $50,000 federal) is available for the state/federal loan repayment program. To date, two physicians have participated in the program; both have completed their obligation. Health Department staff report that much of the problem with the program has been the requirement that the physicians work with either a public or not-for-profit practice in a health professional

GLOBAL REFORMS

Primary Care Workforce Reform

Physician Loan Repayment (cont'd)

Status: (cont'd) shortage area. DOH has had several applicants who were ineligible because they worked for a for-profit practice.

State Program: The Virginia Health Care Foundation is encouraging the Department of Health to issue regulations for the state-sponsored program in order to facilitate their support of the program.

GLOBAL REFORMS

Primary Care Workforce Reform

Nurse Practitioner Scholarships

1993 Appropriated $25,000 in general funds for five nurse practitioner scholarships per year.

1995 Requested an increase of $10,000 to raise the average scholarship amount from $5,000 to $7,000. The request was not approved. All five scholarships were awarded for FY 1995.

Status: Since 1993, 15 scholarships have been awarded to 13 recipients. Of the 13 recipients, 8 have graduated with 6 working in underserved areas. DOH has revised the program guidelines to more clearly state recipients' obligation to working in a "Virginia" underserved area.

DOH also administers scholarships that are linked with the Old Dominion University Distance Learning Program, which is funded by the Virginia Health Care Foundation. Four scholarships were awarded in 1995. All recipients have graduated; three are working in medically underserved areas.

GLOBAL REFORMS

Primary Care Workforce Reform

Dental Scholarships

Contact Person: Eula Moore, Department of Health (786-4891)

1994 Moved administrative responsibility from VCU/MCV to the Department of Health to consolidate scholarship programs and amended the "pay-back" provisions.

Transferred $25,000 in general funds from VCU/MCV to the Department of Health in each year of the 1994-1996 biennium for ten scholarships per year.

1995 Requested an increase of $85,000 to increase the average scholarship amount from $2,500 to $11,000. The request was not approved. All ten scholarships were awarded for FY 1995. Recipients agree to work in a dental shortage area upon completion of their training.

GLOBAL REFORMS

Primary Care Workforce Reform

Dental Scholarships (cont'd)

Status: A total of 86 recipients have participated in the program since 1976. Of this number, 38 graduates have worked or are working in dental areas of need; 23 graduates chose monetary payback.

Regulations recently were changed to require "triple-payback" if the recipient does not work in a dental area of need. DOH reports some awardees have declined the scholarship because of this change. Thus far in FY 96, only 2 scholarships have been awarded.

GLOBAL REFORMS

Primary Care Workforce Reform

Area Health Education Centers Program

Contact Person: Jeff Johnson, Statewide AHEC (828-7639)

1990 Established Statewide Area Health Education Centers Program (AHEC) and appropriated $150,000 per year in state general funds to match federal funds.

1992 Increased annual general fund appropriation to $200,000.

1994 Increased annual general fund appropriation to $240,000.

1995 Increased FY 1996 general fund appropriation to $358,139. Earmarked $118,139 to support AHEC activities related to the Generalist Initiative.

Earmarked $200,000 of the general fund appropriation to the Medical College of Hampton Roads for support of the Eastern Virginia AHEC.

GLOBAL REFORMS

Primary Care Workforce Reform

Area Health Education Centers Program (cont'd)

1996 Appropriated $300,000 in general funds for FY 1998 for the Northwest and Southside AHECs which will no longer be eligible for core federal funding in 1998.

Status: The Statewide AHEC Program just received a federal grant of $1.87 million for FY 1997. This funding constitutes the 6th year of federal funding for AHEC and the 2nd year of a 3 year funding cycle approved in 1995.

GLOBAL REFORMS

Primary Care Workforce Reform

Prescriptive Authority for Nurse Practitioners

Contact Person: Robert Nebiker, Department of Health Professions (662-9966)

1991 Authorized nurse practitioners to prescribe a limited schedule of controlled substances under the supervision of a physician. The private sector supervision ratio was set at one physician per two nurse practitioners. The public/non-profit sector ratio was set at one physician per four nurse practitioners.

1995 Conformed the private sector supervision ratio to the public/non-profit sector ratio by allowing private physicians to supervise up to four prescribing nurse practitioners at one time.

Status: As of December, 1995, of the 2,540 licensed nurse practitioners, 780 have prescriptive authority.

GLOBAL REFORMS

Primary Care Workforce Reform

Prescriptive Authority for Nurse Practitioners (cont'd)

Status (cont'd) The Board of Nursing has begun regulatory action to implement the change in the supervisory ratio for nurse practitioners' prescriptive authority in private practice pursuant to SB 984 of the 1995 Session.

GLOBAL REFORMS

Limits On Physician Self-Referral

Contact Person: Robert Nebiker, Department of Health Professions (662-9966)

1992 Directed the Secretary of Health and Human Resources to study physician ownership and financial interest in health care facilities in Virginia and the subsequent patient referral patterns to these facilities.

1993 Placed limits on physician referrals to health care facilities outside their office practice at which they do not directly provide care or services when they or an immediate family member have an investment in the facility.

Status: The Department of Health Professions (DHP) reported that a few cases have been investigated; however, none have uncovered sufficient evidence to result in charges against a licensee. Provisions of the law are not effective until July 1, 1996 for any investments acquired prior to February 1, 1993. This may account for the low level of activity thus far.

GLOBAL REFORMS

Certificate Of Public Need Reform

Contact Person: Paul Parker, Department of Health (786-7463)

1989 Extended the moratorium on new nursing home beds through January 1, 1991. (The moratorium was extended in each Session from 1990 through 1994).

1992 Required that hospital capital expenditures of $1 million or more be regulated under COPN. Also required regulation of the introduction or replacement of certain high technology services such as cardiac catheterization and lithotripsy, among others.

1993 Requested the Secretary of Health and Human Resources to study the utility and feasibility of establishing limits on total capital spending by medical care facilities as a means of discouraging unnecessary expansions of facilities and services. (This study was never conducted).

GLOBAL REFORMS

Certificate Of Public Need Reform (cont'd)

1994 Extended the moratorium on new nursing home beds through June 30, 1996 and directed the Commissioner of Health, in cooperation with the Department of Medical Assistance Services, to evaluate the continued need for the moratorium.

1995 Passed budget language directing the State Health Commissioner to make an assessment of the five-year budget impact of all Certificates of Public Need issued over the last two years. The study was to be reported to the Chairmen of the House Appropriations and Senate Finance Committees by July 1, 1995.

1996 Passed legislation (HB 1302) establishing a "Request for Applications" (RFA) process to replace the current COPN process for nursing home beds.

Passed legislation (HB 1194) which enacted several changes to the COPN laws including: (i) requiring any facility licensed as a hospital to be subject to COPN; (ii) revising the COPN requirements for replacing medical equipment; (iii) increasing the threshold for capital expenditures needing a COPN from $1

GLOBAL REFORMS

Certificate Of Public Need Reform (cont'd)

1996 (cont'd) million to $5 million; and (iv) adopting a minimum application fee of $1,000 and raising the maximum fee from $10,000 to $20,000.

Status: DOH reports that the target implementation date for the RFA process is December, 1996. HB 1302 directs the Commissioner of Health to study the need for and appropriateness of requiring higher level adult care residences to be subject to COPN. Legislation also directs the Joint Commission on Health Care to study the appropriateness of the COPN regulations and requirements, including whether outpatient or ambulatory surgical centers should be subject to COPN.

MEDICAID REFORM

Program Expansions For Women And Children

Contact Person: Joseph Teefey, Department of Medical Assistance Services (786-8099)

1989 Provided funds to support optional Medicaid coverage for children from age 1 to age 2 whose family income is at or below 100% of federal poverty guidelines. (Initial year general fund cost: $200,000).

1991 Provided funds to support mandated coverage of women and children up through age six. (Initial year general fund cost: $30.2 million).

Provided funds to support mandated coverage for: (i) families leaving the Aid to Dependent Children (ADC) program due to increased earnings (12 mo. limit); and (ii) families who qualify for the Unemployed Parent component of the ADC program. Also provided funds to support new eligibles resulting from federal changes in the ADC eligibility guidelines. (Initial year general fund cost: $9.3 million)

MEDICAID REFORM

Program Expansions For Women And Children (cont'd)

1993 Provided funds to support optional phased-in coverage of children under 19 who are not already covered. (Initial year general fund cost: $5 million)

Status: The number of people covered by the Virginia Medicaid program increased from 379, 876 in 1988 to 723,930 in 1995, an increase of 91%.

MEDICAID REFORM
Medicaid Managed Care

Contact Person: Joseph Teefey, Department of Medical Assistance Services (786-8099)

1990 Directed the Department of Medical Assistance Services (DMAS) to study the feasibility of a managed care demonstration project.

1991 Directed DMAS to implement a managed care program for Medicaid patients.

1992 DMAS initiated pilot test of Medallion, a primary care case management program for AFDC recipients.

1993 DMAS initiated state-wide phase-in of Medallion program for AFDC recipients.

1994 Directed the Department of Medical Assistance Services to implement a voluntary capitated managed care program through the execution of contracts with qualified provider organizations. The Options program was developed in which HMOs contract to provide care for Medicaid AFDC recipients.

MEDICAID REFORM

Medicaid Managed Care (cont'd)

1995 Expressed legislative intent to expand managed care for the purpose of improving access and containing costs. Directed DMAS to develop detailed implementation plan by September 1, 1995.

Directed DMAS to expand mandatory enrollment in Medallion to all Medicaid recipients except those who receive Medicare and those who participate in community-based waivers effective July 1, 1995.

Directed DMAS to seek the necessary waiver to begin phasing in the Medallion II program in the Tidewater area effective January 1, 1996. Medallion II involves mandatory enrollment in health maintenance organizations except for long-term care clients.

Directed DMAS to seek the necessary waiver to implement one or more PACE (Providing All-Inclusive Care for the Elderly) demonstration projects.

MEDICAID REFORM

Medicaid Managed Care (cont'd)

1996 Expressed legislative intent through budget language which:

(i) requires Medallion II marketing and enrollment services to be provided exclusively through an enrollment broker;
(ii) delays expansion of Medallion II into Northern Virginia until May 1, 1997;
(iii) directs DMAS to study alternative patient-focused models for inclusion of the mentally disabled in mandatory managed care;
(iv) requires quarterly reports on the status of Medallion II;
(v) directs DMAS to evaluate the feasibility of expanding Medallion II to include medically underserved areas in the Tidewater area; and
(vi) directs DMAS to contract for an independent evaluation of Medallion II after its first six months.

Passed a resolution (SJR 62) directing the Joint Commission to study the effects of Medicaid managed care on durable medical equipment and pharmacy services.

MEDICAID REFORM

Medicaid Managed Care (cont'd)

1996 (cont'd) Passed legislation (HB 1130) which provides a one-year exemption from certain capitalization requirements for certain Pre-PACE, long-term care health plans. HB 1130 also directs the Joint Commission on Health Care, in cooperation with DMAS and the Bureau of Insurance to study exemptions to and appropriate state regulatory policy for PACE and Pre-PACE projects.

Status: As of April, 1996, 372,818 Medicaid clients were eligible for managed care, and 41,378 were in the process of being enrolled.

Medallion: As of April, 1996, 201,402 Medicaid clients were enrolled in Medallion.

Options: As of April, 1996, a total of 36,203 Medicaid clients were enrolled in the Options program. The 1996 Options enrollment numbers are more than double the number of enrollees in March, 1995 (15,719).

Medallion II: The Medallion II program was implemented in Tidewater on January 1, 1996. As of April, 1996, a total of

MEDICAID REFORM

Medicaid Managed Care (cont'd)

Status: (cont'd) 93,835 Medicaid clients were enrolled. DMAS currently contracts with five HMOs (Optimum Choice, HealthKeepers Plus by Priority, Chartered Health Plan, Sentara Family Care, and HealthKeepers Plus by Peninsula). DMAS reports few problems with Medallion II.

The Department has formed an HMO Oversight Committee composed of representatives of providers, HMOs, state government and other interested parties. The committee has met twice thus far. DMAS is moving forward to meet the requirements contained in the Appropriation Act regarding Medallion II.

MEDICAID REFORM

Limits on Transfer of Assets

Contact Person: Joseph Teefey, Department of Medical Assistance Services (786-8099)

1993 Tightened transfer of asset provisions under the Medicaid program in order to limit the Commonwealth's exposure in financing long-term care services in the future.

The 1993 legislation had three components: provisions to allow liens on certain property of Medicaid recipients of long-term care, provisions to allow certain term life insurance policies to be counted as resources of Medicaid long term care applicants, and provisions authorizing the Department of Medical Assistance Services to operate an estate recovery program.

Status: DMAS reports 247 unduplicated individuals were denied Medicaid payment for nursing facility or waiver services because of a transfer of assets between August, 1993 and August, 1995. DMAS estimates that approximately $3 million in Medicaid payments were avoided for a total of 2,583 months of care. Savings could have been greater had federal law not prohibited a more

MEDICAID REFORM

Limits on Transfer of Assets (cont'd)

Status: (cont'd) effective transfer of assets rule. DMAS did not recommend legislation during the 1996 General Assembly Session to provide the Department authority to utilize liens because of potential changes in federal law through Medicaid reform.

COMMERCIAL INSURANCE REFORM

Small Business Market Reform

Contact Person: Ann Colley, Bureau of Insurance (371-9813)

1992 Enacted insurance reforms for small groups up to 50 employees. The legislation required guaranteed renewable coverage, disallowed the practice of excluding individuals within groups, and placed limits on pre-existing condition exclusions.

Established the Essential Health Benefits Panel to develop an essential health benefits plan and a standard health services plan for the Commonwealth, and requested the Insurance Commissioner to conduct a study of small group health insurance reform.

1993 Required insurance carriers to guarantee the issue of the Essential and Standard plans and to use modified community rating for small groups with no more than 25 employees. Guarantee issue products were patterned after the products developed by the Essential Health Benefits Panel.

COMMERCIAL INSURANCE REFORM

Small Business Market Reform (cont'd)

1994 Made several amendments to the 1993 legislation . A key provision is a requirement that insurers participating in the primary small group market must community rate these groups based on the claims experience for all groups within the insurer's primary small group market. Effective date extended to July 1, 1994.

1996 Passed legislation (HB 700) extending small group reforms (guaranteed renewability, no exclusions from group, limits on waiting periods for pre-existing conditions, and credit for waiting periods in previous coverage) to groups up to 99 employees.

Passed legislation (HB 835) to clarify that persons receive credit for any waiting periods served while enrolled in Medicare, Medicaid, CHAMPUS, other publicly funded programs and HMOs.

Status: Regulations governing the Essential and Standard Benefit Plans became effective May 1, 1995. Carriers have to register with the Bureau and have their Essential and Standard plans approved to

COMMERCIAL INSURANCE REFORM

Small Business Market Reform (cont'd)

Status: (cont'd)

market in the primary small group market. The Bureau reported on March 13th that 83 carriers (21 HMOs, 60 insurers, and 2 health services plans) had registered as a Small Employer Carrier.

Three carriers (2 insurers and 1 HMO) reported issuance of Standard and Essential benefits plans in the primary small employer market. Fifteen primary small employer groups covering a total of 65 persons have purchased the Essential or Standard plans. The Bureau expected these numbers to be relatively low due to the short period of time the reforms have been in effect.

A process for revising and updating the Essential and Standard plans needs to be developed to keep the products current in the marketplace.

COMMERCIAL INSURANCE REFORM

Individual Market Reform

Contact Person: Ann Colley, Bureau of Insurance (371-9813)

1995 Enacted legislation which: (i) reduces the maximum waiting period for a pre-existing condition from 24 months to 12 months; and (ii) requires insurers, HMOs, and health services plans to provide credit for any waiting periods for pre-existing conditions that an individual has served in a previous group or individual health insurance policy.

Passed a resolution requesting the Bureau of Insurance to examine individual and conversion health care coverage and market reforms.

1996 The Bureau of Insurance study recommended additional reforms, including guaranteed renewability for all individual products, and guaranteed issue and modified community rating for the Essential and Standard plans.

Passed legislation (HB 1026) requiring guaranteed renewability for individual policies.

COMMERCIAL INSURANCE REFORM

Individual Market Reform (cont'd)

Status: HB 1026 directs the Joint Commission, and the Bureau of Insurance to study: (i) guaranteed issue and modified community rating; (ii) the applicability of these reforms to multiple employer welfare arrangements (MEWAs); and (iii) the impact of guaranteed issue reform on the taxation of open enrollment carriers.

PROGRAMS FOR THE UNINSURED

Indigent Health Care Trust Fund

Contact Person: Dave Austin, Department of Medical Assistance Services (371-2451)

1989 The Indigent Health Care Trust Fund was established as a public/private partnership to address uncompensated charity care for private acute care hospitals. A Technical Advisory Panel was created to oversee the operations of the Trust Fund.

Status: In FY 1995, 85 hospitals participated in the Trust Fund. There were 35 hospitals which actually received payments from the fund. Payments from the Trust Fund totaled $10.1 million, with approximately $6 million coming from state general funds and $4.1 million from the hospital industry.

Indigent Health Care Trust Fund Reconfiguration (Pilot)

1989 Created a Trust Fund Technical Advisory Panel consisting of state officials and hospital industry representatives.

PROGRAMS FOR THE UNINSURED

Indigent Health Care Trust Fund Reconfiguration (Pilot) (cont'd)

1990 Expanded the Trust Fund Technical Advisory Panel to include three business representatives and requested the Panel to develop a report on how to bring business representatives into the Trust Fund.

1993 Expanded Technical Advisory Panel to include representatives from the insurance industry, the Commissioner of Insurance, the Virginia Health Care Foundation, and the physician industry.

Allowed hospitals to voluntarily return their Trust Fund payments for use in projects to establish alternative health insurance systems for the uninsured.

Requested the Technical Advisory Panel to develop a proposal to reconfigure the Trust Fund to support strategies for increasing access to health insurance.

PROGRAMS FOR THE UNINSURED

Indigent Health Care Trust Fund Reconfiguration (Pilot) (cont'd)

1994 Authorized the use of voluntary donations to the Trust Fund to support a pilot program to offer a subsidized insurance product for the working uninsured.

1995 Passed a resolution directing the Technical Advisory Panel to continue its efforts to convert the fund.

Authorized the use of local government donations to support Trust Fund pilot projects.

Directed DMAS to seek a Medicaid 1115 waiver which would allow the use of Medicaid funds to provide reinsurance as part of a Trust Fund pilot project in Northern Virginia.

Status: No donated funds have been received yet. One hospital system, INOVA, has expressed firm interest in making voluntary donations. At least one pilot in Fairfax County is anticipated for the initial phase. There is potential for additional donations and pilots in Tidewater and Bedford.

PROGRAMS FOR THE UNINSURED

Indigent Health Care Trust Fund Reconfiguration (Pilot) (cont'd)

Status: (cont'd)

While some progress has been made, much work must still be done. Full implementation of the program requires completion of four components: (i) a Medicaid 1115 waiver must be submitted and approved by HCFA; (ii) an administrative structure must be established; (iii) regulations must be promulgated; and (iv) contract(s) must be executed with the health plan(s). The waiver is expected to be submitted to HCFA in June, 1996. DMAS hopes to issue emergency regulations (which would expedite the process) and have the regulations in place by April, 1997. Remaining components would be ready by this date.

The Technical Advisory Panel last met in July, 1995.

PROGRAMS FOR THE UNINSURED

State and Local Hospitalization Program

Contact Person: Dave Austin, Department of Medical Assistance Services (371-2451)

1989 Transferred the program from the Department of Social Services to the Department of Medical Assistance Services.

Required localities to participate in the program.

Established uniform eligibility criteria for all localities.

1996: Passed legislation (SB 36, HB 188) which revises the process for submitting and processing claims such that applications will discontinue in any locality where funds are no longer available. The DMAS Director will continue to estimate the cost of the program through trend analyses, and will submit a report each year to the Senate Committees on Health and Education, and Finance and the House Committees on Health, Welfare, and Institutions, and Appropriations.

PROGRAMS FOR THE UNINSURED

State and Local Hospitalization Program (cont'd)

Status: The SLH Program approved claims totaling $31.9 million in FY 1995. Of this amount, $13.2 million (state share: $11.6 million; local share: $1.6 million) was reimbursed through the program, leaving $18.7 million in unpaid claims.

PROGRAMS FOR THE UNINSURED

State Teaching Hospitals

Contact Person: Robert W. Cantrell, M.D., UVA ((804) 924-2444);
John E. Jones, M.D., VCU-MCV (828-9770)

1992 Implemented a new funding policy whereby part of the indigent care appropriation was routed through the Medicaid program to obtain federal matching funds under the disproportionate share payment policy.

1993 Requested the Joint Commission to work with the Governor to develop a long-term strategy for the role of the academic medical centers in indigent care and medical education.

1994 Gave the state teaching hospitals flexibility to develop cooperative ventures with private entities in an effort to remain competitive in a changing health care market.

1995 Passed Medicaid budget amendments which included a $12.8 million (federal and state) reduction in planned FY 1996 expenditures for enhanced Medicaid disproportionate share payments at the two state teaching hospitals. This reduction was

PROGRAMS FOR THE UNINSURED

State Teaching Hospitals (cont'd)

1995 (cont'd) mostly technical, reflecting a decline in expected inpatient days at the two institutions.

Passed budget language directing the Secretary of Education, in cooperation with the Department of Planning and Budget, VCU, and UVA, to study the feasibility of privatizing the two state teaching hospitals.

1996 Passed legislation (SB 389, HB 884) providing greater administrative flexibility for UVA Medical Center, and passed legislation (SB 607, HB 1524) establishing the MCV Hospitals Authority.

Status: *Budget.* The state teaching hospital appropriation now comes entirely from Medicaid disproportionate share payments. In FY 96, MCV received $55.8 million and UVA received $35.1 million in DSH payments. The projected figures for 1997 and 1998 are the same as FY 96.

PROGRAMS FOR THE UNINSURED

State Teaching Hospitals (cont'd)

Status (cont'd)

Flexibility. VCU-MCV

VCU has created University Health Services, Inc., (UHS) as a holding corporation for joint ventures. The board of the corporation includes representatives from the VCU board and faculty. The following entities have been established under the UHS Board:

UHS and MCV/VCU Hospital Hospitality House: UHS and the Hospital Hospitality House formed a non-profit corporation, and purchased a hotel which now provides housing for out-of-town patients receiving a variety of services at MCV.

UHS at Blackstone: UHS purchased the Blackstone Family Practice Center and operates it as a facility managed by MCV. Final arrangements are nearing completion.

UHS Managed Care: UHS formed Managed Care, Inc. as a for-profit entity to participate in a joint venture with Virginia Chartered Health Plans. Managed Care, Inc. purchased a 30% interest in Chartered's Statewide HMO.

PROGRAMS FOR THE UNINSURED

State Teaching Hospitals (cont'd)

Status (cont'd)

Flexibility. VCU-MCV

UHS at Stony Point: UHS formed UHS at Stony Point, Inc. to participate in a joint venture with the Richmond Eye and Ear Hospital Authority. Discussions are ongoing with Columbia/HCA regarding participation in this venture.
UHS at Chester: UHS formed UHS at Chester, Inc. to participate in a joint venture with Columbia/HCA to construct an ambulatory surgery center in Chester.

Flexibility. UVA

UVA medical center has formed the Blue Ridge Health Alliance with the UVA Health Services Foundation (the faculty practice plan). The major product of this partnership is QualChoice, a licensed HMO with "point of service" options.

PROGRAMS FOR THE UNINSURED

State Teaching Hospitals (cont'd)

Status (cont'd)

Flexibility. UVA

QualChoice: As of April, 1996, QualChoice covered approximately 30,000 lives associated with 107 employers. Seventy percent of the eligible UVA employees selected QualChoice during the 1996 enrollment period. QualChoice expects to add another 30,000 enrollees by January, 1997. QualChoice is expanding its service area to include providers in Augusta, Rockingham, and Culpeper counties, as well as the Richmond and Roanoke areas. A collaborative relationship has been established with Sentara in the Hampton Roads area.

Healthcare Partners: This is a joint venture of UVA Medical Center and the Health Services Foundation. Healthcare Partners has been involved in: (i) purchasing primary care practices; (ii) financing and upgrading the Medical Information Referral System; (iii) financing a new comprehensive directory of physicians; and (iv) creating a health informatics company.

HealthSouth Joint Venture: UVA Medical Center has formed a joint venture with HealthSouth Corporation to provide rehabilitation services to the Medical Center's service area.

PROGRAMS FOR THE UNINSURED

Virginia Health Care Foundation

Contact Person: Debbie Oswalt, Virginia Health Care Foundation (828-5804)

1992 Established the Virginia Health Care Foundation to encourage public/private partnerships that provide access to primary care for underserved Virginians. Appropriated $4.6 million in general funds to the Department of Health for this purpose for the 1992-94 biennium.

1993 Allocated funding directly to the Health Care Foundation.

1994 Passed a resolution encouraging private entities to support the work of the Foundation.

1995 Reduced FY 1996 appropriation from $2.37 million to $2.23 million and enacted a series of new reporting requirements.

Authorized local health departments to accept private donations for projects conducted under the auspices of the Foundation, as well as other primary and preventive health care projects.

LONG TERM CARE REFORM

Restructuring The Long-Term Care System

Contact Person: Cathy Saunders, Department of Medical Assistance Services (786-6147)

1992 Requested the Secretary of Health and Human Resources to develop a plan to streamline the planning, administration, and operation of health care and long-term care related boards and agencies.

1993 Established a long-term care policy for the Commonwealth.

Requested the Secretary of Health and Human Resources to reorganize programs serving the elderly at the state level.

Requested the Secretary of Health and Human Resources to develop and implement a statewide comprehensive case management system by July 1, 1994.

Extended the life of the Long-Term Care Council for one year to facilitate the restructure of the system.

LONG TERM CARE REFORM

Restructuring The Long-Term Care System (cont'd)

1993 (cont'd) Developed a plan to consolidate state long-term care and aging services.

1994 Requested the Secretary to review the consolidation plan and to develop additional plans for the coordinated delivery of services at the state and local levels. Extended the life of the Long Term Care Council through July 1, 1995.

1996 Passed a resolution (HJR 219) directing the Joint Commission to explore the options available to consumers when choosing long-term care.

Status: The report on the coordination of long-term care services at the local level was submitted by the Secretary of Health and Human Resources on April 19th. Recommendations regarding local level issues did not include any significant re-structuring. The recommendations on state-level consolidation included: (i) having the focal point for long-term care services at DMAS; (ii) maintaining a separate department for the aging and

LONG TERM CARE REFORM

Restructuring The Long-Term Care System (cont'd)

Status: (cont'd) strengthening the Department for the Aging's focus on educating the public on aging issues; and (iii) consolidating the certification and licensing functions of DOH and the licensing of adult care programs of Department of Social Services at either the Department of Health or DMAS.

LONG TERM CARE REFORM

Adult Care Residences

Contact Person: Ray Goodwin, Department of Social Services (692-1900)

1993 Established a two-tiered licensing system for Adult Care Residences effective January 1, 1994.

Appropriated $1 million in general funds to support the levels of care system for June, 1994.

1994 Appropriated $11.8 million in general funds to support the levels of care system in the new biennium. Rates were contingent upon the adoption of regulations for the levels of care by the Board of Social Services. Regulations were not adopted due to disagreements over the scope of services provided by Adult Care Residences, patient assessment requirements, and staffing standards.

LONG TERM CARE REFORM

Adult Care Residences (cont'd)

1995 Passed legislation to clarify the original statute. The major provisions of the new legislation clarified the list of conditions which may be treated in an Adult Care Residence; revised staffing requirements; and required an independent assessment of patient needs.

1996 Passed legislation (HB 1302) directing the Commissioner of Health to study the need for and appropriateness of requiring higher level adult care residences to be subject to COPN.

Passed legislation (SJR 96, HJR 86) directing JLARC to examine and recommend the best method for providing mental health, mental retardation and substance abuse services to persons in adult care residences.

Status: Regulations supporting a two-tiered licensing structure for ACRs became effective February 1, 1996.

LONG TERM CARE REFORM

Adult Care Residences (cont'd)

Status: (cont'd) As of December, 1995, there were 568 licensed ACRs with a licensed capacity of 26,793 beds. Higher level ACRs (assisted living and intensive assisted living) become eligible to receive Medicaid funds beginning August 1, 1996, for auxiliary grant (public pay) residents. Department of Social Services' (DSS) staff believe most of the 568 ACRs will be licensed as an assisted living facility.

DSS indicates that DMAS' budget includes $8.6 million in general funds for each year of the 1996-98 biennium for assisted living and intensive living vendor payments.

APPENDIX C:

Current Joint Commission on Health Care's Membership and Staff

JOINT COMMISSION ON HEALTH CARE

Chairman
The Honorable Stanley C. Walker
Vice Chairman
The Honorable Kenneth R. Melvin

The Honorable William T. Bolling
The Honorable Joseph V. Gartlan, Jr.
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Edward L. Schrock
The Honorable Jane H. Woods
The Honorable Thomas G. Baker, Jr.
The Honorable David G. Brickley
The Honorable Julia A. Connally
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable George H. Heilig, Jr.
The Honorable Harvey B. Morgan

Secretary of Health and Human Resources
The Honorable Robert C. Metcalf

Staff

Director
Jane Norwood Kusiak

Senior Health Policy Analysts
Scott F. Cannady

Patrick W. Finnerty

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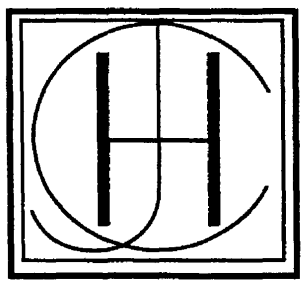
Mamie V. White



Joint Commission on Health Care
Old City Hall, Suite 115
1001 East Broad Street
Richmond, Virginia 23219
(804) 786-5445
(804) 786-5538 (FAX)