Joint Commission on Health Care

2006

Annual Report

COMMONWEALTH of VIRGINIA

Joint Commission on *Health Care*

Delegate Phillip A. Hamilton
Chairman

Kim Snead
Executive Director

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August 16, 2007

TO: The Honorable Timothy M. Kaine, Governor of Virginia
and
Members of the Virginia General Assembly

Pursuant to the provisions of the *Code of Virginia* (Title 30, Chapter 18, §§ 30-168 through 30-170) establishing the Joint Commission on Health Care and setting forth its purpose, I have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 2006.

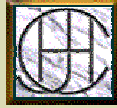
This *2006* Annual Report includes a summary of the Joint Commission's activities and legislative recommendations to the 2007 Session of the General Assembly. In addition, executive summaries of the studies completed in 2006 are included. The final reports of the completed studies were published and made available on the General Assembly website. The reports may be accessed from the Joint Commission's website also.

Respectfully submitted,

Phillip A. Hamilton
Chairman

MEMBERS

Delegate Phillip A. Hamilton
Chairman



Delegate Stephen H. Martin
Vice-Chairman

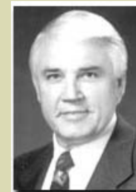
Delegate Clifford L. Athey, Jr.

Senator J. Brandon Bell, II

Senator Harry B. Blevins

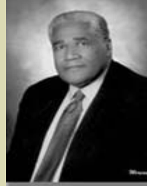
Delegate Robert H. Brink

Delegate Benjamin L. Cline



Delegate Franklin P. Hall

Senator R. Edward Houck



Senator Benjamin J. Lambert

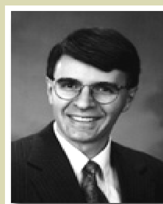
Delegate Kenneth R. Melvin

Delegate Harvey B. Morgan

Delegate David A. Nutter

Delegate John M. O'Bannon, III

Senator Linda T. Puller



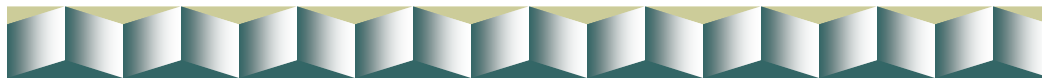
Senator Nick Rerras

Senator William C. Wampler, Jr.

Delegate John J. Welch, III

The Honorable Marilyn B. Tavenner

Staff



Kim Snead
Executive Director

Catherine W. Harrison
Senior Health Policy Analyst

Jaime H. Hoyle
Senior Staff Attorney

April R. Kees
Principal Health Policy Analyst

Sylvia A. Reid
Health Policy Research Assistant

Mamie White Jones
Office Manager

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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 2006. In addition, JCHC staff would like to recognize and thank the administration and staff of the Eastern Virginia Medical School Library for their invaluable assistance.

Introduction

Commission Profile

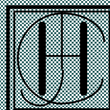
The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

Membership

The Joint Commission on Health Care is comprised of 18 legislative members. Eight members of the Senate are appointed by the Senate Committee on Rules and 10 members from the House of Delegates, of whom three shall be members of the House Committee on Health, Welfare and Institutions, are appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates.

Members of the Commission shall serve terms coincident with their terms of office. Members may be reappointed. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments.

The Commission shall elect a chairman and vice-chairman from among its membership. A majority of the members shall constitute a quorum.



Executive Summaries

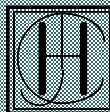
During 2006, the Joint Commission, the Behavioral Health Care Subcommittee, and the Long-Term/Medicaid Reform Subcommittee conducted studies in response to legislative requests. In keeping with its statutory mandate the Joint Commission completed the following study reports.

Access to and Availability of Geriatricians

House Joint Resolution 135 (HJR 135) of the 2004 General Assembly Session would have required a study of the access to and the availability of geriatricians. Although HJR 135 was tabled in the House Rules Committee, Delegate Harvey Morgan requested that the Joint Commission on Health Care (JCHC) staff study this issue and report the findings and recommendations to the Commission.

Geriatricians are physicians who have expertise in age-related issues or gerontology, the study of the aging process. There is a national shortage of geriatricians in the United States, which is projected to worsen as baby boomers age. Financial disincentives pose the greatest barrier to entry into the field of geriatrics. Low Medicare reimbursement rates are considered to be a major reason that relatively few physicians choose to specialize in geriatrics. Consequently, many believe federal reforms are needed, including modifying Medicare's payment system and the payment policy for federal training programs.

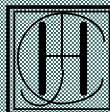
Virginia began funding the Virginia Geriatric Education Center, after Congress discontinued funding such centers in 2005. The Center and the Geriatric Academic Career Awards Program were provided a total of $375,000 GFs and $375,000 NGFs for each year of the 2006-2008 biennium. The funding is designed to "continue geriatric training and education programs across Virginia for a wide range of health-related professionals and service providers."



In response to the 2006 JCHC study, the following legislative options were adopted by the Commission:

◊ Request by letter from the Chairman that the Virginia Geriatric Education Center report to the Commission prior to the 2008 Session on its recommendations for improving access to and availability of geriatricians.

◊ Request by letter from the Chairman that the Health Workforce Advisory Committee in its deliberations consider the issues of the access to and availability of geriatricians in the context of future health workforce shortages associated with the aging of Virginia's population.



Effects of Health Care Cost Increases on Health Insurance Premiums

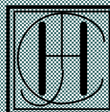
Senate Joint Resolution 4 (2006) directed the Joint Commission on Health Care (JCHC) to "study the derivative effects of increases in health care costs on health insurance premiums."

Employer-sponsored health insurance is the primary source of health insurance for the non-elderly in the United States. The percentage of employers, particularly small employers offering health insurance is decreasing. While the increasing cost of premiums for employer-sponsored health insurance has slowed in recent years, the 2006 increase of 7.7 percent exceeded the increase in overall inflation (3.5 percent) and in worker earnings (3.8 percent). (Source: Kaiser Family Foundation/Health Research and Educational Trust *2006 Employer Health Benefits Survey*.)

More than 150 million Americans currently receive their health insurance through employers.

In response to rising health insurance costs, some employers have increased employee cost-sharing requirements, reduced retiree health benefits, or discontinued providing health insurance as a benefit. As employers reduce or eliminate health insurance benefits, some employees move to the more expensive individual health insurance market, while others access government programs or become uninsured. Employers, health insurers, and health care providers have undertaken a number of cost containment and quality improvement efforts in an attempt to reduce the cost of health insurance. However, these cost containment efforts are expected to be marginally effective in containing rising health insurance costs.

The Joint Commission on Health Care approved the staff recommendation to continue addressing the issue of health insurance costs as part of a 2007 JCHC study based on HB 1324 (to expand health insurance into rural areas of the Commonwealth). This continuance will allow for consideration of data and findings from other ongoing studies and reports in making recommendations prior to the 2008 General Assembly Session.



Follow-Up Care and Tracking Systems for Preterm and Low-Birth Weight Infants

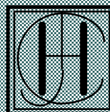
Preterm and low-birth weight (LBW) infants are at an increased risk of developmental delay by the circumstances of their birth. Immediate delays may not be readily apparent at birth or soon after, but are often recognized once the child enters school. The optimal time for providing services is early in life when the development of the brain and central nervous system may be influenced. By the time a child reaches school age, this time has passed.

In recognition of the importance of early identification and provision of services for babies born early or with low birth weights, a study was included in the 2006 Joint Commission on Health Care (JCHC) workplan. A workgroup was convened by JCHC staff to examine the adequacy of follow-up services and the potential need for a tracking system for preterm and low-birth weight infants in Virginia.

The work group consisted of representatives of:

Office of the Secretary of Health and Human Resources;
Department of Education;
Department of Health;
Department of Mental Health, Mental Retardation and Substance Abuse Services;
March of Dimes;
Medical Society of Virginia;
Virginia Association of Community Services Boards;
Virginia Association of Health Plans; and
Virginia Hospital and Healthcare Association.

The workgroup cited anecdotal evidence that families are having difficulty accessing services for their preterm and low-birth weight infants, with contributory factors including a general lack of understanding regarding the importance of follow-up services, the cost of services particularly since reimbursement for services is low, and the restrictive eligibility criteria for public programs. It is difficult to determine the extent to which access to services is a problem since data that is specific to preterm and low-birth weight infants is lacking. JCHC voted to convene a workgroup in 2007 to determine whether existing data and tracking systems can be adapted to provide information about preterm and low-birth weight infants.



Impact of Barrier Crime Laws on Social Service and Health Care Employers

Senate Joint Resolution 106 (SJR 106) of the 2006 General Assembly Session directed the Joint Commission on Health Care (JCHC) to study the impact of barrier crime laws on social service and health care employers. SJR 106 is a two-year study, with staff researching the issue and reporting findings and options to the Commission in 2007. The final report and recommendations will be presented to the Governor and the 2008 General Assembly.

Barrier crime laws prohibit persons convicted of certain statutorily-defined crimes from obtaining employment with certain employers, primarily those employers specializing in the care of vulnerable populations, such as children, the elderly, and those with mental disabilities.

Preliminary research indicates that as workplace violence and crime rates grew, as well as negligent hiring lawsuits, the list of barrier crime laws and mandatory background checks also grew.

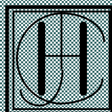
Additionally, preliminary interviews reveal that persons with a history of mental illness and/or substance abuse problems often have criminal backgrounds related to their illness or substance abuse problems, and often have difficulty obtaining employment, making rehabilitation more difficult. Furthermore, some employers report on having difficulty maintaining a qualified workforce.

Virginia Barrier Crime Laws

Currently, Virginia has barrier crime laws pertaining to such social service and health care employers as:

Department of Mental Health, Mental Retardation and Substance Abuse Services' employees at state facilities, those that handle state funds and those employees in direct consumer care positions;

Child welfare agencies;
Licensed nursing homes;
Home care organizations;
Community service boards;
Child day centers;
Assisted living facilities;
Foster and adoptive homes;
Hospital pharmacy employees;
Licensed hospice;
Behavioral health authorities;
Family day homes; and
Adult day centers.



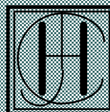
The Code of Virginia § 63.2-1719 defines 31 types of crimes as “barrier crimes”	
Twenty-six of these crime are felonies, and include:	
Murder	Malicious wounding
Abduction	Abduction for immoral purpose
Assaults & bodily wounding	Robbery
Carjacking	Felony stalking
Sexual assault	Arson
Drive-by shooting	Use of machine gun
Use of sawed-off shotgun	Aggressive use of machine gun
Pandering	Crimes against nature (children)
Taking indecent liberties	Indecent liberties (custodial relationship)
Abuse & neglect of children	Possession of pornography, intent to distribute
Possession child pornography	Electronic facilitation pornography
Abuse & neglect of incapacitated adults	Delivery of drugs to prisoners
Escape from prison	Felonies by prisoners

For child welfare agencies or foster and adoptive homes, additional barrier crimes include:

- Burglary,
- Felony violation relating to possession or distribution of drugs,
- Conviction of any other felony not included in the definition of barrier crime unless five years have elapsed since conviction,
- A founded complaint of child abuse and neglect.

For the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), community services boards (CSBs), and behavioral health authorities (BHAs) additional barrier crimes for direct consumer care positions include:

- Burglary,
- Extortion by threat,
- Distribution of drugs, and
- Possession of drugs.



Virginia Barrier Crime Law Exceptions

There are some statutory exceptions to Virginia's barrier crime laws:

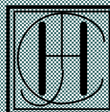
> Nursing homes, home care organizations, hospice, assisted living facilities, and adult day centers may employ a person if he/she had one misdemeanor conviction, not involving abuse or neglect, and more than five years have elapsed since the conviction.
>
> Child day centers and family day homes may employ a person if he/she was convicted of not more than one misdemeanor offense of assault if 10 years have elapsed following conviction, unless the offense was committed while employed in a child day center or the offense was committed against a minor.
>
> DMHMRSAS, CSBs, and BHAs may employ a direct consumer care provider if he/she was convicted of not more than one misdemeanor for assault or assault on a family or household member if more than 10 years have elapsed.

A special screening assessment is provided in the *Code of Virginia* §§ 37.2-416, 37.2-506 which states:

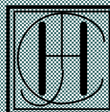
> "At Adult Substance Abuse Treatment facilities, a person who was convicted of a misdemeanor relating to (i) unlawful hazing; (ii) reckless handling of a firearm; or any misdemeanor or felony related to (a) reckless endangerment of others by throwing objects (b) threat; (c) breaking & entering a dwelling house w/intent to commit misdemeanor; or (d) possession burglarious tools; or any felony violation relating to the distribution of drugs, except an offense pursuant to 18.2-248 H1 and H2; or an equivalent offense in another state, if the hiring provider determines, based upon screening assessment, that criminal behavior was substantially related to applicant's substance abuse and that person has been successfully rehabilitated and is not a risk to consumers based on criminal history and substance abuse history."

Year Two Workplan

Over the next year, staff will examine applicable federal barrier crime laws and regulations, identify pending legislation, determine if there are any barrier crime law exceptions that are barred by federal law, and conduct a 50 state statutory analysis to compare Virginia's barrier crime laws to those in other states.



Additionally, staff will analyze the effectiveness of barrier crime laws in protecting consumers, residents, patients, and clients; as well as gather information on employment discrimination based on an individual's criminal record. Furthermore, staff will conduct interviews and receive additional comments from affected entities and individuals to examine the difficulty experienced by prospective employees in finding jobs and prospective employers in finding qualified applicants. Finally, staff will address the issue of negligent hiring and its impact on barrier crime legislation. Policy options will be presented to the Joint Commission on Health Care for consideration prior to the 2008 General Assembly Session.

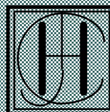


Medicare Part D - Update

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created Medicare Part D and was enacted on December 8, 2003. Medicare Part D offers outpatient prescription drug coverage for Medicare beneficiaries who enroll. Beneficiaries in Medicare fee-for service may seek coverage through a stand-alone prescription drug plan (PDP) or through a Medicare Advantage Prescription Drug (MA-PD) plan which covers all Medicare benefits. The Kaiser Family Foundation reported in February 2007, 43 million or 81% of Medicare beneficiaries were enrolled in a fee-for-service program and 8.3 million or 19% were enrolled in a Medicare Advantage plan. Medicare Advantage plans are "private health plans that receive payments from Medicare" and may receive a small additional monthly fee from the Medicare beneficiary. (Source: Kaiser Family Foundation, *Medicare Fact Sheet on Medicare Advantage*, February 2007.)

In June 2006, staff of the Joint Commission on Health Care (JCHC) provided an update on such Medicare Part D issues as cost sharing under the prescription drug benefit, and provisions related to dual eligibles and low-income beneficiaries. In exchange for the federal government generally assuming the cost of prescription drug coverage for dual eligibles, Virginia was expected to have a "clawback" payment to the federal government of $165,787,204 in FY 2007 and $178,243,970 in FY 2008. (Dual eligibles are individuals who are eligible for both Medicare and Medicaid.)

JCHC staff reported that 18 companies offered 41 Medicare prescription drug plans (PDPs) and 10 companies offered 26 Medicare Advantage Prescription Drug (MAPD) plans in Virginia.



Needs of Patients Found Not Guilty by Reason of Insanity or Incompetent to Stand Trial

Senate Joint Resolution 324 (SJR 324) introduced during the 2005 General Assembly Session, initially requested that the Joint Legislative Audit and Review Commission (JLARC) study the needs of patients found not guilty by reason of insanity (NGRI) and the impact on the mental health system of individuals found incompetent to stand trial (IST). The resolution was amended to direct the study to the Joint Commission on Health Care (JCHC) through its Behavioral Health Care Subcommittee.

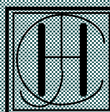
The BHC Subcommittee continued its study of NGRI/IST for a second year in 2006. (Study findings and actions taken by JCHC during the first year of the study are detailed in Senate Document 5 – 2006.) In conducting this study, JCHC staff and a study workgroup continued to address the objectives of the NGRI-acquittee system including: protection of public safety by ensuring that acquittees are not released into the community until they are ready for such release; fair treatment in terms of balancing an acquittee's need for treatment with the curtailment of his freedom, and consideration of the best use of inpatient bed capacity within Virginia's psychiatric hospitals.

The following legislative options were approved by the Joint Commission:

◊ Amend *Code of Virginia*, Title 19.2, Chapter 11 throughout to recognize the role of the CSB/BHA director or director's designee in outpatient restorations (SB 1103).

◊ Amend *Code of Virginia* §19.2-169.3 where the "director of the treating facility" appears to read the "director of the treating facility or his designee" to reflect current practice with regard to completion of reports (SB 1103).

◊ Amend *Code of Virginia* §19.2-175 and introduce an accompanying budget amendment to increase the fees provided for evaluations related to sanity and competence issues (SB 965/HB 2368). *(A budget amendment was not introduced since funding was included in the Governor's introduced budget.)*



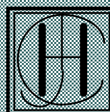
◊ Amend *Code of Virginia* §19.2-182.6.B to make it clear that the court is required to order the DMHMRSAS Commissioner to appoint two evaluators "to assess and report on the acquittee's need for inpatient hospitalization" *only in instances in which the petitioner for release is the acquittee* (SB 1134).

◊ Amend *Code of Virginia,* Title 19.2, Chapter 11.1 throughout to:

Replace the language "the community services board where the acquittee was acquitted" and the language "the community services board serving the locality in which the acquittee will reside" with "the community services board or the behavioral health authority as designated by the Commissioner"

Add "or behavioral health authority" where community services board appears to recognize the existence of such authorities (SB1104/HB2369).

◊ Introduce a budget amendment to provide funding to DMHMRSAS for outpatient restorations for adults. *Funding was not approved.*



Pain Management Standards for Long-Term Care Facilities

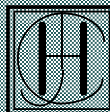
House Joint Resolution 160 (HJR 160) of the 2004 General Assembly Session would have required the Joint Commission on Health Care (JCHC) to "examine the issue of developing a pain management standard for long-term care facilities in Virginia." The House Rules Committee tabled HJR 160 but requested a review of the issue by JCHC.

This three-year study included a staff report in 2004 on Virginia's previous efforts to address pain management, a report in 2005 by the Virginia Health Quality Center titled *Virginia-Specific and National Findings on the Nursing Home Quality Initiative Related to Pain Management,* and a final JCHC report in 2006.

A stakeholder work group was convened by JCHC staff in 2006 to examine the need for new pain management standards for long-term care facilities in Virginia. The following organizations were represented on the work group:

- Virginia Assisted Living Association,
- Virginia Association for Home Care and Hospice,
- Virginia Association for Hospices,
- Virginia Association of Nonprofit Homes for the Aging,
- Virginia Board of Nursing,
- Virginia Health Care Association, and
- Virginia Health Quality Center.

The workgroup identified three major barriers to effective pain management in long-term care facilities including education, cultural challenges, and systemic problems. However, the workgroup also found that a number of initiatives were underway in Virginia to help address these barriers. After considering the numerous public and private initiatives that were underway, the workgroup concluded that establishing specific pain management standards for long-term care facilities would be both ineffective and unnecessary.



Update on Development of the Reporting System for Acute Psychiatric Beds

The Behavioral Health Care Subcommittee of the Joint Commission on Health Care (JCHC) voted to include the development of a bed-reporting system in its 2006 workplan. The system would allow for real time reporting on the availability of acute psychiatric beds. The need for such a system was identified as early as 2001 thereby, predating JCHC involvement in behavioral health care issues.

JCHC staff convened meetings of a stakeholder work group to establish the bed-reporting system parameters. The work group ultimately recommended that the Department of Mental Health, Mental Retardation and Substance Abuse Services contract with Virginia Health Information to develop and operate the system. A budget amendment for $50,000 was introduced on behalf of JCHC, in order to fund the development and operation of the proposed bed-reporting system. *Funding of $25,000 was included in the approved budget for FY 2008.*

Workgroup members:

Representatives of community services boards;

Private psychiatric facilities;

Commission on Youth;

Department of Medical Assistance Services;

Department of Mental Health, Mental Retardation and Substance Abuse Services;

Office of the Secretary of Health and Human Resources;

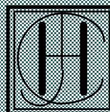
Psychiatric Society of Virginia;

Virginia Commonwealth University;

Virginia Department of Health;

Virginia Health Information; and

Virginia Hospital and Healthcare Association.



Commission Activities

In keeping with its statutory mandate, the Joint Commission completed studies; considered the comments of advocates, industry representatives and other interested parties; and introduced legislation to advance the quality and availability of health care, behavioral health care and long-term care in the Commonwealth. The 2006 meeting presentations for the Joint Commission, the Behavioral Health Care Subcommittee and the Long Term/Medicaid Reform Subcommittee follow.

Joint Commission on Health Care

Meeting Dates and Presentation Topics

April 27, 2006

Status of Legislation and Proposed Workplan for 2006
  Kim Snead, Executive Director

Election of Officers
  Delegate Harvey B. Morgan, Chairman

June 14, 2006

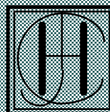
Discussion Regarding Emergency Preparedness
  Kim Snead

Member Discussion Regarding Additions to Workplan for 2006
  Delegate Phillip A. Hamilton, Chairman

August 22, 2006

The Asheville Program
  John Miall, President
  Miall Consulting

Findings of the Governor's Task Force on Cervical Cancer
  David E. Suttle, M.D., Director, Office of Family Services
  Virginia Department of Health



Dialogue for Action: Preventing Colorectal Cancer in Virginia
Theresa Teekah, Manager Cancer Control Project
Virginia Department of Health

H. Bryan Tomlinson, II, Director Healthcare Services
Department of Medical Assistance Services

Lucie Ferguson, Co-Chair
Cancer Prevention Action Coalition

Closing the Gap: Improving Patient Safety Through Research and Action
James B. Battles, Ph.D., Senior Service Fellow for Patient Safety
Agency for Healthcare Research and Quality

eHealth Initiatives in Virginia
James Burns, M.D., MBA, CIO
Virginia Department of Health

Report on Riverside Information Systems
John Stanley, CIO and Charles Frazier, M.D.
Riverside Health System

Report on Electronic Medical Records at Carilion
Brent Lambert, M.D.
Carilion Health System

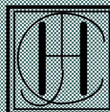
September 14, 2006

Kaiser Permanente Technology Capabilities
Ken Hunter, Chief Administrative Officer
Kaiser Permanente Health System

Patient Advocate Foundation Services
Nancy Davenport-Ennis, President, CEO
Patient Advocate Foundation

Healthy Returns^{sm}: Medicaid Disease Management
Patrick W. Finnerty, Director
Department of Medical Assistance Services

Developing a FAMIS Buy-In Program
Linda L. Nablo, Director, Division of Maternal and Child Health
Department of Medical Assistance Services



Staff Report: Preterm Infants – Follow-up Care and Tracking Systems
Catherine W. Harrison, Senior Health Policy Analyst

Staff Report: Access and Availability of Geriatricians
April R. Kees, Principal Health Policy Analyst

Interim Staff Report: Impact of Barrier Crime Laws on Social Service and Health Care Employers (SJ 106)
Jaime H. Hoyle, Senior Staff Attorney

October 19, 2006

Quality-in Sights®: Hospital Incentive Program (Q-HIP)
Lindsey Gilbert, Director of Network Performance
Anthem Blue Cross and Blue Shield

Second Hand Smoke: What Science Says About the Health Risks
Keenan Caldwell, State Director of Government Relations
American Cancer Society

Dr. Robert M. Shepard
St. Peter's Hospital & New West Health Services, Helena, Montana

Virginia Health Information - 2006 Annual Report
Gail Thompson, President
Virginia Health Information Board of Directors

Michael Lundberg, Executive Director
Virginia Health Information

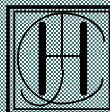
Public Health and Health Care Preparedness of the Commonwealth
Dr. Lisa G. Kaplowitz, Deputy Commissioner for Emergency Preparedness & Response
Virginia Department of Health

Dr. William Nelson, Director
Chesterfield County Health Department

Study on Health Savings Accounts
Doug Gray, Executive Director
Virginia Association of Health Plans

Staff Report: Effects of Health Care Cost Increases on Health Insurance Premiums (SJR 4)
Kim Snead

Staff Report: Update on Federal Funding of HIV/AIDS Prevention and Treatment Programs
Catherine Harrison



November 9, 2006

Update on State Employee Participation in Health Savings Accounts (HSAs) and Long-Term Care Plans

Sara Wilson, Director
Department of Human Resource Management

Decision Matrix and Report on Subcommittees' Actions

Kim Snead

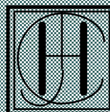
January 9, 2007

Discussion of Changes in Proposed Legislation and Budget Amendments

Kim Snead

Identification of Patrons for Legislation

Delegate Phillip A. Hamilton



Behavioral Health Care Subcommittee

Meeting Dates and Presentation Topics

The Behavioral Health Care Subcommittee was established in July 2003. Senator Stephen H. Martin serves as subcommittee chairman and Senator R. Edward Houck is vice chairman.

Other Commission members serving on this subcommittee are:

Delegate Robert H. Brink
Delegate Franklin P. Hall
Delegate Harvey B. Morgan
Delegate David A. Nutter
Delegate John M. O'Bannon, III
Senator Linda T. Puller
Senator William C. Wampler, Jr.
Delegate Phillip A. Hamilton, *ex officio*

April 27, 2006

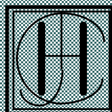
Proposed Workplan for 2006
Kim Snead, Executive Director

June 14, 2006

Autism Spectrum Disorders: A Brief Descriptive Report
Susan K. Williams, Ph.D., Assistant Professor
Virginia Treatment Center for Children, Virginia Commonwealth University

Review of Community Residential Services for Adults with Mental Retardation/Systemic Review of State-Operated Training Centers
James W. Stewart, III , Inspector General
Department for Mental Health, Mental Retardation and Substance Abuse Services

Report on Jail Survey Results and Other Forensic Initiatives
James J. Morris, Ph.D., Director of Forensic Services
Department of Mental Health, Mental Retardation and Substance Abuse Services



July 11, 2006

Health and Human Resources Priorities

The Honorable Marilyn B. Tavenner
Secretary of Health and Human Resources

Mental Health System Transformation in Virginia

Raymond R. Ratke, Chief Deputy Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services

Recommended Steps to Achieve a Comprehensive Continuum of Behavioral Health Care Services

James A. Thur, MSW, MPH, Executive Director
Fairfax-Falls Church Community Services Board

An Integrated Policy and Plan to Provide & Improve Access to MH, MR and SA Services for Children, Adolescents and their Families

Shirley Ricks, Director, Office of Child and Family Services
Department of Mental Health, Mental Retardation and Substance Abuse Services

Brian L. Meyer, Ph.D. Chair
Child and Family Behavioral Health Policy and Planning Committee

Review of Mental Health Case Management for Adults

James W. Stewart, III, Inspector General
Department for Mental Health, Mental Retardation and Substance Abuse Services

Educational Services for Students with Autism

Patricia C. Abrams, Director of Special Education Instructional Services
Department of Education's Division of Special Education & Student Services

September 14, 2006

State of the Commonwealth in Autism: Analysis of 'Autism Problem' from a Virginia Perspective

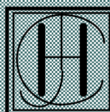
Carol M. Schall, Ph.D., Director
Virginia Autism Resource Center

Barrier Crimes and Rehabilitation Assessments

Mary Ann Bergeron, Executive Director
Virginia Association of Community Services Boards

Discussion: Funding for Children's Services

James S. Reinhard, M.D., Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services



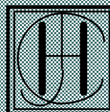
Suspension Versus Termination of Medicaid for Individuals in Public Institutions
Cindy Olson, Eligibility Section Manager
Department of Medical Assistance Services

Staff Report: Update on Development of a Reporting System for Acute Psychiatric Beds
Kim Snead

Staff Report: Needs of Patients Found Not Guilty by Reason of Insanity (SJ 324)
Kim Snead

November 9, 2006

Decision Matrix
Kim Snead



Long-Term Care/Medicaid Reform Subcommittee

The Long-Term Care Subcommittee, established in 1997, was expanded to include medicaid reform in 2006. Delegate John M. O'Bannon, III serves as subcommittee chairman and Senator Harry B. Blevins is the vice chairman.

Other Commission members serving on this subcommittee are:

Delegate Robert H. Brink
Senator J. Brandon Bell, II
Delegate Benjamin L. Cline
Delegate Franklin P. Hall
Delegate Phillip A. Hamilton
Senator R. Edward Houck
Senator Benjamin J. Lambert, III
Senator Stephen H. Martin
Delegate Harvey B. Morgan
Delegate David A. Nutter
Senator Linda T. Puller
Delegate John J. Welch, III

April 27, 2006

Proposed Workplan for 2006
April Kees, Principal Health Policy Analyst

June 14, 2006

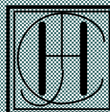
Alzheimer's Assisted Living Waiver
Terry A. Smith, Director, Division of Long-Term Care
Department of Medical Assistance Services

Medicaid Reform in Virginia
Patrick W. Finnerty, Director
Department of Medial Assistance Services

Medicaid Reform and the Deficit Reduction Act of 2005
Catherine Harrison, Senior Health Policy Analyst

State Initiatives Related to Medicaid Reform
April Kees

Medicare Part D Update
Catherine Harrison



July 11, 2006

Report on Long-Term Care Issues
Bill Lukhard, Executive Council Member
AARP Virginia

Update on Regulation of Medication Aides and Assisted Living Administrators
Elaine Yeatts, Senior Policy Analyst
Department of Health Professions

Update on Regulation of Assisted Living Facilities
Carolynne Stevens, Director of Licensing
Department of Social Services

Impact of Assisted Living Regulations
Walt Smiley, Team Leader
Joint Legislative Audit and Review Commission

Comments Regarding Assisted Living Regulations
Bob Williams, Assisted Living Facility Owner/Operator
Virginia Adult Home Association Board Member

Carter Harrison, President
Virginia Coalition for the Aging

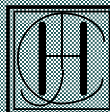
August 22, 2006

Update on Medicaid Reform
Steve Ford, Director of Policy and Research
Department of Medical Assistance Services

State Consolidation of Long-Term Care Services
Catherine Harrison

Health Insurance Primer
Doris Irvine, Senior Insurance Market Examiner
Bureau of Insurance

Overview of Nursing Home and Assisted Living Facility Liability Insurance
April Kees
Eric Lowe, Principal Analyst
Bureau of Insurance



October 19, 2006

Update on Medicaid Reform Initiatives

Patrick Finnerty, Director
Department of Medical Assistance Services

No Wrong Door

Julie Christopher, Commissioner
Department for the Aging

Disease Management

Megan Philpotts Padden, Vice President of Government Programs
Sentara Health Plans

Shannon Stepp, National Account Executive
Health Management Corporation

Pain Management Standards for Long-Term Care Facilities

Catherine Harrison

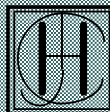
PACE Update

Catherine Harrison

November 9, 2006

Decision Matrix

Catherine Harrison



2007 Legislative Initiatives

The Commission's legislative package included five bills and two resolutions. There were eleven budget amendments introduced in both chambers.

The bills addressed such issues as procedures involved in pleading not guilty by reason of insanity and removing the sunset clause on health data reporting requirements.

Resolutions were introduced that addressed: (i) requesting DMAS to study the impact of modifying its insurance subsidy programs; and (ii) encouraging DMAS to expand the use of managed care where feasible.

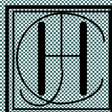
House and Senate Bills

Senate Bill 1103 - Senator Puller
Acts of Assembly Chapter 781

Amend *Code of Virginia* Title 19.2, Chapter 11 to recognize the role of the CSB/BHA director (or director's designee) in outpatient restorations and to amend *Code of Virginia* § 19.2-169.3 to add "or his designee" wherever "director of the treating facility" appears in relation to the completion of reports for the court.

Senate Bill 1134 - Senator Lambert
Acts of Assembly Chapter 785

Amend *Code of Virginia* §19.2-182.6B to clarify that the court is only required to order the DMHMRSAS "Commissioner to appoint two persons…to assess and report on the acquittee's need for inpatient hospitalization" when the petition for release has been submitted by the acquittee (and not when submitted by the Commissioner).



House Bill 2367 - Delegate Hamilton
Acts of Assembly, Chapter 21

Senate Bill 1112 - Senator Houck
Acts of Assembly Chapter 6

Amend *Code of Virginia* Title 32.1, Chapter 7.2 to remove the sunset clause for health care data reporting.

House Bill 2368 - Delegate Nutter
Acts of Assembly Chapter 829

Senate Bill 965 - Senator Puller
Left in House Appropriations

Amend *Code of Virginia* §19.2-175 to increase the cap on fees from $400 to $750 for professional services provided by mental health experts to courts.

House Bill 2369 - Delegate Brink
Acts of Assembly Chapter 485

Senate Bill 1104 - Senator Puller
Acts of Assembly Chapter 565

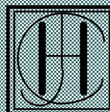
Amend *Code of Virginia* Title 19.2, Chapter 11.1: (1) to replace the language "the community services board where the acquittee was acquitted" and "the community services board serving the locality in which the acquittee will reside" with "the community services board or behavioral health authority as designated by the Commissioner" and (2) to add (where omitted) "or behavioral health authority" wherever "community services board" appears.

House Joint Resolution 653 - Delegate Nutter – *Laid on Table*
Senate Joint Resolution 388 - Senator Blevins – *Stricken at Patron Request*

Introduce a joint resolution requesting the Department of Medical Assistance Services to study the potential impact of modifying its insurance subsidy program. This was a recommendation of the Medicaid Revitalization Committee.

House Joint Resolution 657 - Delegate Melvin – *Passed by Indefinitely*
Senate Joint Resolution 384 - Senator Lambert – *Stricken at Patron Request*

Introduce a joint resolution encouraging the Department of Medical Assistance Services to expand the use of managed care where feasible. This was a recommendation of the Medicaid Revitalization committee.



Introduced Budget Amendments

Chief Patron:		
Hamilton	**Item 312 #22h**	
Houck	**Item 312 #6s**	
Martin	**Item 312 #14s**	

Health And Human Resources	**FY 06-07**	**FY 07-08**	
Grants To Localities	$0	$1,200,000	GF

Language:

Page 345, line 20, strike "$277,367,145" and insert "$278,567,145".

Page 348, line 43, strike "1,000,000" and insert "2,200,000".

Explanation:

(This amendment provides funding to increase children's service capacity by providing mental health services in the nine remaining juvenile detention centers (JDC) currently without such services. Seven JDCs currently receive funding and eight facilities received $125,000 each in Chapter 3, 2006 Virginia Acts of Assembly. This is a priority funding recommendation of the Child and Family Behavioral Health Policy and Planning Committee and a recommendation of the Joint Commission on Health Care.)

Funding in the amount of $900,000 was approved.

Chief Patron:		
Hamilton	**Item 312 #25h**	
Houck	**Item 312 #9s**	
Martin	**Item 312 #13s**	

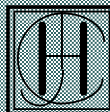
Health And Human Resources	**FY 06-07**	**FY 07-08**	
Grants To Localities	$0	$50,000	GF

Language:

Page 345, line 20, strike "$277,367,145" and insert "$277,417,145".

Explanation:

(This amendment provides funding for the development of a "real time" reporting system to allow hospitals to report on the availability of acute psychiatric beds for children and adolescents. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) will contract with Virginia Health Information (VHI) to develop the reporting system. This is a recommendation of the Joint Commission on Health Care.) **Funding in the amount of $25,000 was approved.**



Chief Patron: Morgan **Item 337 #2h**
Lambert **Item 337 # 1s**

Health And Human Resources	**FY 06-07**	**FY 07-08**	
Department Of Social Services	$0	$39,367,392	GF

Language:
Page 366, line 35, strike “$46,109,669” and insert “$85,477,061”.
Page 299, line 32, strike “$1,048” and insert “$1,500”.

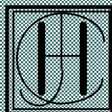
Explanation:
(This amendment provides funding to increase the state share of the maximum monthly auxiliary grant rate from $1,048 to $1,500 on July 1, 2007. A separate amendment to Item 302 provides for an increase in Medicaid enrollment as a result of this increase. The local share of funding ($9.8 million) is not reflected in this amendment. The auxiliary grant is the primary source of funding for assisted living for low-income Virginians. In June 2006, JLARC reported that Virginia’s auxiliary grant rate was “well below the market price” in paying for 33 to 59 percent of the average cost of assisted living facility care.
Funding in the amount of $995,280 was approved.

Chief Patron: Hamilton **Item 203 #7h**
Martin **Item 203 #12s**
Houck **Item 203 #13s**

Education: Higher Education	**FY06-07**	**FY 07-08**
Virginia Commonwealth University	$0	$288,500

Language:
Page 216, line 27, strike “$440,786,648” and insert “$441,075,148”.

Explanation:
(This amendment would provide general fund to enhance training and technical assistance activities related to working with individuals with autism.)
Funding was not approved.



Chief Patron: O'Bannon **Item 282 #1h**
Lambert **Item 282 #1s**

Health And Human Resources	**FY 06-07**	**FY 07-08**	
Department For The Aging	$0	$50,000	GF

Language:
Page 294, line 2, strike "$2,973,350" and insert "$3,023,350".

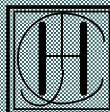
Explanation:
(This amendment provides funding to support the establishment of an education and awareness campaign regarding the benefits of long-term care (LTC) insurance. Federal long-term care partnership regulations permit state Medicaid programs to allow citizens to protect some of their assets even if they ultimately receive Medicaid for LTC services; Virginia has received approval to allow for long-term care partnerships. Citizens must have a "qualified" LTC insurance policy to qualify for asset protection.
Funding was not approved.

Chief Patron: O'Bannon **Item 302 #25h**
Blevins **Item 302 #16s**

Health And Human Resources	**FY 06 07**	**FY 07 08**
Department of Medical Assistance Services	$0	$250,000

Language:
Page 313, line 30, strike "5,443,850,8329, line 45, strike "$250,000" and insert "$500,000".
Page 329, line 45, strike "$250,000" and insert "$500,000".
Page 329, line 49, after "Virginia" insert "and a site to be determined by the department."

Explanation:
(This amendment provides $250,000 in start-up funding for one additional Program of All-Inclusive Care for the Elderly (PACE) program in Virginia. PACE provides an array of community-based services to elderly clients which often allows for institutional care to be delayed or avoided. Last October, six PACE programs were awarded start-up funding for at least two potential programs did not receive funding. Funding for one additional PACE program (to be located in Northern Virginia) was included in the Governor's introduced budget. This is a recommendation of the Joint Commission on Health Care.)
Funding was not approved.



Chief Patron: Morgan **Item 302 #26h**
Lambert **Item 302 #19s**

Health And Human Resources	**FY 06-07**	**FY 07-08**	
Department Of Medical Assistance	$0	$14,688,870	GF
Services	$0	$14,688,870	NGF

Language:
Page 313, line 30, strike "$5,433,850,896" and insert "$5,463,228,636".

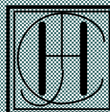
Explanation:
(This amendment includes $14.7 million the second year from the general fund and an equal amount of federal Medicaid matching funds to pay for additional caseload growth expected from a $452 increase in the monthly auxiliary grant payment contained in Item 337. Increasing the monthly auxiliary payment has the effect of expanding Medicaid eligibility, because auxiliary grant recipients are automatically eligible for Medicaid. This is a recommendation of the Joint Commission on Health Care.)
Funding was not approved.

Chief Patron: Brink **Item 312 # 6h**
Puller **Item 312 #10s**

Health And Human Resources	**FY 06-07**	**FY 07-08**	
Grants To Localities	$0	$360,000	GF

Language:
Page 345, line 20, strike "$277,367,145" and insert "$277,727,145".

Explanation:
(This amendment provides funding for outpatient competency restoration of adults. Title 19.2, Chapter 11 of the Code of Virginia requires restoration of competency to be completed on an outpatient basis unless inpatient treatment is required. Typically, outpatient restoration services are provided by staff of community services boards (CSBs), although funding is not provided. Funding is, however, provided for competency restoration of juveniles. Lack of funding results in mentally ill adults remaining in jails longer awaiting restoration services, particularly as the number of competency restoration orders received by CSBs has increased significantly in the last few years.)
Funding was not approved.



Chief Patron: O'Bannon **Item 312 #23h**
Puller **Item 312 #8s**

Health And Human Resources	**FY 06-07**	**FY 07-08**	
Grants To Localities	$0	$400,000	GF

Language:
Page 345, line 20, strike "$277,367,145" and insert "$277,767,145".

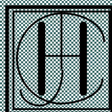
Explanation:
(This amendment provides funding for evidence-based training for currently practicing behavioral health clinicians who treat children and adolescents and for health care practitioners such as pediatricians and primary care physicians. This is a priority funding recommendation of the Child and Family Behavioral Health Policy and Planning Committee and a recommendation of the Joint Commission on Health Care.)
Funding was not approved.

Chief Patron: O'Bannon **Item 312 #24h**
Martin **Item 312 #7s**

Health And Human Resources	**FY 06-07**	**FY 07-08**	
Grants To Localities	$0	$300,000	GF

Language:
Page 345, line 20, strike "$277,367,145" and insert "$277,667,145".

Explanation:
(This amendment provides funding to enhance workforce capacity by establishing a university-based teaching center for training clinicians for children's behavioral health treatment across Virginia. This is a priority funding recommendation of the Child and Family Behavioral Health Policy and Planning Committee and a recommendation of the Joint Commission on Health Care.)
Funding was not approved.

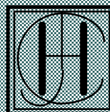


Chief Patron: Hamilton **Item337#1h**
Lambert **Item 337 #2s**

Health And Human Resources	**FY 06-07**	**FY 07-08**	
Department Of Social Services	$0	$6,459,544	GF

Language:
Page 366, line 35, strike "$46,109,669" and insert "$52,569,213".

Explanation:
(This amendment provides funding to eliminate the local match for the auxiliary grant, assuming the increase to $1,048 each month included in the Governor's budget is provided. The auxiliary grant, the primary source of non-federal funding to pay for assisted living for low-income Virginians, is funded with 80 percent state and 20 local funds. This is a recommendation of the Joint Commission on Health Care that found the local match of 20 percent is burdensome for localities in which a number of assisted living facilities have located near state psychiatric hospitals.)
Funding was not approved.



Statutory Authority

§ 30-168. (Effective until July 1, 2010) Joint Commission on Health Care; purpose.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

(1992, cc. 799, 818, §§ 9-311, 9-312, 9-314; 2001, c. 844; 2003, c. 633.)

§ 30-168.1. (Effective until July 1, 2010) Membership; terms; vacancies; chairman and vice-chairman; quorum; meetings.

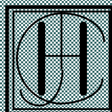
The Commission shall consist of 18 legislative members. Members shall be appointed as follows: eight members of the Senate, to be appointed by the Senate Committee on Rules; and 10 members of the House of Delegates, of whom three shall be members of the House Committee on Health, Welfare and Institutions, to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates.

Members of the Commission shall serve terms coincident with their terms of office. Members may be reappointed. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments.

The Commission shall elect a chairman and vice-chairman from among its membership. A majority of the members shall constitute a quorum. The meetings of the Commission shall be held at the call of the chairman or whenever the majority of the members so request.

No recommendation of the Commission shall be adopted if a majority of the Senate members or a majority of the House members appointed to the Commission (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the Commission.

(2003, c. 633; 2005, c. 758.)



§ 30-168.2. (Effective until July 1, 2010) Compensation; expenses.

Members of the Commission shall receive such compensation as provided in § 30-19.12. All members shall be reimbursed for reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the costs of compensation and expenses of the members shall be provided by the Joint Commission on Health Care.

(2003, c. 633.)

§ 30-168.3. (Effective until July 1, 2010) Powers and duties of the Commission.

The Commission shall have the following powers and duties:

1. To study and gather information and data to accomplish its purposes as set forth in § 30-168;

2. To study the operations, management, jurisdiction, powers and interrelationships of any department, board, bureau, commission, authority or other agency with any direct responsibility for the provision and delivery of health care in the Commonwealth;

3. To examine matters relating to health care services in other states and to consult and exchange information with officers and agencies of other states with respect to health service problems of mutual concern;

4. To maintain offices and hold meetings and functions at any place within the Commonwealth that it deems necessary;

5. To invite other interested parties to sit with the Commission and participate in its deliberations;

6. To appoint a special task force from among the members of the Commission to study and make recommendations on issues related to behavioral health care to the full Commission; and

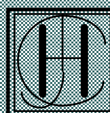
7. To report its recommendations to the General Assembly and the Governor annually and to make such interim reports as it deems advisable or as may be required by the General Assembly and the Governor.

(2003, c. 633.)

§ 30-168.4. (Effective until July 1, 2010) Staffing.

The Commission may appoint, employ, and remove an executive director and such other persons as it deems necessary, and determine their duties and fix their salaries or compensation within the amounts appropriated therefor. The Commission may also employ experts who have special knowledge of the issues before it. All agencies of the Commonwealth shall provide assistance to the Commission, upon request.

(2003, c. 633.)



§ 30-168.5. (Effective until July 1, 2010) Chairman's executive summary of activity and work of the Commission.

The chairman of the Commission shall submit to the General Assembly and the Governor an annual executive summary of the interim activity and work of the Commission no later than the first day of each regular session of the General Assembly. The executive summary shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

(2003, c. 633.)

§ 30-169.

Repealed by Acts 2003, c. 633, cl. 2.

§ 30-169.1. (Effective until July 1, 2010) Cooperation of other state agencies and political subdivisions.

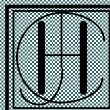
The Commission may request and shall receive from every department, division, board, bureau, commission, authority or other agency created by the Commonwealth, or to which the Commonwealth is party, or from any political subdivision of the Commonwealth, cooperation and assistance in the performance of its duties.

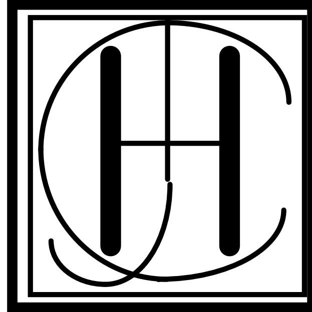
(2004, c. 296.)

§ 30-170. (Effective until July 1, 2010) Sunset.

The provisions of this chapter shall expire on July 1, 2010.

(1992, cc. 799, 818, § 9-316; 1996, c. 772; 2001, cc. 187, 844; 2006, cc. 113, 178.)





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