JOINT COMMISSION ON HEALTH CARE

COMMONWEALTH OF VIRGINIA
REPORT DOCUMENT 7 (2011)

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

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Chairman

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May 17, 2011

The Honorable Robert F. McDonnell
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, VA 23219

Members of the Virginia General Assembly
General Assembly Building
Richmond, VA 23219

Dear Governor McDonnell and Members of the 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, 2010.

This 2010 Annual Report includes a summary of the Joint Commission's activities and legislative recommendations to the 2011 Session of the General Assembly. In addition, staff studies are submitted as written reports, published, and made available on the General Assembly's website and the Joint Commission's website.

Respectfully submitted,

Benjamin L. Cline
Chairman

Preface

The Joint Commission on Health Care (JCHC), a standing Commission of the General Assembly, was established in 1992 to continue the work of the Commission on Health Care for All Virginians. *Code of Virginia*, Title 30, Chapter 18, states in part: "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." In July 2003, the definition of "health care" was expanded to include behavioral health care.

Membership

The Joint Commission on Health Care is comprised of 18 legislative members; eight members of the Senate appointed by the Senate Committee on Rules and 10 members of the House of Delegates appointed by the Speaker of the House.

In 2010, the Joint Commission welcomed three new members. The Speaker of the House of Delegates appointed **The Honorable T. Scott Garrett** from the 23rd District and **The Honorable Christopher K. Peace** from the 97th District. In addition, **The Honorable William A. Hazel, Jr.,** Secretary of Health and Human Resources joined JCHC as an ex officio member.

The Joint Commission would like to recognize **The Honorable Clifford L. Athey, Jr.** for his dedicated service. Delegate Athey served on the Joint Commission from 2002 to 2010.

During the Commission's May 2010 meeting, **Delegate Benjamin L. Cline** was elected as the Chair and **Senator Linda T. Puller** was elected to serve as Vice-Chair. Senator Puller stepped down from co-chairing the Healthy Living/Health Services Subcommittee and Delegate Cline appointed **Senator Patricia S. Ticer** to serve in that position along with Delegate John M. O'Bannon, Jr. The Behavioral Health Care Subcommittee co-chairs are Senator L. Louise Lucas and Delegate Harvey B. Morgan.

Membership

Virginia House of Delegates

The Honorable Benjamin L. Cline, Chair

The Honorable Robert H. Brink
The Honorable David L. Bulova
The Honorable Rosalyn R. Dance
The Honorable T. Scott Garrett
The Honorable Algie T. Howell, Jr.
The Honorable Harvey B. Morgan
The Honorable David A. Nutter
The Honorable John M. O'Bannon, III
The Honorable Christopher K. Peace

Senate of Virginia

The Honorable Linda T. Puller, Vice-Chair

The Honorable George L. Barker
The Honorable Harry B. Blevins
The Honorable R. Edward Houck
The Honorable L. Louise Lucas
The Honorable Ralph S. Northam
The Honorable Patricia S. Ticer
The Honorable William C. Wampler, Jr.

The Honorable William A. Hazel, Jr.
Secretary of Health and Human Resources

Staff

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Executive Director

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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, behavioral health, and long-term care in the Commonwealth.

Joint Commission on Health Care

The potential impact of federal health reform for the Commonwealth was the subject of a number of presentations to the Joint Commission including: Virginia's lawsuit (Attorney General Cuccinelli); Virginia Health Reform Initiative (Secretary Hazel and Cindi Jones); health insurance changes (Commissioner Gross and Deputy Commissioner Cunningham); perspectives of Stephen Horan, Ph.D. of Community Health Solutions and Shirley Gibson of the Virginia Nurses Association; and a staff overview of the major components of the Patient Protection and Affordable Care Act (Michele L. Chesser, Ph.D.).

Meetings

May 26

August 4

October 6

November 3

January 5, 2011

Staff reports presented to JCHC addressed:

- Catastrophic health insurance
- State funding for cancer research
- Medical care for uninsured individuals with life-threatening conditions
- Indigent and charity care provided by hospitals
- Chronic health care homes
- Feasibility of replicating the JMU Caregivers Community Network

Behavioral Health Care Subcommittee

The BHC Subcommittee addressed such issues as priorities of the Department of Behavioral Health and Developmental Services, preliminary findings of a mental health survey of colleges and universities, and potential effects of federal health reform for individuals with serious mental illness.

Healthy Living/Health Services Subcommittee

The HL/HS Subcommittee heard presentations addressing priorities and initiatives of the Virginia departments of health professions, health, and medical assistance services while staff reports addressed FAMIS eligibility levels, prevention and treatment of HIV/AIDS, and treatment of Lyme Disease using long-term antibiotics.

JCHC Staff Activities

Staff served as members of the following organizations:

- Age Wave Plan for Greater Richmond: Leadership Committee, Well Communities Subcommittee, and Data Advisory Group
- Children's Health Insurance Program Advisory Committee (CHIPAC) and CHIPAC Data Review Subcommittee
- National Center for the Analysis of Healthcare Data, Advisory Board
- Virginia Department of Health - Workforce Advisory Committee
- Virginia Department of Health Professions – Healthcare Workforce Data Center, Physicians Advisory Committee
- Virginia Oral Health Coalition, Advisory Board
- Virginia State Rural Health Plan – Workforce Council and Data and Rural Definitions Council

Staff presentations were made to:

- 2010 Rural Health Care Summit
- Children's Health Insurance Program Advisory Committee
- Continuing Medical Education lecture for physicians
- Leadership Metro Richmond Graduation Ceremony
- Mental Health Law Reform Commission
- VCU class on Aging Social Policy
- Virginia Bar Association: The 11th Annual Virginia Health Law Legislative Update
- Virginia Health Reform Initiative, Technology Reform Task Force
- Virginia Organizations Responding to AIDS

In addition, JCHC staff attended on-going meetings of the Health Information Technology Advisory Commission, Lyme Disease Task Force, Minority Health Advisory Committee (VDH), Project 2025, United Way's Summit on Aging, Virginia Alzheimer's Disease and Related Disorders Commission, Virginia Stroke Systems Task Force, and the Advisory Council of the Virginia Health Reform Initiative.

Executive Summaries

The following staff reports were presented in 2010.

Catastrophic Health Insurance

House Joint Resolution 99, introduced by Delegate Christopher P. Stolle in 2010, directed JCHC to "determine the availability and usage of catastrophic health insurance policies in the Commonwealth, examine the results of efforts in other states to increase the use of catastrophic health insurance policies, and evaluate the potential benefits and risks of facilitating the offering within the Commonwealth of health insurance policies or plans that provide catastrophic coverage only."

Findings

Catastrophic health insurance policies provide payment for medical services once a policyholder reaches a predetermined level of medical expenses. These policies financially

protect policyholders from responsibility for high health care expenses while being structured so the policyholder is fully responsible for a predetermined amount of initial medical expenses. The most common type of catastrophic health insurance is the high-deductible health plan (HDHP), which is typically less expensive than traditional health insurance. In Virginia, the number of individuals covered by qualified HDHPs increased from 50,100 individuals in 2006 to 114,700 individuals in 2008.

Insurance plans similar to HDHPs encourage consumers to become more cost-conscious and consequently both appropriate and inappropriate medical care is avoided. HDHPs are beneficial for some individuals, but low-income and moderately sick individuals often have poorer health outcomes in high-cost sharing plans like HDHPs when compared to traditional health insurance coverage.

Steps Taken to Encourage HDHP Adoption. Virginia has undertaken four of the five most common steps taken by state governments to encourage HDHP adoption.

Actions Taken in Virginia

Financial	Repealed state tax on health savings account contributions in 2004.
Insurance Market	Allowed HDHPs to be used in conjunction with health savings accounts and for conversion of medical savings accounts to health savings accounts in 2005.
Availability	Mandated State Employee Health Plan offer a HDHP option in 2005.
Transparency	Allowed dissemination of aggregate cost information for 25 common procedures in 2008.

Virginia could take the fifth step and provide greater transparency of cost and quality information through the use of an All-Payer Claims Database. Maine, Massachusetts, Minnesota, New Hampshire, and New York have enacted legislation to provide greater transparency of cost and quality information. These states have made available specific out-of-pocket cost estimates for procedures by specific provider or facility for uninsured and insured consumers. This information allows consumers to gauge more accurately out-of-pocket costs for procedures.

Policy Option

JCHC members approved the policy option to include in the JCHC 2011 work plan, a study to review (i) other states' efforts to publicly disseminate expansive cost and quality information by specific facility and provider for selected medical procedures; and (ii) legal, financial, data and other requirements for Virginia Health Information to provide similar specific cost and quality information through an All-Payer Claims Database in order to improve quality and health outcomes.

In addition, request by letter of the JCHC Chairman, that Virginia Health Information, the Virginia Association of Health Plans, the Medical Society of Virginia, and the Virginia Hospital and Healthcare Association provide assistance with the JCHC study which will be reported by November 2011.

State Funding for Cancer Research

Senate Joint Resolution 292 (2009) introduced by Senator Stephen H. Martin, directed JCHC to conduct a two-year study to "(i) examine the sufficiency of current funding sources for both the Massey Cancer Center and the University of Virginia Cancer Center; (ii) review history and successes of cancer research at each center; (iii) explore benefits to the Commonwealth of expanding state support of both centers; and (iv) research additional funding opportunities for both centers." SJR 292 was left in House Rules Committee; however, Joint Commission members voted to include the study in the 2009 and 2010 Commission work plan.

Findings

In the United States, an estimated $264 billion will be spent on cancer-related health care costs this year. In Virginia, approximately 36,400 new cases of cancer will be diagnosed and more than 14,000 will die of the disease.

In 2008, there were 25,454 inpatient hospitalizations in Virginia due to cancer at a total cost of more than $1 billion.

Virginia has two National Cancer Institute (NCI) designated Cancer Centers: the University of Virginia Cancer Center and VCU Massey Cancer Center. Both Centers receive financial support from NCI, as well as from other federal agencies such as the National Institutes of Health, and from private organizations and philanthropic donors. The State provides an annual appropriation of $1 million in general funds to each Center which is below the national average of $2.4 million. Most of Virginia's neighboring states provide significantly greater funding (for example, North Carolina and Maryland provide $50 million and $25 million per year, respectively). Increasing State support for Virginia's NCI Cancer Centers could result in the following positive outcomes:

Cancer continues to have a negative impact on both the health of individuals and the economy. One half of men and one third of women will be diagnosed with cancer in their lifetime.

- Longer, better lives for Virginians as a result of advanced cancer care that is closer to home, expanded statewide access to clinical trials, and development of new and effective prevention and control interventions and public education programs.
- Economic improvements due to a reduction in lost productivity resulting from illness and death, job-creation (via grants, contracts, and clinical activity), enhanced investment in health industry, company spin-offs and licensing revenues from intellectual property, increased early detection and prevention practices that can lower Medicaid expenses, and a reduction in loss of revenue due to Virginians going out of state for cancer treatment.

- Attainment of Comprehensive status for the two NCI Cancer Centers. Being designated as a NCI Comprehensive Cancer Center increases each Center's ability to access additional grant funding mechanisms and receive larger NCI support grants, recruit top physician-scientists and staff, provide more cutting-edge clinical trials for Virginians, and enable more cancer-related discoveries and better treatment options for Virginians. Of the 12 most populous states, only Virginia and Georgia do not have a NCI Comprehensive Cancer Center.

More specifically, greater State funding can provide resources for new/innovative types of research for which federal support is difficult to obtain without preliminary data gathered through seed funding. The State also can provide matching funds that often are required for grants and philanthropic donations. Finally, many components of clinical trials usually are not covered by federal, pharmaceutical, and non-profit grants (approximately $5,000 to $20,000 per patient will not covered by these sources) and the State can provide the supplemental funding needed for these clinical trials.

Policy Options

Joint Commission members approved introducing a budget amendment (language and funding) during the 2011 Session to increase the State funding for Virginia's NCI Cancer Centers from $1 million GFs for each center to $5 million GFs for each center.

Members added and voted to approve a policy option to include in the 2011 JCHC work plan, a review of how the various cancer research centers in Virginia could be involved in advancing cancer research and treatment.

Legislative Action

Language and funding of $3 million to support cancer research at the University of Virginia Cancer Center.

- *Item 189 #1c added $3 million for FY 2011*

(The Governor's introduced budget included an increase of $5 million for the VCU Massey Cancer Center, so no budget amendment was introduced on behalf of JCHC.)

Medical Care for Uninsured Individuals with Life-Threatening Conditions

Senate Joint Resolution 339, introduced by Senator George L. Barker in 2009, directed JCHC to study ways to ensure that individuals with life-threatening conditions (ILTCs) receive the care they need, regardless of resources.

Findings

There are avenues for uninsured ILTCs to receive free and discounted care, particularly from providers and pharmaceutical companies that seek to assist low-income individuals. Although many programs are available, program eligibility and benefits vary significantly; as a result specialized assistance is often needed to enable ILTCs to find and access available resources.

The following six programs have received State funding to assist the uninsured:

- *Virginia Cares Uninsured Program (VCUP)* was established in 2007, when State funding was provided to assist uninsured Virginians who were unable to access needed medical care. VCUP is funded through the Virginia Department of Health and administered by the Patient Advocate Foundation which provides professional case management assistance to Virginians in navigating the health care system in order to access medical care. Eligibility is limited to uninsured individuals with chronic, life-threatening, or debilitating diseases. Virginia has provided funding to PAF for VCUP since 2007 and 3,945 Virginians have been served.

- *Virginia's Uninsured Medical Catastrophe Fund (UMCF)* is a State program that is administered through the Department of Medical Assistance Services for low-income individuals who have a life-threatening illness or injury. UMCF was established in 1999 and has been funded by tax contributions and State funding.

- *Rx Partnership* is a public-private partnership that solicits free medications in bulk from pharmaceutical companies. A total of $46 million in medication has been donated to the program and 21 nonprofit affiliate pharmacies in Virginia now distribute the medication. Rx Partnership has received a small, annual State appropriation since its creation in 2004 ($105,000/year for 2011-2012 biennium).

- *The Pharmacy Connection (TPC)* provides computer software, developed by the Virginia Health Care Foundation in 1997 to expedite the application process to receive free medication from the various patient assistance programs. Currently, 150 hospitals and health safety organizations use TPC and $163 million in free medication was

distributed in FY 2010. TPC has received a small, annual State appropriation since FY 2005 ($125,000/year for 2011-2012 biennium).

- *RxRelief* provides funding to allow medication assistance caseworkers to assist uninsured individuals in applying for free chronic care medication through TPC. At this time, 28 medication assistance programs are funded and serve 76 localities. In FY 2010, RxRelief helped 14,911 patients receive medications valued at $48.5 million. In FY 2010, the Virginia Health Care Foundation received State funding of $1.85 million to disburse in grants to the medication assistance programs.

- *HIV/AIDS Medications* are provided by two programs administered by the Virginia Department of Health:
  - The AIDS Drug Assistance Program (ADAP) provides AIDS medication coverage to individuals without insurance coverage or third-party benefits whose income is at or below 400 percent FPL.
  - The State Pharmaceutical Assistance Program (SPAP) works with the ADAP program as a cost-effective means for the State to assist in paying for AIDS medication through the Medicare Part D program.

- *Virginia Bleeding Disorders Program* provides assistance for individuals with Hemophilia A/B, von Willebrand disease, or other congenital bleeding disorders. Funding for medical treatment and medications is available for individuals whose income is less than 200 percent FPL. The program is funded through Title V of the Social Security Act which requires a state funding match ($214,247 in State funding was appropriated in FY 2011).

Policy Options

JCHC members approved the following policy options:

- Request by letter of the JCHC Chairman that the Department of Social Services: i) work with the Patient Advocate Foundation to communicate with agency case workers concerning the Virginia Cares Uninsured Program, and the Uninsured Medical Catastrophe Fund; and (ii) emphasize patient assistance organizations and the Uninsured Medical Catastrophe Fund on the 2-1-1 Virginia website.

- A budget amendment to provide an additional $100,000 GFs in FY 2012 to the Uninsured Medical Catastrophe Fund

Legislative Action

The introduced budget amendment was not included in the approved State budget.

Indigent and Charity Care Provided by Hospitals

House Joint Resolution 27 introduced by Delegate Harry R. Purkey in 2010 requested that JCHC "(i) determine the volume of indigent health care provided…and the financial cost of [that] indigent health care to private, specialty, and not-for-profit hospitals in the Commonwealth; [as well as] identify and analyze potential tax and other incentives that may be offered to private and specialty hospitals and other health care providers to encourage the provision of care to indigent individuals."

Findings

In 2008, Virginia hospitals provided the equivalent in $400 million in charity care; in general, not-for-profit hospitals provided more charity care than for-profit hospitals as a percentage of revenues. Charity care policies are set by each hospital and there is no State standard defining the calculation of charity care. Recent federal changes will provide for greater federal oversight of tax-exempt hospitals: the Internal Revenue Service (IRS) revised Form 990 to standardize how hospitals report charity care expenses and the U.S. Treasury was mandated to review hospitals' tax-exempt status every three years.

Furthermore in 2014, the requirement within the Patient Protection and Affordable Care Act (PPACA) for individual health insurance coverage, if enacted, is expected to decrease significantly the number of uninsured Virginians and concomitantly decrease the need for hospital-provided charity care. However, before considering new policies regarding hospital charity care, additional review of the actual impact of federal health reform should be undertaken. By 2016, specific assessments of PPACA's impact on charity care could be gauged and multiple years of hospital charity care data from the revised IRS Form 990 will be available. If PPACA provisions decrease the need for charity care, there may be justification for lowering the charity care conditions within Virginia's Certificate of Public Need (COPN) program.

Policy Options

Joint Commission members approved two policy options:

- Request by letter of the Chairman, that the Virginia Department of Health report to JCHC by August 30, 2012 regarding the impact of federal health reform on existing COPN charity care conditions and recommendations to address any program, regulatory, or statutory changes that may be needed.

- Include in the JCHC 2011 work plan, a staff review of ways to define hospital-offered charity care to include determining the availability of data to support any charity-care definitions being considered. The purpose of the review would be to further future State-level charity care discussions and analyses. (This option was added at the request of JCHC members.)

Consideration of FAMIS Eligibility Levels

Senate Bill 266 was introduced by Senator Mary Margaret Whipple in 2010 to increase eligibility levels in Family Access to Medical Insurance Security (FAMIS), Virginia's health insurance program for children. SB 266 was approved by the Senate with the provision that it take effect only if funded in the biennial budget. Because funding was not provided, the Health, Welfare and Institutions Committee continued SB 266 until 2011, and requested that JCHC review the issues surrounding changing eligibility levels in the FAMIS program from 200 to 225 percent of the federal poverty level.

Background

The federal Children's Health Insurance Program (CHIP) was created in 1997 to provide health insurance coverage to low-income families who earn too much to qualify for Medicaid but too little to afford private insurance. Virginia's CHIP is the FAMIS program.

Impact of CHIPRA on FAMIS. CHIP was originally authorized for 10 years and reauthorized in 2009 when Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA). Under CHIPRA, states pay a share of all CHIP expenditures, and that state funding is matched by federal CHIP dollars up to a capped allotment. Within the capped allotment, states receive an "enhanced" federal matching rate that is higher than the standard matching rate for their Medicaid programs. In Virginia, the standard matching rate for Medicaid is 50 percent and 65 percent for FAMIS. Under CHIPRA, states received a higher initial allotment. As such, Virginia received an allotment of $175.6 million in FY 2009, an 81 percent increase over the previous year.

Impact of Federal Health Reform on FAMIS. The Patient Protection and Affordable Care Act require states to maintain the eligibility levels and enrollment policies which were in place on March 23, 2010. The Act also extends CHIP through 2019, but only provides two years of federal funding through September 2015. PPACA calls for a 23 percent increase in federal funding for CHIP matching rates between 2016 and 2019, which will bring the federal matching rate to at least 88 percent for every state including Virginia. However, in 2014, children with family incomes below 133 percent of FPL will be eligible for Medicaid, meaning that some low-income children who are currently eligible for CHIP will become eligible for Medicaid.

Increasing FAMIS eligibility levels as outlined in SB 266 would increase family gross income limits from 200 to 250 percent of FPL:

	Monthly Gross Income	
	200% FPL	**250% FPL**
Family of 3	$3,052	$3,433
Family of 4	$3,675	$4,135

The fiscal impact statement for SB 266 indicated that approximately 6,500 additional children would be enrolled in FAMIS in FY 2011, if the income limit had been increased to 225 percent FPL at a cost of $2.7 million GFs and $5.0 million NGFs. Beyond that, costs were estimated to increase based on a projected enrollment growth rate of 5 percent increasing to $3.7 million GFs and $6.9 million NGFs by FY 2015.

Considerations in Raising the Eligibility Level

States have an incentive to maximize the use of federal funds since states that do so will receive a higher future allotment, and states that fail to spend allotments will receive a reduced federal allotment. However, there is concern regarding Virginia's ability to spend the federal allotments. DMAS had not received its FFY 2011 allotment which would report on Virginia's FFY 2010 spending. Although the entire federal allotment has not been spent, DMAS did not anticipate that the allotment would be significantly affected (see chart below). Still, it is difficult to make judgments on future spending without knowing with certainty that the FFY 2011 allocation will not be significantly reduced.

DMAS Reported FAMIS Information

	SFY/FFY 2008	SFY/FFY 2009	SFY/FFY 2010
Expanded Federal Funds	$120,419,421	$141,318,450	$162,555,292
Federal Grant Funding Received	$90,860,630	$175,860,300	$184,454,740
Difference	**$29,558,791**	**$34,541,950**	**$21,899,448**
Expended State Funding*	$64,611,667	$75,631,052	$85,402,089
Total FAMIS Expenditures	$185,031,088	$216,949,402	$247,957,381

*State funding includes FAMIS Trust Funds of approximately $14 million each year and GFs.
Source: JCHC staff analysis of DMAS report. *Total Program Expenditures by State Fiscal Year.*

Policy Option

JCHC members approved the policy option to support, by letter of the Chairman to the Health, Welfare and Institutions Committee, SB 266 to increase the eligibility level for FAMIS to 225 percent of FPL if it is possible to return to the lower threshold in the future if funding is no longer available.

Virginia HIV/AIDS
Prevention and Treatment Programs

Based on presentations by Kathy Hafford, Director of Virginia Department of Health's (VDH) Division of Disease Prevention and Sue Rowland, Executive Director of Virginia Organizations Responding to AIDS (VORA), JCHC members voted to include a study of Virginia's current HIV prevention and treatment programs in the 2010 JCHC work plan. The approved study request indicated that focus should be given to assessing program and policy effectiveness in reducing the incidence of new HIV cases in Virginia.

Findings

Approximately 21,000 Virginians (1 in 380) were known to be living with HIV infection in 2009, and it is estimated that an additional 4,500 individuals did not know they were infected. Of all Virginians living with HIV infection, about 59 percent are not receiving treatment. For every 5 people diagnosed with HIV infection in Virginia, approximately: 4 are men, 3 African American, 3 live in the Eastern or Northern region, 3 are men who have sex with men, and 2 are ages 20 to 34 at time of diagnosis.

Study results indicated that the VDH Division of Disease Prevention provided and/or supported a range of prevention and treatment programs that have been effective in stabilizing new HIV infection rates over the past two decades; however, increased prevention funding and greater access to testing, post-testing services, and treatment are needed to further reduce HIV transmission in Virginia.

An estimated $380,000 in health care costs are saved for every case of transmission that is prevented.

Research has shown that extensive HIV testing combined with early treatment for HIV-positive individuals is an effective prevention model. Highly Active Anti-Retroviral Treatment (HAART) results in a significant reduction in transmission rates by decreasing an individual's viral load to very low levels. A 2009 study of 5,021 serodiscordant heterosexual couples found a 92 percent decrease in transmission among groups receiving HAART.

The AIDS Drug Assistance Program (ADAP) is central to the success of Virginia's HIV/AIDS prevention and treatment efforts; however, this program is experiencing new funding challenges due to large increases in program enrollment and expenditures over the last several years.

For the first time, VDH expects to have a waitlist for ADAP assistance. The chart shows estimated program shortfalls, which are expected to result in approximately 408 potential clients per year will no longer qualify for ADAP services. Furthermore, Virginia's program would no longer meet established standards of care set by the Centers for Disease Control and Prevention (CDC).

	SFY 2011	SFY 2012	SFY 2013
Annual Medication Costs	$30 M	$35 M	$40.6 M
Budget Shortfall	$ 2.267 M*	$14.6 M**	$20.2 M**
Estimated PPACA Savings		$2 M	$2.5 M
Total Budget Shortfall	**$2.267 M***	**$12.6 M****	**$17.7 M****

Projections based on current trends of level funding, increased enrollment, and current eligibility requirements.
*Actual shortfall = $6.9 M; Received $4.68 M in one-time only funding assistance.
**Estimated shortfall. Shortfalls would be larger, but include $1-1.4 M in redirected funds from HIV Services budget. (This will result in a 15%-20% decrease in HIV services.)

Policy Options

Joint Commission members approved four of the eight policy options that were presented. Three of the options involved requests by letter of the JCHC chairman:

- That the Medical Society of Virginia encourage physicians to routinely offer opt-out HIV testing for all patients between 13 and 64 years of age regardless of recognized risk factors, as per the Centers for Disease Control and Prevention recommendation; or b) when testing for other sexually transmitted diseases.
- That the Virginia Hospital and Healthcare Association encourage hospitals to routinely offer opt-out HIV testing in their emergency departments for all patients between 13 and 64 years of age.
- That the Virginia Association of Health Plans encourage all health plans (including grandfathered/exempt plans) to include HIV testing among the preventive services covered free of cost (as part of the new federal health care reform preventive care provision).

In addition, JCHC members approved the policy option to introduce a budget amendment to provide $12.6 million of additional general funds to ADAP to address the expected shortfall in FY 2012.

Legislative Action

The introduced budget amendment was not included in the approved State budget.

Prescription of Antibiotic Therapy for Lyme Disease

House Bill 512 was introduced by Delegate Thomas D. Rust in 2010 to allow licensed physicians "to prescribe, administer, or dispense long-term antibiotic therapy to a patient diagnosed with Lyme disease" and specify that "the Board of Medicine shall not initiate a disciplinary action against a licensed physician solely for prescribing, administering, or dispensing long-term antibiotic therapy to a patient clinically diagnosed with Lyme disease."

HB 512 was continued until 2011 in the Health, Welfare and Institutions Committee and referred by letter to JCHC for further study.

Findings

Lyme Disease is a bacterial illness transmitted by a bite from the black-legged tick, or "deer tick." Between 3-30 days after being bitten by an infected tick, 70-90 percent of people develop a "bull's eye rash" called erythema migrans. Lyme Disease may also cause headache, fever, muscle and joint aches, and fatigue. If left untreated, Lyme Disease may progress to affect the joints, nervous system, or heart. Diagnosis is based on symptoms, objective physical findings (such as the unique rash, facial palsy, or arthritis), and a history of possible tick exposure.

The National Institutes of Health (NIH) have conducted multiple studies on the treatment of Lyme Disease and concluded that most patients can be cured with a few weeks of oral antibiotics. Patients treated with antibiotics in the early stages of infection usually recover rapidly and completely. Longer courses of antibiotics have been proven ineffective and have been linked to serious complications, including the development of drug-resistant infections, and even death.

There is a minority of physicians and patients who believe that Lyme Disease can be a persistent and relapsing infection, often referred to as Chronic Lyme Disease or post-Lyme syndrome. These physicians often treat their patients with combinations of antibiotics over a long time period until symptoms resolve; a course of treatment that conflicts with the short-term treatment guidelines set forth by the Infectious Diseases Society of America (IDSA). Physicians who support the use of long-term antibiotics, offer alternative research and studies that suggest post-Lyme syndrome could result

from an autoimmune reaction to the Lyme bacteria; or certain genetic traits, and finally that the Lyme bacterium is capable of surviving the short-term doses of antibiotics by hiding in the tissues of the body. As the debate continues, physicians who disagree with the short-treatment recommendations of the IDSA sometimes find themselves investigated and tried by their state medical licensing board. To date, there have been no disciplinary proceedings by the Virginia Board of Medicine against a physician for treating Lyme Disease with long-term antibiotics. (The recent case of the Board-disciplined physician from the Eastern Shore, involved inappropriate prescribing of narcotics and the physician is still able to administer long-term antibiotic treatment to Lyme Disease patients.)

Policy Option

JCHC members approved the following policy option:

- By letter of the JCHC Chairman to the Secretary of Health and Human Resources, request a report on the findings and recommendations of the Governor's Task Force on Lyme Disease. In addition, by letter of the JCHC Chairman to the Department of Health Professions and Board of Medicine request that JCHC be notified of any plans to take action or consider regulations to take action against physicians related to prescribing antibiotics over an extended period to treat Lyme Disease, Chronic Lyme Disease, or post-Lyme Syndrome. (This option was added at the request of JCHC members.)

Statutory Language on Barrier Crimes

In 2006, Senator Jeannemarie Devolites Davis introduced Senate Joint Resolution 106 requesting that JCHC "study the impact of barrier crimes laws on social service and health care employers, prospective employees, consumers, residents, patients, and clients."

Findings

Although barrier crime laws for employers caring for children, the elderly, and the disabled have become more restrictive in recent years, a different movement has been underway in the mental health and substance abuse arena. The New Freedom Commission on Mental Health, established by President George W. Bush, focused on recovery and making mental health care more consumer and family-driven. In Virginia, the System Transformation Initiative sought to transform the "services delivery system to one that truly embraces the concepts of recovery, self-determination and empowerment." (Source: *The System Transformation Initiative*, DMHMRSAS 2007 website.)

In keeping with federal and State initiatives, representatives of community services boards (CSBs) and private providers support considering the circumstances surrounding criminal convictions of individuals in recovery from mental illness in evaluating their suitability to be considered for employment. Individuals who have experienced mental health concerns can be effective peer counselors and employment supports their recovery while helping to address the workforce need for mental health staff. A provision for considering the influence an individual's mental illness had on his criminal convictions mirrors the rationale behind the review process established in 2001 to exempt convictions for specific crimes related to an individual's substance use disorder, so those convictions would not serve as absolute barriers to employment in adult substance abuse treatment facilities.

Based on JCHC study findings, two bills were introduced in 2008 to ease some employment restrictions to allow a job applicant (in recovery from mental illness) who had a misdemeanor assault and battery conviction to be considered for employment in an adult behavioral health care treatment program. The Table on the next page describes the legislative history of those bills as well as subsequent legislation. In the end, statutory changes were enacted to ease some restrictions, although an individual with a misdemeanor conviction of assault or assault and battery against a family member may

be assessed for employment by a CSB but not by a private provider licensed by the Department of Behavioral Health and Developmental Services.

Session	Legislation	Provisions	Actions Taken
2008	HB 1203 (Melvin) SB 381 (Martin) *Code of VA* §§ 37.2-416 and 506	Legislation to ease a few employment restrictions introduced on behalf of JCHC. HWI voted to remove provision to allow for one misdemeanor conviction of assault against a family or household member to be an exception to barrier crimes for working in adult BHC facilities.	HB 1203 was amended as requested. But in SB 381, the provision was removed for private BHC facilities but not for CSB-operated facilities. SB 381 was signed by the Governor last and became law.
2009	HB 2288 (Cline) SB 1228 (Barker) *Code of VA* § 37.2-506	Legislation to address the mistake made the previous year introduced on behalf of JCHC.	Bills left in Senate Ed & Health to allow for JCHC review.
2010	SB 260 (Lucas) *Code of VA* §§ 37.2-416 and 506	Legislation introduced on behalf of JCHC to <u>return provision</u> allowing for one misdemeanor conviction of assault against a family member to be an exception to barrier crimes for working in private adult BHC facilities.	Senate and House conferees unable to agree on bill wording.
2010	HB 867 (Cline) *Code of VA* § 37.2-506	Legislation introduced to <u>remove provision</u> to allow for one misdemeanor conviction of assault against a family member to be an exception to barrier crimes for working in a CSB-operated adult BHC facility.	Bill left in Senate Ed & Health to allow for JCHC review.

Policy Options

Three policy options were presented for consideration and JCHC members approved the option to take no action.

Meeting Presentations and Documents

Joint Commission on Health Care

May 26, 2010

Newsletter from the Chairman

Proposed Work Plan
Kim Snead, Executive Director

Overview of Major Components of Federal Health Reform
Michele L. Chesser, Ph.D., Senior Health Policy Analyst

August 4, 2010

Update on Virginia's Health Reform Initiative
The Honorable William A. Hazel, Jr.
Secretary of Health and Human Resources

Jacqueline A. Cunningham, Deputy Commissioner, Life and Health Division
Bureau of Insurance, State Corporation Commission

Considerations in Addressing Health Reform
Steve Horan, President
Community Health Solutions

Patient Protection and Affordable Care Act
Shirley Gibson, President
Virginia Nurses Association

October 6, 2010

Review of Public Comments
Kim Snead

Initiatives of Virginia Health Information
David A. Adams, Board President

Michael T. Lundberg, Executive Director
Virginia Health Information

Developing a Comprehensive Plan for Serving People with Autism Spectrum Disorders and Developmental Disabilities
Heidi R. Dix, Assistant Commissioner
Department of Behavioral Health and Developmental Services

Staff Reports:
Catastrophic Health Insurance - HJR 99
Stephen W. Bowman, Senior Staff Attorney/Methodologist

State Funding for Cancer Research - SJR 292 (2009)
Michele L. Chesser, Ph.D.

Medical Care for Uninsured Individuals with Life-Threatening Conditions - SJR 339 (2009)
Stephen W. Bowman

Other Written Reports
Virginia Health Information 2010 Annual Report and Strategic Plan Update

November 3, 2010

State Plan for Home and Community-Based Services Option
Steven E. Ford, Director of Policy & Research
Department of Medical Assistance Services

Staff Reports:
Indigent and Charity Care Provided by Hospitals – HJR 27
Stephen W. Bowman

Interim Report: Chronic Health Care Homes – HJR 82
Jaime H. Hoyle, Senior Staff Attorney/Health Policy Analyst

Interim Report: Feasibility of Replicating JMU Caregivers Community Network
Michele L. Chesser, Ph.D.

Decision Matrix: Review of Policy Options and Legislation for 2011

Other Written Reports
Delivery of Home and Community-Based Services through the Medicaid State Plan and the §1915(i) State Plan Option, RD No. 329 (2010)

January 3, 2011

Update on the Federal Health Care Lawsuit
The Honorable Kenneth T. Cuccinelli, II
Attorney General of Virginia

AIDS Drug Assistance Program Update
Karen Remley, MD, MBA, FAAP
State Health Commissioner

Discussion Regarding Proposed JCHC Legislation and Budget Amendments
Kim Snead

Other Written Reports
Report of the Virginia Health Reform Initiative Advisory Council

Department of Behavioral Health and Developmental Services Action Plan for Services for Individuals with Autism Spectrum Disorders

Report on Department of Human Resource Management Ombudsman Services for FY 2010

Office of Inspector General: Behavioral Health and Developmental Services Semiannual Report, RD No. 365 (2010)

Healthy Living/Health Services Subcommittee

Co-Chairs

Senator Patricia S. Ticer
Delegate John M. O'Bannon, III

Senator George L. Barker
Senator Harry B. Blevins
Senator R. Edward Houck
Senator Ralph S. Northam
Senator Linda T. Puller

Delegate Robert H. Brink
Delegate Rosalyn R. Dance
Delegate T. Scott Garrett
Delegate Harvey B. Morgan
Delegate David A. Nutter
Delegate Christopher K. Peace
Delegate Benjamin L. Cline (ex-officio)

May 26, 2010

Proposed Work Plan for 2010
Stephen W. Bowman

September 7, 2010

Department of Health Professions Priorities and Initiatives
Dianne L. Reynolds-Cane, M.D., Director
Department of Health Professions

Policy Recommendations: Childhood Obesity/Adult Obesity and Menu Labeling
Elena L. Serrano, Ph.D., Associate Professor
Human Nutrition, Foods, & Exercise
Virginia Tech

Virginia Stroke Systems Task Force Update
Dr. Nina J. Solenski, M.D., Co-Chair

Dr. Richard Zweifler, M.D., Co-Chair

Safe Nurse Staffing
Barbara Brown, Ph.D., RN, Vice President
Virginia Hospital & Healthcare Association

Terri Haller, MS, RN, MBA, NEA-BC
Virginia Nurses Association

Kathy Baker, MSN, RN
Ursula Butts, MSHA, RN
Virginia Organization of Nurse Executives

Staff Review:
Consideration of FAMIS Eligibility Levels
Jaime H. Hoyle

October 6, 2010

Review of Public Comments
Jaime H. Hoyle

Chronic Disease Management Programs
George K. Heuser, MD, Vice-President and Senior Medical Director
Optima Health

Priorities and Initiatives: Virginia Department of Health
Karen Remley, M.D., M.B.A.
State Health Commissioner

Priorities and Initiatives: Department of Medical Assistance Services
Gregg A. Pane, M.D., Director
Department of Medical Assistance Services

Staff Reports:
Virginia's HIV/AIDS Prevention and Treatment Programs
Michele L. Chesser, Ph.D.

Prescription of Antibiotic Therapy for Lyme Disease - HB 512
Jaime H. Hoyle

Behavioral Health Care Subcommittee

Co-Chairs

Senator L. Louise Lucas
Delegate Harvey B. Morgan

Senator George L. Barker
Senator R. Edward Houck
Senator Ralph S. Northam
Senator Linda T. Puller
Senator Patricia S. Ticer
Senator William C. Wampler, Jr.

Delegate Robert H. Brink
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Delegate Rosalyn R. Dance
Delegate Algie T. Howell, Jr.
Delegate David A. Nutter
Delegate John M. O'Bannon, III
Delegate Benjamin L. Cline (ex-officio)

May 26, 2010

Proposed Work Plan for 2010
Kim Snead

August 4, 2010

History of Involvement with ASD Issues
Kim Snead

DBHDS Priorities and Behavioral Health Care Updates
James W. Stewart, III, Commissioner
Department of Behavioral Health and Developmental Services

The Community Perspective: Comments on the Closure of the Adolescent Unit and the Planned Closure of the Geriatric Unit at Southwestern Virginia Mental Health Institute
Lisa H. Moore, Executive Director
Mt. Rogers Community Services Board

Other Written Reports
Far Southwest Virginia Regional Geriatric Service Master Plan

September 7, 2010

Virginia College Mental Health Survey
Richard J. Bonnie, L.L.B., Commission Chair
Commission on Mental Health Law Reform

Health Reform 2010 and Beyond
Jill Hanken, Staff Attorney
Virginia Poverty Law Center

Health Care Reform: People Living with Serious Mental Illness
Mira Signer, Executive Director
Virginia Office of the National Alliance on Mental Illness

Staff Review:
Statutory Language on Barrier Crimes
Kim Snead

Barrier Crimes Statutes
Jessica Eades, Senior Attorney
Division of Legislative Services

Other Written Reports
Report on the Virginia College Mental Health Survey

Legislative Initiatives – 2011 Session

HB 1710 – Delegate Algie T. Howell SB 803 – Senator L. Louise Lucas

Amend *Code of Virginia* Title 22.1 to require schools to provide the opportunity for students in grades K-8 to participate in regular physical activity; elementary students shall participate for an average of at least 150 minutes per week and middle school students for an average of at least 225 minutes per week.

Final Action:

HB 1710 was incorporated into HB 1644 (O'Bannon); HB 1644 was passed by the House, but was stricken at the request of the patron in Senate Committee on Education and Health.

SB 803 was incorporated into SB 966 (Northam). SB 966 as amended was passed by the Senate and the House but vetoed by the Governor.

HB 2303 – Delegate Robert H. Brink SB 988 – Senator Linda T. Puller

Amend *Code of Virginia* § 30.170 to extend the sunset date for the Joint Commission on Health Care to July 1, 2016.

Final Action:

HB 2303 and SB 988 were amended several times and ultimately were referred to a conference committee. The committee report recommendation to extend the sunset date to July 1, 2015 was agreed to and passed by the House and the Senate.

2011 Acts of Assembly, Chapters 501 and 607

Introduced Budget Amendment:

Language and funding of $5 million to support cancer research at the University of Virginia Cancer Center.

Item 189 #1c was approved and added $3 million for FY 2011

Funding was <u>not</u> appropriated for the following introduced budget amendments:

DMAS – $782,842 GFs and $782,842 NGFs to offer coverage to legal immigrants who are Medicaid-eligible pregnant women.

DMAS – $109,675 GFs and $203,681 NGFs to offer coverage to legal immigrants who are FAMIS-eligible pregnant women.

DMAS – $100,000 to provide additional funding for the Uninsured Medical Catastrophe Fund.

VDH – $6.4 million to provide additional funding for the AIDS Drug Assistance Program (ADAP) for FY 2012. (*Item 284 #1c reduced funding by $1 million for FY 2012)*

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:
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.

§ 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. (Expires July 1, 2012) Sunset.
The provisions of this chapter shall expire on July 1, 2012.
(1992, cc. 799, 818, § 9-316; 1996, c. 772; 2001, cc. 187, 844; 2006, cc. 113, 178; 2009, c. 707)

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