JOINT COMMISSION ON HEALTH CARE

2013 Annual Report

COMMONWEALTH OF VIRGINIA
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2013 Annual Report of the Joint Commission on Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #164

COMMONWEALTH OF VIRGINIA
RICHMOND
2014

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

Senator Linda T. Puller
Chair

Kim Snead
Executive Director

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June 6, 2014

The Honorable Terence R. McAuliffe
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

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

Dear Governor McAuliffe 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, 2013.

This report includes a summary of the Joint Commission's activities including legislative recommendations to the 2014 Session of the General Assembly. In addition, staff studies are submitted as written reports, published, and made available on the Reports to the General Assembly website and the Joint Commission on Health Care.

Respectfully submitted,

L T Puller

Linda T. Puller

Joint Commission on Health Care

Membership

Senate of Virginia

The Honorable Linda T. Puller, Chair

The Honorable George L. Barker
The Honorable Harry B. Blevins
The Honorable Charles W. Carrico, Sr.
The Honorable L. Louise Lucas
The Honorable Stephen H. Martin
The Honorable Jeffrey L. McWaters
The Honorable Ralph S. Northam

Virginia House of Delegates

The Honorable John M. O'Bannon, III, Vice-Chair

The Honorable Robert H. Brink
The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable Rosalyn R. Dance
The Honorable T. Scott Garrett
The Honorable Algie T. Howell, Jr.
The Honorable Riley E. Ingram
The Honorable Christopher K. Peace
The Honorable Christopher P. Stolle

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

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Executive Director

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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.

Senator Linda T. Puller served as Chair and Delegate John M. O'Bannon, III as Vice Chair of the Joint Commission in 2013. Senator L. Louise Lucas and Delegate Christopher P. Stolle served as Co-Chairs of the Behavioral Health Care Subcommittee and Senator Harry B. Blevins and Delegate Robert H. Brink as Co-Chairs of the Healthy Living/Health Services Subcommittee.

The Joint Commission would like to recognize two distinguished members for their service to the General Assembly and the Joint Commission.

Harry B. Blevins served as a member of the House of Delegates from 1998 until September 2001 when he was elected to fill the vacated seat for Senate District 14.

Senator Blevins has been an active, conscientious member of the Joint Commission since his appointment in 2004, serving as Vice Chair of the Long-Term Care/Medicaid Reform Subcommittee in 2006 and 2007 and as the current Co-Chair of the Healthy Living/Health Services Subcommittee.

Senator Blevins retired from the General Assembly in August 2013.

Ralph S. Northam, who served Senate District 6 from 2008 through 2013, was appointed to the Joint Commission within months of his election. Senator Northam has been a dedicated, knowledgeable member who served on JCHC-subcommittees and initiated studies to examine rural obstetrical care and the needs of individuals with autism spectrum disorder in transitioning from secondary schools.

On January 11, 2014, Dr. Northam was sworn in as the 40th Lieutenant Governor of Virginia.

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Activities

In keeping with its statutory mandate, the Joint Commission completed studies; received reports and considered comments from public and private organizations, advocates, industry representatives, and other interested parties; and introduced legislation to advance the quality of health care, long-term care, and behavioral health care in the Commonwealth.

Joint Commission on Health Care

The full membership of the Joint Commission met four times in 2013. These four meetings were held May 21, September 17, October 22 and November 18. Meeting materials including presentations, handouts, and minutes are posted on the website at http://jchc.virginia.gov.

The following staff reports were presented during the 2013 JCHC meetings:

- Update on the Virginia Physician Workforce Shortage
- Implementation of Expedited Partner Therapy
- Factors Affecting Health Care Costs
- State Designee for the Federal Rural Health Grant Program
- Costs Associated with Untreated Dental Disease
- Update on Eating Disorders Study Outcomes

In addition, JCHC members heard from the following invited presenters.

Michael T. Lundberg of Virginia Health Information (VHI) gave an update on Virginia's All-Payer Claims Database during the meeting in May.

In the September meeting, Commissioner James A. Rothrock provided an overview of the newly-formed Department for Aging and Rehabilitative Services, Beth A. Bortz described several projects and priorities of the Virginia Center for Health Innovation, and Dr. Dianne Reynolds-Cane, discussed findings of the 2012 Physicians Survey Report completed by the Department of Health Professions.

In the meeting in October, Alfred D. Hinkle, Jr. and Michael T. Lundberg presented VHI's 2013 Annual Report.

During the meeting in November, Ashley Chapman and Kelly Fitzgerald discussed the results of a survey that addressed cost sharing for specialty tier medications which was followed by discussion of the Decision Matrix.

Behavioral Health Care Subcommittee

Meetings of the Behavioral Health Care Subcommittee were held on May 21 and September 17. Three staff reports were presented to the Behavioral Health Care Subcommittee:

- Overview of article on Mental Health Provisions of PPACA and Medicaid Expansion in Virginia
- Avenues for Expanding Telehealth for Mental Health Services
- Needs of Individuals with ASD Transitioning from Secondary Schools

BHC Subcommittee
Co-Chairs
Senator L. Louise Lucas
Delegate Christopher P. Stolle

Senator George L. Barker
Senator Charles W. Carrico, Sr.
Senator Stephen H. Martin
Senator Ralph S. Northam
Senator Linda T. Puller

Delegate Robert H. Brink
Delegate David L. Bulova
Delegate Rosalyn R. Dance
Delegate T. Scott Garrett
Delegate Algie T. Howell, Jr.
Delegate Riley E. Ingram
Delegate John M. O'Bannon, III

In addition during the May meeting, the Subcommittee heard from John J. Pezzoli regarding the major programs and initiatives of the Department of Behavioral Health and Developmental Services (DBHDS); in September, Dr. Michael Schaefer and Victoria Cochran discussed several presentations heard during a conference on *Cross-Systems Collaboration between Legal and Mental Health.* (The conference was sponsored by the Substance Abuse and Mental Health Services Administration and the National Association of State Mental Health Program Directors and was hosted by DBHDS.)

Healthy Living/Health Services Subcommittee

HL/HS Subcommittee
Co-Chairs
Senator Harry B. Blevins
Delegate Robert H. Brink

Senator George L. Barker
Senator Stephen H. Martin
Senator Ralph S. Northam
Senator Linda T. Puller

Delegate David L. Bulova
Delegate Rosalyn R. Dance
Delegate T. Scott Garrett
Delegate Riley E. Ingram
Delegate John M. O'Bannon, III
Delegate Christopher K. Peace
Delegate Christopher P. Stolle

The Healthy Living/Health Services Subcommittee met in June and October of 2013. Two staff reports were presented to the Healthy Living/Health Services Subcommittee:

- Follow-Up Study on Cost Sharing for Specialty Tier Prescription Medications Transfers
- Age Restrictions for Tanning Bed Use

The Subcommittee heard presentations in June regarding Hampton University's Proton Therapy Institute and the CHIP of Virginia Prenatal and Early Childhood Home Visiting Program. During the meeting in October presentations regarding Breakfast after the Bell, Virginia's settlement agreement with the Department of Justice, recommendations of the Mental Health Work Group of the Governor's Task Force on School and Campus Safety, and *The Virginia Cancer Plan 2013-2017.*

Additional Staff Endeavors

In 2013, JCHC staff served as members:

Age Wave Plan for Greater Richmond – Leadership Committee, Well Communities Subcommittee, and Data Advisory Work Group
Children's Health Insurance Program Advisory Committee (CHIPAC) – Data Review Subcommittee
National Center for the Analysis of Healthcare Data, Advisory Board
Virginia Chamber of Commerce – Employer Health Care Subcommittee, Advisor
Virginia Commonwealth University – Department of Health Administration, Adjunct Professor
Virginia Health Innovation Plan, Improving Transparency and Availability of Data Innovation Team, Advisor
Virginia Telehealth Network, Board Member

Staff made presentations:

Senate Finance Committee's Health and Human Resources Subcommittee
Student chapter of the American Medical Association, VCU Medical School
The Women's Initiative Board on Health Care Reform and Mental Health – Virginia Autism Council
Virginia Bar Association, Health Law Section, Annual Health Law Extravaganza
Virginia Chamber of Commerce's Employer Health Care Subcommittee
Virginia Commonwealth University Health Care Policy Class
Virginia Health Workforce Development Authority

Staff attended:

Academy Health National Health Policy Conference
All-Payer Claims Database Advisory Committee
Aon Hewitt Health Care Forum
Board of Medicine informal conference/disciplinary hearing on Lyme Disease
Catalyst for Payment Reform, National Summit on Provider Market Power
Commonwealth Autism Services, Autism Conference
Connect Virginia
Health Insurance Reform Commission
Home Visiting Conference
Madison University "Investing from the Start" Conference
Medicaid Innovation and Reform Commission
Mental Health Workgroup
Mid-Atlantic Telehealth Resource Center Summit
School Safety Task Force
Virginia Commonwealth University Briefing
Virginia Health and Hospital Association - Behavioral Health Forum
Virginia Health Innovation Plan - Educating and Engaging Consumers to Purchase Value

Staff publication:

Michele Chesser, Ph.D., "Mental Health Provisions of Affordable Care Act; Impact of Medicaid Expansion in Virginia," *Developments in Mental Health Law* 32:2 (April 2013): 1-9.

Executive Summaries

During 2013, Commission staff conducted studies in response to requests from the General Assembly or from the Joint Commission on Health Care (JCHC) membership. In keeping with the Commission's statutory mandate, the following studies were completed.

Update on the Virginia Physician Workforce Shortage

House Joint Resolution (HJR) 689, introduced by Delegate Harry R. Purkey, directed JCHC to study whether a shortage of medical doctors in Virginia exists and if shortages exist to provide avenues for alleviating the shortages. In addition to addressing the issues raised in HJR 689, this study updated demographic information included in two previously-published JCHC reports: *Interim Report: Analysis of Virginia's Health Workforce Pipelines* RD No. 118 (2009) and *Final Report: Analysis of Virginia's Health Workforce Pipelines* RD No. 90 (2010).

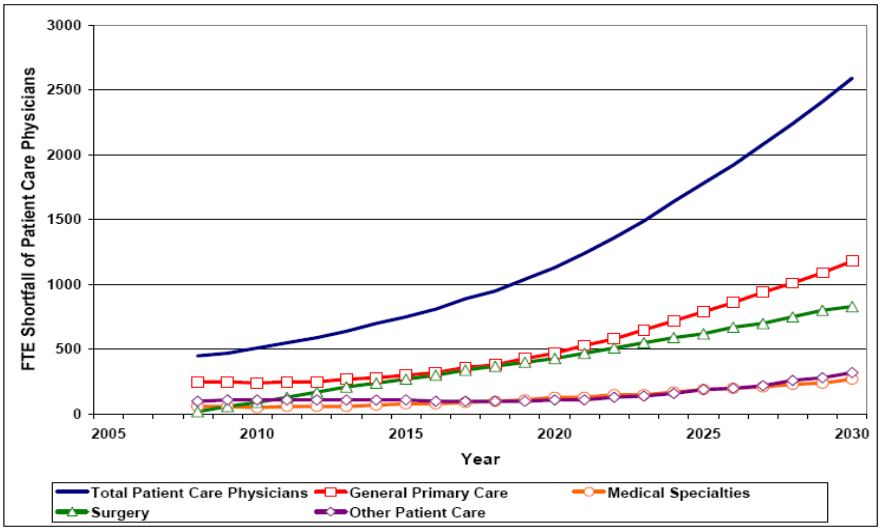
Findings

Virginia currently has more than 16,000 practicing physicians; 40 percent of whom practice as family, internal medicine, or pediatric physicians. While the total number of physicians generally appears to be adequate to serve the Commonwealth's current population, there is a maldistribution in which certain, primarily rural areas of the State have relatively few physicians. In addition, future workforce shortages, particularly in primary care and surgery specialties, have been projected. By 2030, 18 percent of the State's population (1.8 million individuals) is expected to be over 65 years of age, an increase from 12 percent in 2000.[1] This is an important change since older individuals in general require significantly more care from physicians.

In 2010, the Healthcare Workforce Data Center of the Department of Health Professions, released *Physician Forecasting in Virginia 2008-2030* which made projections regarding general primary care, medical specialties, surgery, and other patient care physicians as shown on the next page. Taking physician hours worked into consideration, the report noted current and future physician deficits and shortages would be most prevalent in primary care and surgery specialties. Targeted government and private sector efforts will be necessary as the health care labor market does not ensure that practitioners will practice where they are needed or select the specialties that are needed. To address shortages and maldistribution, states may want to provide incentives for practicing within certain specialties and locating in underserved areas. Establishing effective incentives will be challenging as physicians are courted by medical practices, hospitals, and clinics located within and outside the state.

[1] Cai, Quin, *Virginia's Diverse and Growing Older Population*, Weldon Cooper Center for Public Policy, The Virginia News Letter, Vol.85 No.2 April 2009 at http://www.coopercenter.org/sites/default/files/publications/vanl0409.pdf

Virginia Supply and Demand Model Physician Shortfall Projections



The following sections review some current programs as well as additional opportunities that could be considered by the Commonwealth.

J-1 Visa Waiver Program. Under the J-1 Visa Waiver Program, the Immigration and Naturalization Service may allow an international medical graduate (IMG), who completes his/her medical training in the U.S., to stay and practice in the U.S. (Without the waiver, the foreign residency requirement requires IMGs to return home for at least two years before they can apply to reenter the U.S.) In exchange for waiving the foreign residency requirement, the IMG enters into an agreement with a government agency to practice for at least three years within an area designated as being medically underserved.[2] Virginia's program, which typically has 30 slots available, has been successful in improving both the short-term and long-term supply of physicians in underserved areas; in 2012 and 2013 all available slots were filled.[3]

State Loan Repayment Program. The federal State Loan Repayment Program (SLRP) provides cost-sharing grants to states and territories to support loan repayment programs for primary care providers working in health professional shortage areas. Currently 32 states are eligible to participate with HRSA matching, on a dollar for dollar basis, the funds provided by a state or community source. A maximum of $400,000 per year is available in federal funding for the Virginia SLRP. Educational loan repayments available for physicians, nurse practitioners, and physician assistants; the repayment amounts range from $50,000 to $120,000 over a four-year period for physicians.[4] No State funding was provided for SLRP during the 2012-2014 biennium.

State-Supported Family Practice Residency Programs. Virginia has addressed primary care shortages by supporting family practice residency programs at the Eastern Virginia Medical School, the University of Virginia, and Virginia Commonwealth University. In 2013, these programs received more than $6.3 million in dedicated funding in the State budget.[5] Sixty-one percent of the graduates from these three programs chose to practice in Virginia.[6]

Telemedicine. Telemedicine allows a health care provider to communicate through an audio or video connection to another location in order to provide such services as patient diagnosis, consultation, or

[2] J-1 Visa Waiver Program Overview at http://www.vdh.state.va.us/healthpolicy/primarycare/incentives/j1visa/index.htm and at http://www.raconline.org/topics/j-1-visa-waiver .
[3] Documents provided to JCHC staff by representatives of the Virginia Department of Health's Office of Minority Health and Health Equity.
[4] *Id.*
[5] JCHC staff correspondence with representative from Virginia Department of Planning and Budget.
[6] JCHC staff correspondence with State-supported family practice residency programs.

monitoring. While telemedicine can help to address local provider shortages and maldistribution, issues with provider reimbursement have limited the adoption of telemedicine across the State. Legislation enacted in 2010 (Senate Bill 675) requiring health insurers to cover health care services provided via telemedicine has helped to address some of the reimbursement issues.

Geriatric Training and Education. In 2010, the Virginia Geriatric Education Center (VGEC) was established through collaboration between EVMS, UVA, and VCU. In 2010, VGEC received a $2.1 million federal grant over five years to improve the training of health professionals in geriatrics.[7] VGEC's main objectives are to support faculty training and retraining to provide instruction in geriatrics; to develop curricula regarding the treatment of health problems of older adults; to support continuing education of health professionals who provide geriatric care; and to provide students with clinical training in geriatrics.[8]

Team-based Care and Legislative Changes. As the practice of medicine is evolving, more attention is being given to team-based care in which a combination of two or more physicians, nurse-practitioners, physician assistants, pharmacists and other health care professionals coordinate their efforts across settings to provide care to the patient. As team-based care allows for more coordination, provider resources are more efficiently used which expands health care access. In addition, team-based care has become more accepted by consumers and identified as one avenue to address medical service shortages.[9]

To allow for more team-based care, legislative changes were enacted in 2012 and 2013 that addressed the work of nurse practitioners and physician assistants.

- In 2012, HB 346 expanded the permitted duties of a nurse practitioner, when serving on a patient care team in collaboration and consultation with a physician on the team.
  - HB 346 also allowed the team physician to collaborate with as many as six nurse practitioners (previously a physician could supervise as many as four nurse practitioners) and the requirement for the physician to be located onsite when a nurse practitioner provides care was eliminated.[10]
- In 2012, SB 106 expanded the scope of practice for physician assistants under certain conditions to "use fluoroscopy for guidance of diagnostic and therapeutic procedures."
  - SB 106 also increased the number of physician assistants that one physician is allowed to supervise from two to six.[11]
- In 2013, HB 1501 allowed nurse practitioners, who work as patient care team-members, and physician assistants, who are supervised by a physician, to collaborate directly with pharmacists.[12]

Regulatory Flexibility for Certain Health Care Workers A task force, of the Virginia Hospital and Healthcare Association, recently considered Virginia's future health care workforce challenges and concluded that "[i]ncremental change or maintaining the status quo will not provide a sufficient health professional workforce…."[13] Task force recommendations included supporting "Troops to healthcare health system [as well as a] continued push on regulatory flexibility for qualified veterans" and for the health care workforce in general.[14] One specific avenue for regulatory flexibility, which would allow certain health care providers to be exempt from scope of practice laws.

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[7] Edward F. Ansello, Ph.D., *Filling the Gap*, Age in Action Vol. 25, Fall 2010, Virginia Center on Aging and Virginia Department for the Aging.

[8] Virginia Geriatric Education Center website at http://www.vgec.vcu.edu/index.html

[9] Linda Green, et al. *Primary Care Physician Shortages Could Be Eliminated Through the Use of Teams, Nonphysicians and Electronic Communication*, Health Affairs 32 no.1, January 2013.

[10] 2012 *Virginia Acts of Assembly*, Chapter 213 (HB 346 – O'Bannon)

[11] 2012 *Virginia Acts of Assembly*, Chapter 81 (SB 106 – Edwards)

[12] 2013 *Virginia Acts of Assembly*, Chapter 192 (HB 1501 – O'Bannon)

[13] Chris Bailey, *VHHA Healthcare Workforce Development Plan*, presentation (Slide 3) to the Virginia Healthcare Workforce Development Authority, December 4, 2013.

[14] *Id* (Slide 16).

Actions by the Joint Commission on Health Care

JCHC members voted to:

- Introduce budget amendments for $400,000 GFs per year (with federal match funding) for the Virginia State Loan Repayment Program; two amendments were introduced – Item 283 #2s, #1h. (At the time this annual report was published, a budget had not been agreed to by the General Assembly.)
- Request that the Department of Health Professions: report to JCHC in 2014 regarding efforts to consider and accept applicable military training as evidence that the educational requirements for certification for certain health professions have been met and convene a workgroup to consider and report back to JCHC in 2015 regarding the idea of establishing a mid-level provider license.
- Request that the Virginia Health Workforce Development Authority convene a workgroup to consider and report back to JCHC in 2015 regarding graduate medical education and new State-supported residencies.
- Include a 2014 JCHC study of allowing certain providers working within an approved facility to be exempt from Virginia's scope of practice laws when established conditions have been met.

Factors Affecting Health Care Costs

House Joint Resolution 687, introduced by Delegate John M. O'Bannon, III on behalf of the Virginia Chamber of Commerce in 2013, directed JCHC to "(i) study and report on promising policies, practices, and initiatives expected to help control health care costs while maintaining quality of care; (ii) identify factors considered to be the primary contributors to the increase of health care costs; (iii) review approaches undertaken in other states and countries to control health care costs; and (iv) examine the likely impact of federal Patient Protection and Affordable Care Act provisions on the cost of health care."

Findings

It is a well-known fact that per-capita health care costs are higher in the United States than other countries. In 2010, the U.S. spent 18 percent of its gross domestic product on health care expenses, while many other countries spent less; for example, France and Germany spent 12 percent, Canada spent 11 percent, Greece and the United Kingdom spent 10 percent, and Italy spent 9 percent (OECD Health Data Set 2012). Furthermore, excellent health care cannot assure an individual's health, which has been found to be primarily influenced by five factors: genetic predisposition, social circumstances, environmental exposures, behavioral patterns, and health care.

Many issues impact health care and multiple rationales for the higher health care costs in the U.S. have been argued; likewise, numerous approaches including governmental and private market approaches have been suggested for containing health care costs. Some general governmental approaches include: structuring the health care market, providing oversight of financing and health care service provision, ensuring transparency in and analysis of the health care sector, and convening and building consensus among market participants. Three general types of private market approaches include changes in health plan designs, provider reimbursement strategies, and provider networks. This JCHC review of health care cost factors will continue in 2014.

Actions by the Joint Commission on Health Care

JCHC members voted in favor of taking the following actions:

- To introduce budget amendments for $25,000 GFs per year to allow the Virginia Center of Health Innovation to support work group efforts to identify core regional population health measurements and to identify 25 quality and safety measures that if targeted could most improve hospital-related care; two amendments were introduced – Item 304 #1s, #1h.
  (At the time this annual report was published, a budget had not been agreed to by the General Assembly.)
  - Accompanying letters from the JCHC Chair will be sent to the Virginia Center of Health Innovation and the Virginia Department of Health regarding these work group efforts.
- To request by letter of the JCHC Chair, presentations in 2014 by the State Health Care Cost Containment Commission on strategies to transform health care and by the Virginia Chamber of Commerce regarding recommendations of Blueprint Virginia's Healthcare Industry Council.
- To establish a JCHC-workgroup to review promising government- and market-based cost-containment, value, and efficiency strategies that also consider and maintain health care quality.

Avenues for Expanding Telehealth for Mental Health Services

This JCHC review of expanding telemental health services was recommended by Dr. Karen Rheuban, President of the Virginia Telehealth Network, in her presentation to JCHC's Behavioral Health Care Subcommittee in 2012.

Findings

Limited access to mental health providers reduces the quality and quantity of mental health services available to patients in rural and underserved communities, sometimes forcing patients to travel long distances to obtain mental health services, or forgo such services altogether. Telemental health (TMH) is a particularly good fit for addressing mental health access needs. TMH allows face-to-face communication with the provider in a personal and intimate manner. TMH can reduce travel time for providers and patients, reduce complications from delayed treatment, and encourage adherence with treatment plans. In recent years, telehealth technology has improved and the cost has decreased significantly.

Private hospitals, universities, State facilities and community services boards (CSBs) have reported positive results, including favorable feedback from patients and staff, regarding use of TMH services. For a relatively small investment, TMH users have reported financial savings, improved access, and reduced waiting times. However, State facility and CSB representatives have reported some barriers including inadequate reimbursement and the cost of the required technology, staffing, and contracts with psychiatrists.

Medicare reimbursement policies and Virginia's licensure regulations currently act as barriers to telehealth expansion. Medicare reimburses for telemedicine encounters if the originating site is:

- Located in a county that is not included in a metropolitan statistical area (MSA),
- Located within a federally designated rural health professional shortage area (HPSA), or
- Provided by an entity that participates in a federal telemedicine demonstration project.

The current federal definition of MSA has meant that some rural communities that are as far as an hour outside of the city limits are defined as being within the MSA and therefore ineligible for reimbursement for telemedicine encounters. The federal definition also fails to include specialty physicians in the telehealth reimbursement formula.

Another barrier is that Virginia requires a provider to be licensed both in his/her state of practice and in the patients' state of residence in order to practice telemedicine. As the practice of telemedicine increases, especially in rural areas, a streamlined system for those doctors wanting to practice in multiple states is advocated by many telemedicine supporters. The Federation of State Medical Boards recently adopted a resolution to explore the use of an interstate compact to increase efficiency in the licensing of physicians who practice in multiple states; representatives of Virginia's Board of Medicine have indicated support for entering into an interstate compact.

Action by the Joint Commission on Health Care

JCHC members voted to send a letter from the Chair, to the Virginia Department of Health and the Virginia Rural Health Association, substantiating the problems that the current federal definition of metropolitan statistical area creates in receiving Medicare reimbursement for telehealth services.

Needs of Individuals with ASD Transitioning from Secondary Schools

Senate Joint Resolution 330, introduced by Senator Ralph S. Northam, directed the Joint Commission to study the needs of individuals with autism spectrum disorder transitioning from public and private secondary schools.

Findings

The associated symptoms of autism spectrum disorder (ASD) affect multiple areas of an individual's life across his/her lifetime, including education/training, employment, housing, and health care. Studies have shown that better interventions and supports across the lifespan can help persons with ASD live more independently.

The Individuals with Disabilities Education Act guarantees services for persons with ASD through age 21 if they are eligible for special education services. After age 21, persons with ASD must seek out services and meet various eligibility requirements. Planning for the transition begins at age 14 in Virginia. Families, ASD advocates, and State representatives report the success of transition planning varies depending on the geographic location of the individual, the school division, and the institutional knowledge of persons included on the transition team.

The primary sources of services and support for adults with ASD include Medicaid waivers for community-based services and the employment assistance provided through the Department for Aging and Rehabilitative Services (DARS). With enrollment caps and waiting lists, Medicaid waivers currently do not provide the necessary support for all adults in need; furthermore, case management services are only available for adults who receive waivers or DARS-supported services. Waiting lists for employment services are maintained by DARS according to disability categories. With regard to providing access to affordable and accessible housing, improvements are being undertaken by the Department of Behavioral Health and Developmental Services through waiver reform and implementation of the settlement agreement with the United States Department of Justice.

Action by the Joint Commission on Health Care

JCHC members voted to take no action.

Cost Sharing for Specialty Tier Prescription Medications

House Joint Resolution 579, introduced by Delegate John M. O'Bannon, III in 2011, requested a two-year JCHC study to determine the impact of cost sharing, coinsurance, and specialty tier pricing on access to prescription medications for chronic health disorders.

Findings

In the U.S., 88 percent of covered workers have a tiered cost-sharing formula for prescription drugs. Traditionally, formularies consisted of no more than three tiers; however, an increasing number of plans have created a fourth tier, often referred to as a specialty tier, primarily for expensive drugs. Originally developed as part of Medicare Part D, specialty tiers are now utilized by the majority of commercial plans.

Tier 1: Generic
Tier 2: Preferred Brand
Tier 3: Non-Preferred Brand
Tier 4: Specialty Drugs

Cost-sharing structures vary among health plans, but most require enrollees to pay a set co-payment for drugs in tiers 1-3 and a percentage of the drug's cost (ranging from 10 to 40 percent) for those in the fourth/specialty tier. Each individual insurer or payer determines whether a drug is placed on a specialty tier.

While no standard definition exists for specialty drugs, most are biologics (derived from living organisms, in contrast to being made from chemical compounds); used to treat complex conditions; administered by injection, infusion, inhalation, or orally; and are very expensive. On average, the monthly cost for a specialty drug is $1,200; and while specialty tier drugs are prescribed for only one percent of commercial health plan enrollees, they account for 12 to 16 percent of commercial pharmacy benefit drug spending.

Factors to consider regarding cost-sharing include:

- The original intent of drug tiers, to provide incentives for consumers to consider costs when making health care decisions, is not applicable for specialty drugs for which there are no suitable, less expensive alternatives.
- Specialty tier pricing may not be cost effective for employers in the long run due to increased medical costs that can result from decreases in treatment adherence.
- The number of conditions that can be treated with specialty drugs – and thus the number of patients eligible for treatment with these high-cost drugs – are both expected to increase significantly over the next 10 years and beyond.
- Biosimilars are expected to reduce drug costs, but their impact will not be seen for many years. Innovator products are granted 12 years of market exclusivity and often are protected by patents lasting longer; and the new FDA approval process is expected to be rigorous and lengthy.
- Biosimilars will not reduce drug costs as much as conventional generic drugs. Due to the complexity of the manufacturing process, biosimilars likely will still be far more expensive than most conventional drugs.

Action by the Joint Commission on Health Care

JCHC members voted to introduce legislation requiring qualified health plans to allow individuals, who are expected to incur costs in excess of the cost-sharing limits set by the

Affordable Care Act, the option of paying their capped out-of-pocket amount in 12 equal installments over the course of the year.

Legislative Action

Senate Bill 201 – Senator Linda T. Puller House Bill 308 – Delegate Rosalyn R. Dance

Final bill language amended the *Code of Virginia* § 38.2-3407.9:01 to require that health insurers provide notice to all subscribers at least 30 days prior to moving a medication from one drug formulary tier to another.

Senate Bill 201 and House Bill 308 were passed as amended; *Acts of Assembly* Chapters 297 and 272 respectively.

Costs Associated with Untreated Dental Disease

Senate Joint Resolution 50, introduced by Senator George L. Barker in 2012, directed JCHC to study the fiscal impact to the Commonwealth that results from untreated dental disease, including "(i) the payments made by Virginia's Medicaid program to hospital emergency departments for dental-related diagnoses, (ii) the amount of uncompensated care provided by hospital emergency departments for dental-related diagnoses, and (iii) the number of dental patients treated and the overall value of the dental-related services provided by Virginia's safety net providers."

Since Virginia's Medicaid program, Smiles for Children, provides coverage for diagnostic, preventive, restorative/surgical procedures, and orthodontia services for children enrolled in FAMIS and FAMIS Plus, this study focused on adult dental care issues.

Findings

The Surgeon General of the United States has called oral and dental disease a persistent, but silent epidemic. Regular preventive care helps people avoid the pain and cost associated with more invasive acute dental care. Often preventive care is not accessed as more than one-third of adults have no dental insurance for such reasons as:

- Employer-sponsored dental insurance has been decreasing, from 77 percent of full-time private U.S. workers in recent years to 57 percent in 2011.
- Private health insurance plans often exclude dental coverage.
- Dental insurance typically costs less per month than health insurance but may have high levels of cost-sharing and maximum benefit caps.

The limited nature of dental benefits and the potential for significant out-of-pocket expenditures may influence the decision to obtain dental insurance. As a result, individuals who do not have dental insurance often cannot afford care and do not receive preventive care which over time can lead to chronic pain, infection, and tooth loss. Furthermore, while dental and medical care are often seen as separate issues, recent research has found numerous links between oral health and overall health and well-being.

Bacteria and inflammation from oral disease contribute to chronic diseases such as cardiovascular disease, stroke, respiratory infection, diabetes, and osteoporosis, and can lead to adverse pregnancy outcomes.

Pregnant women with gum disease are seven times more likely to have a preterm or low birth weight baby.

Tooth decay in the mother also puts the child at a higher risk of also developing cavities, leading to weakened oral health.

Neither the Affordable Care Act (ACA) nor Medicaid expansion (if adopted by Virginia) is expected to result in significant expansion of dental care coverage for adults. ACA does not require individuals to purchase dental care coverage as part of the insurance mandate, although separate dental coverage may be purchased through the Health Benefit Exchange. Medicaid expansion in Virginia would not significantly improve dental care for adults as the benefits would incorporate the current Medicaid provisions of very limited dental services for adults. In spite of the service limitations, DentaQuest, the dental-benefit administrator for Medicaid reported significant increases in the number of adults served and the resulting expenditures in recent years, as shown on the next page.

Adult Dental Costs to Virginia Medicaid

DentaQuest

Smiles For Children

SFY	Members Over 21 Receiving Dental Services	Amount Paid For Dental Services
2006	2,989	$658,404.32
2007	4,652	$1,466,494.85
2008	8,030	$3,004,309.50
2009	13,338	$5,123,747.70
2010	21,009	$9,885,194.40
2011	32,921	$10,974,518.30
2012	36,945	$11,333,009.02

The Department of Medical Assistance Services (DMAS) has not completed an exhaustive analysis of the significant cost increase, but generally explained the growth as follows: "Enrollment spiked and more adults were added 2008-2011 given the economic downturn; DMAS focused on improving access for adults and added additional providers who would treat adults; and, the program through DentaQuest sought to make members aware of the fact that there were dental benefits available."

Adults, who do not have coverage for dental care, frequently seek such care on an emergency or as-needed basis only and often from emergency departments (EDs). This is an expensive alternative and one that often results in only antibiotics or pain medicine being prescribed (as opposed to treating the underlying dental problem). Recent studies found the average cost for an ED visit is $1,000 while preventive care typically would cost only $50 to $100 per visit. The specific costs associated with these ED visits could not be determined since the data is not reported or collected in a uniform or comprehensive manner in Virginia. Dental procedures are coded differently and inconsistently between and within EDs, and often the procedures are coded as pain management or infection rather than a dental-related visit. Virginia's safety net providers play a significant role in meeting dental care needs, although they are not staffed or equipped to accommodate the dental needs of so many uninsured and underinsured patients. Community health centers treated 82,585 persons involving 108,596 dental visits at a cost of $16.7 million in 2012. Free clinics treated 18,454 patients involving 41,407 dental visits at an estimated value of more than $11.2 million in 2011.

Actions by the Joint Commission on Health Care

JCHC members voted to:

- Introduce budget amendments to provide funding of $240,783 GFs/$240,783 NGFs in FY 2015 and $303,387 GFs/$303,387 NGFs in FY 2016 for the Department of Medical Assistance Services to provide funding for preventive dental care for pregnant women who receive Medicaid benefits; three amendments were introduced – Item 301 #2s, #9h, #34h.
  (At the time this annual report was published, a budget had not been agreed to by the General Assembly.)
- Include in the JCHC 2014 work plan, a targeted study of the dental capacity and educational priorities of Virginia's oral health care safety net providers – to include an in depth look at ways to more proactively divert patients from ERs to dental resources within their communities and to include discussion on alternative settings where additional providers (such as registered dental hygienists) can practice to access additional patient populations that are not being reached. The study and its objectives should be led by the many and diverse stakeholders in the oral health community in concert with JCHC staff in determining the need for any additional funding and resources to take care of Virginia's most vulnerable citizens.

Implementation of Expedited Partner Therapy

House Joint Resolution 147, introduced by Delegate Charniele L. Herring in 2012, directed the Joint Commission on Health Care to study options for implementing expedited partner therapy in the Commonwealth.

Findings

Gonorrhea and chlamydia are highly infectious and among the most common sexually transmitted diseases (STDs). These infections in women can lead to serious consequences including pelvic inflammatory disease, infertility, ectopic pregnancy, and chronic pelvic pain. If left untreated in men, gonorrhea can cause epididymitis, a painful condition that can result in infertility. Chlamydia and gonorrhea also can increase a person's risk of acquiring or transmitting HIV.

When a patient is diagnosed with chlamydia or gonorrhea, the Centers for Disease Control (CDC) recommends that every effort be made to ensure that the patient's sex partners (from the past 60 days or most recent partner if none in the previous 60 days) are evaluated by a health practitioner and treated with a recommended regimen of antibiotics. However, if a partner of a patient cannot be linked to evaluation and treatment in a timely fashion, the CDC recommends that Expedited Partner Therapy (EPT) be considered "as not treating partners is significantly more harmful than practicing EPT." EPT is the clinical practice of treating the sex partner of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. Given that male partners are less likely to seek treatment due to stigma and denial (since males are often asymptomatic), in many cases EPT provides a means for treating male partners who otherwise would not have sought treatment and preventing re-infection of the female index patient. EPT is allowed in 35 states, is potentially allowable in nine states (including Virginia), and prohibited in six states.

Key Considerations for Expedited Partner Therapy

Partner Education: The CDC recommends that the partner's prescription or medication should be accompanied by a flyer containing treatment instructions, appropriate warnings about side effects and who should not take antibiotics, and health education about STDs.

EPT Effectiveness: In published clinical trials comparing EPT to traditional patient referral, EPT was associated with fewer persistent or recurrent infections in the index patient, and with a larger reported number of partners being treated.

Antibiotic Resistant Strains of Gonorrhea: Currently, antibiotic resistant strains are primarily a problem in Europe, with the only cases in the U.S. being found in Hawaii. As a result, the CDC continues to recommend EPT for gonorrhea when the partner is unlikely to seek treatment in a timely manner.

Side Effects and Allergic Reactions: Serious adverse reactions are rare with recommended chlamydia and gonorrhea treatment regimens (Azythromycin and Cefixime). All medications used in EPT include information about possible side effects and allergic reactions on the label; and an order can be placed on the prescription for the pharmacist to screen for drug allergies before dispensation.

Practitioner Responsibility and Liability: If authorized, providers will have the option, but will not be legally required, to administer EPT. To provide liability protections for practitioners and pharmacists, the Medical Society of Virginia and the Board of Medicine suggest adding the following language to the *Code of Virginia*: "All health care providers involved in the prescribing or dispensing of Schedule VI antibiotics to partners under this section shall be immune from criminal and civil liability absent gross negligence or willful misconduct."

Estimated State Cost for EPT: The estimated annual cost to VDH for EPT (in 2012 dollars) is $1,911 for chlamydia and $10,075 for gonorrhea. No general funds would be necessary since VDH representatives indicated they would absorb the cost as part of clinic operations. There would be no additional cost to DMAS because Medicaid plans are paid on a per member/per month basis.

Screening for Pregnancy and Pelvic Inflammatory Disease (PID): The CDC-recommended treatment regimens for pregnant women with chlamydia and/or gonorrhea are the same antibiotics that are recommended for EPT. As a result, practitioners typically do not test for pregnancy prior to prescribing antibiotics for chlamydia and gonorrhea for the index patient unless pregnancy is suspected.

Potential Effect of EPT on STD Tracking: According to VDH, averting infection and preventing re-infection are desired outcomes of EPT; and a resulting decline in lab-confirmed cases would potentially demonstrate this outcome and would not hamper STD control efforts. In addition, the Department of Health Professions suggests that tracking is possible by creating a new field in the STD data file for the number of EPT prescriptions written. This would provide additional information about STDs that currently is not available.

Treatment of Uninfected Partners: According to VDH, treating an uninfected partner has not been shown to contribute to antibiotic resistant gonorrhea; however, inadequately treating an infected partner may increase this risk.

Action by the Joint Commission on Health Care

JCHC members voted to take no action.

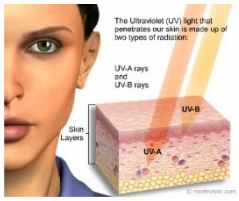
Age Restrictions on Tanning Bed Use

Senator George L. Barker requested that the Commission study the issue of age restrictions on tanning bed use after Senate Bill 1274 was passed by indefinitely in the House Committee on Commerce and Labor.

Findings

An increasing number of cases of skin cancer, including the most serious and deadly form – melanoma, has resulted in greater interest and concern about the safety of tanning and the use of tanning beds and other artificial tanning devices, in particular.

The average American city has 41 tanning salons; there are 40 salons in Chesapeake, 26 salons in Norfolk, 26 salons in Richmond, and 50 salons in Virginia Beach. In the U.S., more than one million people tan in salons each day and 30 million visit a salon each year; a national study found that approximately 30 percent of white female high school students and 25 percent of white women ages 18 to 34 years engaged in indoor tanning during the previous 12 months. According to the American Suntanning Association, three to 10 percent of salon revenue is from clients under the age of 18 years.



Risks Posed by Tanning Device Use. Based on a large and growing body of research accumulated over decades, researchers have found that thenre is no such thing as a safe tan. Cumulative repeated ultra violet (UV) exposure, regardless of whether skin burning occurs, increases the risk of skin cancer. In fact, it is the process of UV radiation causing DNA damage in skin cells that elicits the tanning response, which is the same process that also elevates carcinogenic risk. Burning, via the sun or tanning device, only further increases the risk of skin cancer.

While all UV radiation increases the risk of skin cancer, tanning devices can be more dangerous than the sun because they can be used year round, adding to a person's cumulative exposure. Frequent indoor tanners may receive 1.2 to 4.7 times the yearly dose of UVA radiation received from sunlight, in addition to doses from sun exposure. In 2012, a meta-analysis of 27 observational studies showed the risk of cancer increased 20 percent for persons who have ever used a tanning device. The risk increases 36 to 85 percent if indoor tanning started prior to age 35. Importantly, researchers have found that the risk of melanoma increases by 1.8 percent for each additional tanning bed/booth session. This means that a young woman who uses a tanning bed 50 times (i.e. 4 sessions per month for one year or 1.4 sessions per month for three years) increases her risk of melanoma by 90 percent.

Regulation of Tanning Device Use. In the United States, the federal government, thorough the Food and Drug Administration, regulates the manufacturers of tanning devices but places no restrictions on tanning bed users; while seven states ban the use of tanning beds by individuals under 18 and an additional 31 states place some other type of restriction on use by minors. In Virginia, tanning facilities and their devices are regulated; there are no age restrictions on device-use except consent by a parent or guardian is required for children 14 years of age or younger.

The following countries or provinces have instituted under age 18 bans for tanning salons:

- Australia (New South Wales and South Australia)
- Austria
- Belgium
- Brazil (bans all ages)
- Canadian provinces (British Columbia, Labrador, Newfoundland, Nova Scotia, Ontario, Prince Edward Island, and Quebec)
- Finland
- France
- Germany
- Iceland
- Lithuania
- Netherlands
- Norway
- Portugal
- Spain, and
- All countries of the United Kingdom.

A large number of organizations and associations support an under age 18 ban on tanning salon use including the U.S. Food and Drug Administration, the American Academy of Pediatrics and its Virginia Chapter, the American Academy of Dermatology and its Virginia Chapter, the American Medical Association and the Medical Society of Virginia, the Society of Surgical Oncology the U.S. National Toxicology Program, the World Health Organization, the International Commission of Non-ionizing Radiation Protection, the National Radiological Protection Board in the United Kingdom, and Australia's National Health and Medical Research Council.

Action by the Joint Commission on Health Care

JCHC members voted to introduce legislation prohibiting persons who are 14 years of age or younger from using tanning devices at tanning facilities; and requiring a parent or legal guardian of unemancipated persons 15 – 17 years of age to provide written consent prior to allowing the minor to use a tanning device at a tanning facility.

Legislative Action

Senate Bill 479 – Senator George L. Barker House Bill 681 – Delegate Robert H. Brink

Amend the *Code of Virginia* §§ 59.1-310.3 and 310.5 to prohibit individuals who are 14 years of age or younger from using a tanning device at a tanning facility and to prohibit unemancipated individuals who are 15 – 17 years of age from using a tanning device at a tanning facility unless the individual's parent or legal guardian has given written consent.

Senate Bill 479 was continued to 2015

House Bill 681 was left in House Committee on Commerce and Labor

State Designee for the Federal Rural Health Grant

Delegate T. Scott Garrett submitted a letter in January 2013 requesting for a JCHC-review of designating the Virginia Rural Health Resource Center (VRHRC) to serve as the State Office of Rural Health (SORH). The letter read, in part:

- "Does naming VRHRC as the SORH designated agency require legislative action? Or can this be completed through administrative changes?
- What are the advantages, disadvantages, benefits and losses of housing the SORH in a non-profit agency rather than a government entity? How effective are other non-profit SORHs (e.g. Colorado Rural Health Center, South Carolina Office of Rural Health), in meeting the needs of their rural communities, and can the services be delivered more effectively in Virginia in such a setting?"

Findings

The State Offices of Rural Health program was established in 1991 as a federal-state partnership administered by the Health Resources and Services Administration (HRSA) to establish "a focal point within each State for rural health issues…[to provide] an institutional framework that links communities with State and Federal resources to help develop long-term solutions to rural health problems." (www.hrsa.gov/ruralhealth/about/hospitalstate/stateoffices.html) Core SORH functions include collection and dissemination of information, coordination of rural health activities, and the provision of technical assistance. SORH-grant funding requires a 3-to-1 match of state to federal funds; and the federal funding amount is the same for each state (in FY 2014 federal funding was $172,000 requiring $516,000 in match funding or in-kind contributions). States have substantial flexibility in using grant funding to address their unique needs.

Only one SORH-application per state is accepted by HRSA and authorization to apply must be approved by a senior official of the state agency overseeing health programs which does not involve legislation or approval by the state legislature. Three types of organizational structure are currently used.

General Organizational Structures for the SORHs

In **37 states** (including Virginia) located within the agency that oversees health programs

In **10 states** housed within a state university

In **3 states** established as a non-profit organization

The Virginia Department of Health, which has administered the SORH throughout the history of the Commonwealth's participation in the federal program, received federal approval in 2013 to continue to administer the State Office for fiscal years 2014 through 2017.

JCHC study activities included: in-person, telephone, and email contacts made with rural stakeholder and federal state officials; regional stakeholder meetings held in Charlottesville, Warsaw, Abingdon, and Blacksburg; written surveys sent to 22 states; and a review of relevant federal statutes and federal and state grant programs. During the course of the study, many different opinions were expressed regarding the various organizational structures of State Offices

of Rural Health and how well they function in serving rural areas. In Virginia, irrespective of the entity serving as the State Office, actions could be taken to serve rural areas more effectively and a continued discussion regarding the needs of rural Virginia would be useful.

Actions by the Joint Commission on Health Care

JCHC members voted to send a letter from the Chair to ask that the Virginia Rural Center convene a workgroup to allow for continuation of the discussion on the needs of rural Virginia, including health care, education, workforce, technology, and economic development with any findings and conclusions to be presented to JCHC by October 2015. (This vote occurred immediately after the study presentation with the understanding that the options would not need to be considered as part of the JCHC Decision Matrix.)

Sunset Date for the Joint Commission on Health Care

In 1992, when the Joint Commission on Health Care was established to continue the work of the Commission on Health Care for All Virginians, a sunset date of July 1, 1997 was included. The sunset date has been extended three times resulting in the current sunset date of July 1, 2015.

Findings

An examination of the use of statutory sunset date provisions in Virginia, revealed some other legislative commissions with similar objectives as JCHC that have no sunset provision including:

- Joint Legislative Audit and Review Commission
- Virginia Commission on Youth
- Virginia State Crime Commission

While examples of legislative commissions that have specific sunset dates include:

- Autism Advisory Council
- Health Insurance Reform Commission
- Commission on Electric Utility Regulation

Action by the Joint Commission on Health Care

JCHC members voted to introduce legislation to amend the *Code of Virginia* § 30-170 to extend the sunset provision to July 1, 2019.

Legislative Action

Senate Bill 60 – Senator Linda T. Puller House Bill 680 – Delegate Robert H. Brink
Amend the *Code of Virginia* § 30-170 to extend the sunset provision for the Joint Commission on Health Care to July 1, 2018.

Senate Bill 60 and House Bill 680 were passed as amended.

Selected Presentation Summaries

Improving Health Outcomes, Reducing Medicaid Costs: Prenatal and Early Childhood Home Visiting

Lisa Specter-Dunaway was invited to present to the Joint Commission regarding the work of the Comprehensive Health Improvement Program of Virginia (CHIP) of Virginia. CHIP works with families, caught in the cycle of poverty, who are committed to creating a better life for their children and themselves. Intervening early, using proven best practices, CHIP's registered nurses and parent educators work hand-in-hand with parents, preparing them to be their child's first and most important teacher.

CHIP families face complex social and health issues often related to poverty. Many of these issues snowball to result in significant expense for the state and local communities. These costs include not only financial resources but also lost human capital and capacity. The Commonwealth's small investment changes the life course for families facing generational poverty, limited education, and unemployment. CHIP parents learn to care for their children and themselves, becoming assets to their communities.

CHIP of Virginia utilizes the Commonwealth's funding wisely, leveraging $2.71 per state dollar invested. In addition, CHIP has reduced administrative costs and infrastructure; CHIP operations have been regionally consolidated into seven local sites that now serve 27 localities. Revenue streams have been diversified and fee for service contracts with three Medicaid managed care organizations are part of the business model. Despite these actions the budget reductions of 35 percent that CHIP has taken since 2009 has resulted in waiting lists that continue to grow. For the children CHIP cannot serve, the potential costs in unnecessary emergency department usage and other inefficient use of health care resources, including preventable preterm births and long NICU stays, life-long medical expenses and academic remediation are staggering.

The average cost to an employer for a: healthy baby born at full-term is $2,830; premature baby is $41,610; and baby born at or earlier than 26 weeks cost can rise to $250,000 or more.

Action by the Joint Commission on Health Care

JCHC members voted to introduce budget amendments for funding of $900,000 GFs per year to restore state funding that had been eliminated from the Comprehensive Health Improvement Program of Virginia; two amendments were introduced – Item 291 #4s, #2h (At the time this annual report was published, a budget had not been agreed to by the General Assembly.)

Co-Insurance and Prescription Medication

Ashley Chapman with the Multiple Sclerosis Society and Kelly Fitzgerald with Patient Services, Inc. presented on behalf of the Virginia Alliance for Medication Access and Affordability (VAMAA).

VAMAA indicated that specialty-tiers need to be addressed because they unfairly discriminate against patients with expensive, chronic conditions.

- Research indicates that many people stop taking high-cost medications when that cost reaches a certain impact on their personal budget. At that point, they choose not to purchase and then lose the drug's life-saving benefits.
- "Nearly half of all personal bankruptcies are due in part to medical expense. And research suggests that patients faced with higher cost sharing cut back on both needed and discretionary care.*
- Action is required on the state level because the ACA did not address the issue of specialty-tiers and the limit on out–of-pocket spending was delayed until 2015.

A survey, of Virginians known to VAMAA members to have a condition treated by a specialty drug, was undertaken. The 279 respondents reported:

Had difficulty paying for their specialty tier medications in the past 12 months	35%
Were required to pay co-insurance (i.e. a percentage of the cost for their specialty tier medication rather than a fixed co-pay)	35%
• The average co-insurance was 29 percent of the cost of the medication	
Reported doing the following to save money on their specialty tier medication	
• Delayed filling prescription	25%
• Skipped pills, injections, or dosages	23%
• Chose to not take a particular brand even though they or their doctor felt it was the best medication for their condition	15%
• Delayed starting a new medication	14%
• Split pills, injections, or dosages	8.5%

Action taken by the Joint Commission on Health Care

JCHC members voted to introduce legislation to require health insurance plans to provide a 60-day notice to insured enrollees when a drug is moved from one tier to another and to require health insurance plans to cap the out-of-pocket co-pay for each specialty tier drug to no more than $150 per prescription.

Legislative Action

House Bill 304 - Delegate John M. O'Bannon, III
Amend the *Code of Virginia* §§ 38.2-4319 and 4509 by adding § 38.2-3407.14:1 to define "specialty tier drug" and require health insurers to limit the out-of-pocket copay for subscribers to no more than $150 per prescription for each specialty tier drug.

House Bill 304 was left in the House Committee on Commerce and Labor.

Meeting Agenda Items

Joint Commission on Health Care

May 21, 2013	Work Plan for JCHC and BHC – 2013 Kim Snead, Executive Director
	Work Plan for HL/HS – 2013 Michele L. Chesser, Ph.D., Senior Health Policy Analyst
	Update on Development of Virginia's All-Payer Claims Database Michael T. Lundberg, Executive Director Virginia Health Information
	Discussion of Factors Affecting Health Care Costs Stephen W. Bowman, Senior Staff Attorney/Methodologist
September 17, 2013	Overview of the Department for Aging and Rehabilitative Services James A. Rothrock, Commissioner
	Virginia Center for Health Innovation Beth A. Bortz, President and CEO
	2012 Virginia Physician Workforce Dianne L. Reynolds-Cane, M.D., Director Department of Health Professions
	STAFF REPORTS: Update on the Virginia Physician Workforce Shortage Stephen W. Bowman
	Implementation of Expedited Partner Therapy Michele L. Chesser, Ph.D.
October 22, 2013	Summary of Public Comments Kim Snead
	Virginia Health Information: 2013 Annual Report and Initiatives Alfred D. Hinkle, Jr., President, VHI Board of Directors Michael T. Lundberg, Executive Director
	STAFF REPORTS: Factors Affecting Health Care Costs Stephen W. Bowman
	State Designee for the Federal Rural Health Grant Program Kim Snead
	Costs Associated with Untreated Dental Disease Jaime H. Hoyle, Senior Staff Attorney/Health Policy Analyst
November 18, 2013	Update of Eating Disorders Study Outcomes Michele L. Chesser, Ph.D.

Cost Sharing for Specialty Tier Medications Survey Results
Ashley Chapman, M.S., Senior Manager of Advocacy, Multiple Sclerosis Society
Kelly Fitzgerald, Associate Director
Donor and Government Relations Patient Services, Inc.

Decision Matrix: Review of Policy Options and Legislation for 2014
JCHC Staff

Behavioral Health Care Subcommittee

May 21, 2013

Virginia's Publicly-Funded Behavioral Health System
Overview of Major Programs and Initiatives
John J. Pezzoli, Assistant Commissioner for Behavioral Services
Department of Behavioral Health and Developmental Services

Brief Overview of Article: Mental Health Provisions of PPACA and Medicaid Expansion in Virginia
Michele L. Chesser, Ph.D.

September 17, 2013

Cross Systems Collaboration between Legal and Mental Health Partners
- Use of Diversion Alternatives to Enhance Public Safety
- Forensic Mental Health Issues
- Improving the Utility of Mental Health Products

STAFF REPORTS:
Avenues for Expanding Telehealth for Mental Health Services
Jaime H. Hoyle

Needs of Individuals with ASD in Transitioning from Secondary Schools
Jaime H. Hoyle

Healthy Living/Health Services Subcommittee

June 7, 2013

Update on the Hampton University Proton Therapy Institute
Bill Thomas, Associate Vice President for Governmental Relations
Tyvin A. Rich, M.D., Radiation Oncologist
Hampton University

Improving Health Outcomes, Reducing Medicaid Costs: Prenatal and Early Childhood Home Visiting
Lisa Specter-Dunaway, President & CEO
CHIP of Virginia

Staff Report:
Follow-Up on Cost-Sharing for Specialty Tier Prescription Medications
Michele L. Chesser, Ph.D.

October 22, 2013

Breakfast after the Bell
Lisa Winters, District Supervisor for Child Nutrition Services
Norfolk Public Schools
Susan Mele, Principal
Stewartsville Elementary School, Bedford County, Virginia

Virginia's Settlement Agreement with the Department of Justice
James W. Stewart, III, Commissioner
Department of Behavioral Health and Developmental Services

Report on School Safety Task Force Recommendations
John Pezzoli, Assistant Commissioner for Behavioral Health Services
Department of Behavioral Health and Developmental Services

Cancer Action Coalition of Virginia Report
Vernal H. Branch, Public Policy Manager
Virginia Breast Cancer Foundation

Staff Report:
Age Restrictions for Tanning Bed Use
Michele L. Chesser, Ph.D.

Statutory Authority

§ 30-168. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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. (Expires July 1, 2015) 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, c296.)

§ 30-170. Expires July 1, 2015) Sunset.
The provisions of this chapter shall expire on July 1, 2015.
(1992, cc. 799, 818, § 9-316; 1996, c. 772; 2001, cc. 187, 844; 2006, cc. 113, 178; 2009, c. 707; 2011, cc. 501, 607.)

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