JOINT COMMISSION ON HEALTH CARE

2015 Annual Report

COMMONWEALTH OF VIRGINIA
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2015 Annual Report
Joint Commission on Health Care

To the Governor and the
General Assembly of Virginia

Report Document #167

Commonwealth of Virginia
Richmond
2016

JOINT COMMISSION ON HEALTH CARE

Delegate John M. O'Bannon III, Chair

Senator L. Louise Lucas, Vice Chair

May 26, 2016

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 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, 2015.

This report includes a summary of the Joint Commission's activities including legislative recommendations to the 2016 Session of the General Assembly. In addition, staff studies are submitted as written reports and made available on the Reports to the General Assembly and the Joint Commission on Health Care websites.

Respectfully submitted,

John M. O'Bannon III

Michele L. Chesser, Ph.D., Executive Director
Joint Commission on Health Care
P.O. Box 1322/Richmond, Virginia 23218
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Joint Commission on Health Care

The Honorable John M. O'Bannon III, Chair

The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable T. Scott Garrett
The Honorable Patrick A. Hope
The Honorable Riley E. Ingram
The Honorable Kaye Kory
The Honorable Christopher K. Peace
The Honorable Christopher P. Stolle
The Honorable Roslyn C. Tyler

The Honorable L. Louise Lucas, Vice Chair

The Honorable George L. Barker
The Honorable Charles W. Carrico, Sr.
The Honorable John S. Edwards
The Honorable Stephen H. Martin
The Honorable Jeffrey L. McWaters
The Honorable John C. Miller
The Honorable Linda T. Puller

The Honorable William A. Hazel, Jr.
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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." The Joint Commission's sunset date was extended to July 1, 2018 during the 2014 General Assembly Session (Senate Bill 60 and House Bill 680).

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.

Delegate John M. O'Bannon III served as Chair and Senator L. Louise Lucas served as Vice Chair in 2015. Delegate Christopher P. Stolle and Senator John C. Miller served as co-chairs of the Behavioral Health Care Subcommittee and Delegate T. Scott Garrett and Senator George L. Barker served as co-chairs of the Healthy Living/Health Services Subcommittee.

The following three members will not be returning next year and the Commission would like to thank them for their invaluable and dedicated service.

Senator Stephen H. Martin represented the 11th District as a member of the House of Delegates from 1988 - 1994 and in the Senate from 1994 through 2015. He was appointed to the JCHC twice, the first time in 1996 serving through 2007 and then appointed for a second term in 2010. As chairman of the Joint Commission on Behavioral Health Care, Senator Martin introduced Senate Bill 1253 (2003) to allow that commission to sunset with its responsibilities being assumed by the JCHC. During Senator Martin's eighteen year tenure, he introduced on behalf of the JCHC nine bills, seven study resolutions and a 2006 budget amendment to allow the Department of Mental Health, Mental Retardation and Substance Abuse Services to contract with Virginia Health Information to begin developing the psychiatric bed registry.

Senator Jeffrey L. McWaters represented the 8th District from 2010 through 2015 and was appointed to the Joint Commission in 2012. In 2015, Senator McWaters introduced Senate Bill 773 which amends the criteria for admitting an objecting minor 14 years of age or older for psychiatric treatment to match the criteria for determining whether a non-objecting minor or a minor younger than 14 years of age should be admitted. In addition Senator McWaters introduced Senate Bill 779 which increases from 96 to

120 hours the length of time a minor 14 years of age or older who objects to admission for inpatient treatment or who is incapable of making an informed decision may be admitted to a willing mental health facility.

Senator Linda T. Puller represented the 36th District in the Virginia House of Delegates from 1992 to 1999 and was then elected to the Senate of Virginia in November 1999 and served until her retirement this year. She was appointed to the JCHC in 2000 and she held the positions of Vice Chair (2010 - 2012) and Chair (2012 - 2014). Senator Puller introduced a number of bills on behalf of the JCHC including Senate Bill 1184 (2005) which expanded the disorders included in Virginia's newborn screening program making Virginia one of the first states to meet the guidelines proposed by the American College of Medical Genetics, Senate Bill 135 (2012) authorizing the development of an All-Payer Claims Database, and Senate Bill 201 (2014) requiring health insurers to provide notice at least 30 days prior to moving a medication from one drug tier to a more expensive tier.

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Activities

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

Joint Commission on Health Care

The full Commission met four times in 2015. These meetings were held in Senate Room A of the General Assembly Building on May 28th , June 17th , October 7th and November 4th . Meeting materials (including presentations, handouts and minutes) are posted on the website at http://jchc.virginia.gov.

Four staff reports were presented during the 2015 Joint Commission meetings:

- Allowing Certain Minors to Receive Inpatient Mental Health Treatment without Parental Consent
- Graduate Medical Education in the Commonwealth
- Resources for Unserved and Underserved Populations
- The Advisability of Establishing a Midlevel Provider License

In addition to the staff reports, members received reports and heard presentations from a number of guest presenters:

Beth A. Bortz, President and CEO with the Virginia Center for Health Innovation, presented an update on the State Innovation Models (SIM).

Dr. Qian Cai and Dr. Meredith Strohm Gunter of the Weldon Cooper Center for Public Service discussed incident rates in Virginia for all cancers combined and separately for lung, breast, and prostate cancers from 2001 to 2010. Projected incident rates for these types of cancers for the years 2011 through 2040 also were presented.

Michael T. Lundberg, Virginia Health Information's Executive Director, presented VHI's *2015 Annual Report and Strategic Plan Update*.

Dr. Jack W. Barber, Interim Commissioner with the Department of Behavioral Health and Developmental Services, briefed the members regarding the Hancock Geriatric Center.

Behavioral Health Care Subcommittee

The Behavioral Health Care Subcommittee met on June 17th and September 9th. Marc Leslie, Virginia Violent Reporting System Coordinator with the Office of the Chief Medical Examiner, discussed the numbers and rates of suicide in Virginia for 2003 through 2012. A handout on selected characteristics of suicide was provided to the members.

Anya Shaffer, Suicide and Violence Prevention Coordinator with the Virginia Department of Health, described the Youth Suicide Prevention Program administered by the Department of Health and the Department of Behavioral Health and Developmental Services.

BHC Subcommittee

Delegate Christopher P. Stolle
Senator John C. Miller
Co-Chairs

Delegate David L. Bulova
Delegate T. Scott Garrett
Delegate Patrick A. Hope
Delegate Riley E. Ingram
Delegate Kaye Kory
Delegate John M. O'Bannon III

Senator George L. Barker
Senator Charles W. Carrico, Sr.
Senator John S. Edwards
Senator L. Louise Lucas
Senator Stephen H. Martin
Senator Linda T. Puller

Dr. Briana Mezuk, Assistant Professor at Virginia Commonwealth University School of Medicine's Division of Epidemiology, presented the findings of "Suicide Risk in Long-Term Care in Virginia: 2003 – 2011" which is to be published in the *American Journal of Public Health*.

Cleopatra Booker, Psy.D., Area Care Services Consultant with the Department of Behavioral Health and Developmental Services, provided an update on the operation, benefits and limitations of the acute psychiatric bed registry.

Richard Bonnie, Professor of Public Policy and Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia School of Law, discussed data collected on civil commitment of adults and juveniles in Virginia.

HL/HS Subcommittee

Delegate T. Scott Garrett
Senator George L. Barker
Co-Chairs

Delegate David L. Bulova
Delegate Patrick A. Hope
Delegate Riley E. Ingram
Delegate Kaye Kory
Delegate John M. O'Bannon III
Delegate Christopher K. Peace
Delegate Christopher P. Stolle
Delegate Roslyn C. Tyler

Senator John S. Edwards
Senator Stephen H. Martin
Senator John C. Miller
Senator Linda T. Puller

Victoria Cochran, Deputy Secretary of Public Safety and Homeland Security, described the evolution, structure and initial priorities of the Center for Behavioral Health and Justice.

Healthy Living/Health Services Subcommittee

The Healthy Living/Health Services Subcommittee met on September 9th and October 7th. *A Review of Certain Health-Care System Characteristics in States with and without Certificate of Need* was presented by staff at the September 9th meeting.

Robert H. Brink, Deputy Commissioner of the Department of Aging and Rehabilitative Services (DARS), discussed plans for the Governor's conference on aging, operation of the Public Guardianship and Conservator Program and the Chronic Disease

Self-Management Education Program.

James Rothrock, Commissioner of DARS, gave an update on the Eastern Virginia Care Transitions Partnership.

Dr. Allison Jackson, Operations Manager with Trauma Informed Care of Richmond in the Department of Social Services, described the impact of childhood trauma on health and the benefits of early screening and intervention.

Marissa Levine, State Health Commissioner, presented the report *Metrics to Reflect the Health and Well Being of the People of Virginia.*

Joe Flores, Deputy Secretary of Health and Human Resources, discussed the activities of the Provider Tax Assessment Work Group.

Joe Hilbert, Director of Governmental and Regulatory Affairs at the Virginia Department of Health, gave an update on the activities and information presented to the Certificate of Public Need Work Group.

Jodi Manz, Policy Advisor with the Office of the Secretary of Health and Human Resources, provided an overview of the work and recommendations of the Governor's Task Force on Prescription Drug and Heroin Abuse.

Staff Endeavors

In 2015, JCHC staff served as members of the following organizations:

- Age Wave Plan for Greater Richmond, Leadership Committee
- Age Wave Plan for Greater Richmond, Data Subcommittee, Chair
- Children's Health Insurance Program Advisory Committee (CHIPAC)
- Lt. Governor's Commonwealth Council on Childhood Success, Child Health and Well Being Work Group

Staff gave the following presentations:

- *ACA Employer Penalties* to the Virginia Manufacturing Development Commission
- *Scope of Practice Regulations for Dental Hygienists* to the Department of Health Professions' Regulatory Research Committee
- *A Review of Certain Health-Care System Characteristics in States with and without Certificate of Need* to the Certificate of Public Need Work Group
- *2016 Legislative Session* to the Williamsburg Health Foundation's Chronic Care Collaborative
- *JCHC and Health Policy Development* in the Department of Health Administration's course, "Health Care Politics and Policy," at Virginia Commonwealth University
- *Health Policy in the Commonwealth* to the Institute of Medicine's Robert Wood Johnson Foundation Health Policy Fellows during their state visit to Virginia
- *Health Legislation and Enabling Change* to the Leadership Arlington Class of 2015 during Richmond Day
- *Health Policy and the Role of the JCHC* to the students and faculty at the Schroeder Center for Health Policy, College of William and Mary

Staff attended:

- All-Payer Claims Database Advisory Committee
- Department of Medical Assistance Board Retreat
- Cabinet Secretary Meeting on Early Identification of Childhood Trauma
- Virginia Business Coalition on Health Care Forum, "Emerging Trends in Health Care & Insurance"
- Building Blocks for Emotional Health-Promoting Early Childhood Mental Health & Wellness Conference
- Commonwealth Coordinated Care Advisory Meeting and Managed Long Term Services and Supports Public Forum
- Department of Behavioral Health and Developmental Services-Settlement Agreement Stakeholder Group
- Hospital Payment Policy Advisory Council-Inpatient Hospital Rebasing Advisory Group

In addition, JCHC staff:

- Taught an Introduction to Health Policy course in the Virginia Commonwealth University's Department of Health Care Policy and Research
- Served as a member of the 2015 Masters in Public Health Admissions Committee, Virginia Commonwealth University
- Presented on the Joint Commission on Health Care's activities as a panel member at the Virginia Quality Healthcare Network's Breakfast with the Experts event

Executive Summaries

During 2015, Commission staff conducted studies in response to requests from the General Assembly or from the Joint Commission on Health Care membership. In keeping with the Commission's statutory mandate, the following studies were completed.

Allowing Certain Minors to Receive Inpatient Mental Health Treatment without Parental Consent

During the 2014 General Assembly Session, Senate Bill 184 and House Bill 1097 were introduced to amend the minor consent statute to eliminate the requirement to receive the consent of a minor who is 14 years of age or older for inpatient psychiatric treatment on a voluntary basis. SB 184 and HB 1097 were referred to the JCHC by letter for review. One of the approved policy options, added at the suggestion of Senator Barker, requested "a staff review of the implications of allowing a minor to consent for inpatient treatment at a mental health facility without the consent of the minor's parent….[to] include consideration of: 1) amending *Code* § 16.1-338 to allow a minor 14 years of age or older to consent for voluntary inpatient mental health treatment without the consent of the minor's parent; 2) creating a judicial review regarding release under *Code* § 16.1-339 when the minor desires to continue inpatient treatment and consent for continued admission is withdrawn by the parent who consented to the minor's admission, and 3) reimbursement issues for services provided when a minor receives inpatient mental health treatment without the consent of the minor's parent."

Under the current Virginia statutes the parent(s) and the minor aged 14 through 17 must apply jointly in order for a minor to be admitted voluntarily into an inpatient psychiatric treatment center. In instances in which the minor child (aged 14 through 17) consents but the parent does not consent, a range of actions may be taken including the parent taking custody of the child and returning home, a request for an emergency custody order or temporary detention order, or a report to child protective services for medical neglect on the part of the parent.

A variety of perspectives were expressed regarding the need to change admission requirements. Community Services Board (CSB) staff members, participating in a conference call arranged

through their state association, indicated that they were never involved in a case or situation where the child wanted to be in an inpatient setting and the parents objected. If there is parental objection, there are remedies already in the law to address the situation.

Several hospital administrators reported that there were times when parents objected to inpatient treatment for their minor children, occurring perhaps once or twice a month on average. Clinicians in private practice reported that parental objection disagreements over treatment occur on a regular basis in both the admission stage as well as the continuation of treatment stage of the treatment plan. The disagreements may involve denial by the parents that their child needs inpatient treatment and/or concerns about the cost of treatment.

Relevant Statutes from Other States

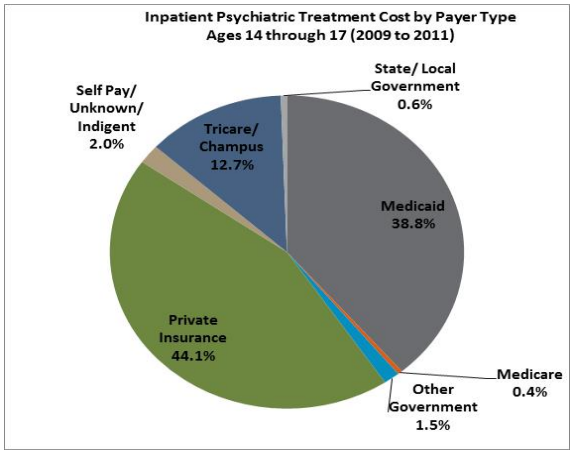
A review of other state statutes found that at least 19 states authorized minors to consent to inpatient mental health care without the consent of a parent. The provisions included in these statutes varied addressing such issues as the application and admission process, relief to the parent for financial obligations, confidentiality, liability for providers, parental notification, and notice to leave or be discharged.

Potential Financial Implications

Determining the financial implications of allowing a minor to consent for inpatient treatment is difficult. The first step is identifying the number of minors between the ages of 14 through 17 who may be affected. In April of 2013, UVA's Institute of Law, Psychiatry and Public Policy surveyed CSB evaluators and found that 10 (6.1 percent) recommendations for inpatient treatment of 165 minors between 14 through 17 years of age included parental objections. This finding suggests that the number of minors affected by parental objection to inpatient treatment may be approximately 120 per year.

According to Virginia Health Information (VHI) data, $86.8 million was spent for inpatient treatment for minors aged 14 through 17 in a private psychiatric hospital or on a mental health unit of a general hospital with an average cost-per-discharge of $6,600.

The following chart displays the payer-mix based on VHI cost data and indicates that private insurance and Medicaid paid 82.4 percent of the cost-of-care for this age group (43.7 percent and 38.7 percent respectively).



Using this payer mix and the previously-reported estimate of 120 instances in which minors would consent to treatment and their parents would object, results in the cost estimates shown below.

Inpatient Psychiatric Treatment for Consenting Minors Aged 14 through 17 Estimated Annual Cost by Payer Type			
Payer Type	**Cost Per Discharge**	**Number of Minors Aged 14 through 17 by Payer Type**	**Annual Cost**
Private Insurance	$5,140	65	$334,100
Medicaid*	$7,994	37	$295,778
Tricare/Champus	$8,883	11	$97,713
Other Government	$4,118	3	$12,354
Unknown	$11,758	1	$11,758
Self-Pay	$5,067	2	$10,134
Medicare	$2,763	1	$2,763
	Average: $6,372	**120**	**$764,600**

** The Virginia Medicaid State match is 50 percent of the total cost or approximately $147,889.*
Source: Virginia Health Information.

Actions Taken by the Joint Commission on Health Care

JCHC members voted to take no action. However, Senator Barker introduced Senate Bill 432 which would have provided a process by which a minor 14 years of age or older may be admitted for inpatient treatment at a mental health facility without the consent of his parents. The bill allowed the minor to obtain a preadmission screening report from the local Community Services Board. If after the minor's parents have been given the opportunity to read and discuss the report with the preparer of the report, the parents still object to admission, the minor may be admitted to a willing mental health facility based on the findings in the report. The bill required judicial review of the admission and the nonconsenting parent shall be given the opportunity to be heard. The bill further provided that a minor 14 years of age or older shall be deemed an adult for the purposes of consenting to inpatient mental health treatment.

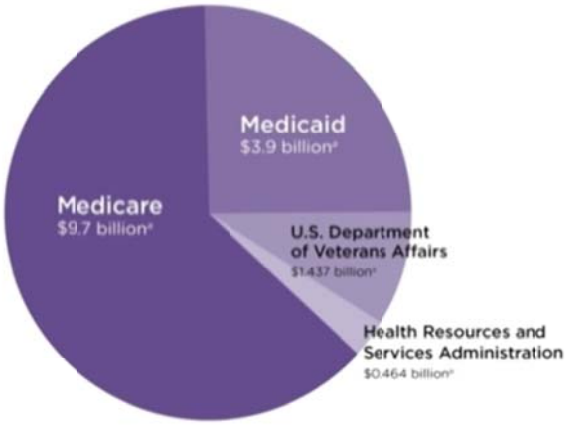
Passed by Indefinitely in the Senate Education and Health Committee

GRADUATE MEDICAL EDUCATION IN THE COMMONWEALTH

In 2013, JCHC members requested during the decision matrix meeting that staff continue to study graduate medical education (GME) in Virginia. In addition, Senate Budget Amendment 301 #19s (2015) requested DMAS to undertake a study of federal and state funding streams for graduate medical education, and explore ways to "incentivize the expansion of clinical training opportunities and retain graduates who train in Virginia….and explore payment mechanisms that encourage primary care training programs and other specialties identified as high needs…as well as preferences for primary care programs that extend their training programs to community settings and underserved areas." The budget amendment was removed from the conference version with the understanding by Senate Finance and House Appropriations Committees that the JCHC would conduct the study.

As shown below, Medicare is the largest source of GME funding providing approximately 63 percent of reported funds.

Primary Sources of GME Funding in the U.S.



Additional unreported funding comes from the Department of Defense, state sources, private insurers, and other private sources.

NOTE: All amounts are estimated. *a* = data from 2012; *b* = data from 2011 and 2013.
SOURCE: IOM (Institute of Medicine). 2014. *Graduate Medical Education That Meets the Nation's Health Needs*. Washington, DC: The National Academies Press. Table 3-1.

Medicare. Medicare (and for most states, Medicaid) GME funding is comprised of two components. The direct GME payment (DGME or DME) is meant to reimburse the hospital for resident stipends and benefits, faculty salaries and benefits, accreditation fees, institutional overhead costs and administrative costs. The DME payment is the product of a per resident amount, the number of resident FTEs, and the proportion of Medicare patients seen. The per resident amount calculation is based on hospital GME costs negotiated in 1983, updated for inflation. As a result, the DME payment scale does not reflect current funding needs of residency training programs and perpetuates significant inequities in GME payments among hospitals, localities and geographic regions.

The majority of hospitals that have a GME program also receive indirect medical education (IME) payments. IME is an additional payment a hospital receives on top of its traditional Medicare inpatient payment that subsidizes the hospital for expenses associated with training resident physicians such as higher utilization of services and longer inpatient stays. Hospitals receive about a 5.5 percent increase in the Diagnosis Related Group (DRG) payments for every approximate 10 percent increase in the resident to bed ratio. IME is the larger of the two GME payments with $7.04 billion of the total $9.7 billion spent on GME going toward IME reimbursement in 2012.

The Balanced Budget Act of 1997 implemented a cap on the number of resident FTEs for which a hospital could receive Medicare GME reimbursement. Each hospital's cap is based on the number of residents the hospital was training in 1996. Given that residency training programs historically developed first in the Northeast, residency slots are most highly concentrated in these states, as is most of Medicare GME funding.

Hospitals that have never been teaching hospitals before (referred to as naïve hospitals) can start new residency programs and have up to five years to establish their residency cap. In addition, rural hospitals can increase their number of slots by starting a new residency program, and urban teaching hospitals can start new rural training track residency programs and receive additional slots for the time that residents spend in the urban teaching hospital as long as residents spend at least half their time in the rural setting.

Medicaid. A state can choose to fund GME through its Medicaid program and receive matching federal funds, and CMS allows states flexibility in how they utilize Medicaid funds for GME payments. In 2012, 43 states had Medicaid GME payment programs, resulting in $3.9 billion in funding. In seven states (including Virginia) Medicaid GME funding exceeded $100 million per year.

Challenges of the Current GME System in the U.S. Recent studies by the Institute of Medicine, the Congressional Budget Office, the Council on Graduate Medical Education, the RAND Corporation, and academic researchers have identified the following issues as characteristics of the current GME system that should be addressed:

- Outdated GME funding system
- Lack of governance, transparency and accountability of GME at both the federal and state level
- Misalignment of the current GME system with the needs of the U.S. health care system and local communities, especially in terms of physician shortages in primary care (and other high need specialties) in rural and underserved areas
- Insufficient workforce data, and corresponding informed goals, to guide GME policy
- Concerns that the number of medical school graduates are outpacing the number of available residency positions
- Retention of residents in the state of their GME training

Characteristics of GME in Virginia

Virginia Medical Schools and Residency Programs. Currently, there are 2,745 residents and fellows training in Virginia; 1,950 are reported as positions funded by Medicare and Medicaid. The remainder includes privately-funded positions and those funded by the military and the Department of Veterans Affairs. While approximately 860 Virginia medical school undergraduates will be applying for residencies each year, Virginia offers about 757 ACGME/AOA approved first-year residency positions of which approximately 50 percent (382) are in primary care (family medicine, internal medicine and pediatrics).

Medical School	Annual Entering Class Enrollment	Estimated # of Graduates from Cohort
Virginia Commonwealth University	216	190-200
Virginia College of Osteopathic Medicine	188	180-186
Liberty University	160	150-158*
University of Virginia	157	145-150
Eastern Virginia Medical School	150	140-145
Virginia Tech Carillion	42	42
	Total Graduates in 2017	**847-881**

* Liberty University College of Osteopathic Medicine will graduate its first cohort in 2018.

GME Funding in Virginia. In addition to Medicaid funding, the Virginia State Budget (FY 2015-2016) includes general fund appropriations for the support of family medicine residency programs at Virginia Commonwealth University ($4,336,607), University of Virginia ($1,393,959) and Eastern Virginia Medical School ($722,146). This funding has remained the same or decreased over time. As a result, funding has not kept pace with the increasing costs of residency programs and there is concern that the number of family medicine resident slots in these programs will be reduced in 2016.

Total Medicare and Medicaid GME Reimbursements, Virginia 2012

Payment Type	Amount
Medicaid In-State DME + IME	$190,350,067
Medicaid In-State Allied Health GME	$ 2,516,132
Medicaid Out-of-State DME+IME+Allied Health GME	$ 2,667,226
Total Medicaid	$195,533,425
	($97,766,712 in State GFs)
Total Medicare	$197,697,966
Total GME Payments	**$393,231,391**

Retention of Residents in Virginia. Given the amount of resources states provide for the undergraduate and graduate training of physicians, there is a desire to increase the percent of medical students and residents trained in Virginia who choose to practice in the state. As the table below indicates, individuals who do both their undergraduate and graduate medical training in Virginia are far more likely to remain in the state once their training is completed. This is especially true for physicians specializing in family medicine.

Virginia Physician Retention, 2012*

	Virginia	Virginia Rank	State Median
% of physicians retained in Virginia from undergraduate medical education (UME)	33.7%	31	38.7%
% of physicians retained in Virginia from UME (public)	33.9%	35	44.9%
% of physicians retained in Virginia from GME	38.8%	40	44.9%
% of physicians retained in Virginia from UME and GME	64.3%	29	68.1%

*State Rank: How a state ranks compared to the other 49. Rank 1 goes to the state with the highest value for the particular category. State Median: The value directly in the middle of the 50 states, so 25 are above the median and 25 are below.
Source: 2013 State Physician Workforce Data Book

Physicians in Rural and/or Underserved Areas of Virginia. Overall, eight percent of Virginia's physicians work in non-metropolitan areas of the state. Only two percent of physicians work in southside Virginia even though the area makes up 6.3 percent of the population. In southwest Virginia, the percentages are three percent and 7.2 percent, respectively; and in the Valley region, five percent and 9.8 percent. According to the Association of American Medical

Colleges, 18.2 percent of Virginia's physicians practice in a geographical medically underserved area compared to 32.4 percent in Maryland, 33.6 percent in Kentucky, 35.3 percent in North Carolina, 40.7 percent in West Virginia and 26.7 percent in Tennessee. Finally, only 13 percent of physicians in Virginia are practicing in primary care in rural areas, compared to a total of 35 percent in the state. Generally, it is recommended that at least 50 percent of physicians in a state practice in primary care.

Considerations for Improving GME in Virginia

This study provides three policy options for addressing the needs of rural and underserved areas in Virginia: provide start-up funding for new residency programs in naïve hospitals, provide start-up funding for residency programs based on the Teaching Health Center GME Program model, and/or provide on-going funding for sole community hospital residency programs.

Additional policy options include updating Virginia's Medicaid GME payment system, increasing Medicaid GME funding for needed specialties, increasing appropriations for the State Loan Repayment Program, establishing a workforce and GME data collection program, and creating a governance structure for Virginia's GME system.

Start-up Funding for Naïve Hospitals. There is interest among hospitals, including those in rural and/or underserved areas, who have never trained residents to start new residency programs. Like current hospitals with GME programs, once naive hospitals begin training residents they will be able to use Medicare and Medicaid GME payments to fund their programs. However, the start-up costs of purchasing equipment, training faculty, developing required infrastructure, etc. can be prohibitive. A program could be developed to provide grants of $500,000 per year for a total of two years for each residency program.

Start-up Funding for Residency Programs Based on the Teaching Health Center GME Program Model. This program is a $230 million, 5-year initiative created by the Affordable Care Act to increase the number of primary care residents and dentists trained in community-based settings, such as federally qualified health centers. While the program is no longer accepting applications, states can develop and provide start-up funding for similar programs. The value of this model is that it encourages training of residents in a community-based setting in which they likely are going to practice, especially in rural and/or underserved areas.

Funding for Sole Community Hospital Residency Programs. Sole community hospitals are located more than 35 miles from other similar hospitals and receive additional Medicare payments and, therefore, are not eligible to receive Medicare IME payments. Virginia could establish a fund to provide the IME payments for sole community hospitals that establish new primary care residency programs. Funding requirements could tie future payments to retention of residents in medically underserved areas of the state.

Updating Virginia's Medicaid GME Payment System. The per resident amount (PRA) payment used to determine reimbursements to teaching hospitals is based on 1998 fee-for-service costs.

While the PRA has been increased for inflation, payments have not kept up with actual per resident costs for many hospitals. On average, Medicaid GME payments cover 40 percent of Medicaid's share of GME costs (based on the Medicaid utilization rate for each hospital), but since payments have not been rebased since 1998, the percent of cost covered varies from 10 percent to over 100 percent of a hospital's cost.

Increasing Medicaid GME Funding for Needed Specialties. The provision of additional funding for needed specialties could be achieved by 1) enhancing Medicaid DME and IME payments to hospitals with residency programs in specialties identified as high-need (family medicine, pediatrics, obstetrics/gynecology, general surgery, psychiatry, geriatrics, emergency medicine, etc.) and/or 2) establishing an additional Medicaid GME supplemental payment. Funding would be based on an average per resident amount of $140,000 and criteria developed by DMAS could set aside half of the available funds for primary care programs and the remainder for other needed specialties.

Establishing a Governance Structure for Virginia's GME System. Neither the federal government nor most states have an organizational structure to provide oversight of the GME system or funding. A governing body could guide workforce and GME data collection, provide policy recommendations, oversee policy implementation and assure that the GME system is meeting the needs of the state and each of its regions. Equal regional representation within the governing body could be achieved through the creation of regional organizations that would oversee initiatives in their region.

Actions Taken by the Joint Commission on Health Care

1. Request by letter of the JCHC Chair that DMAS determine a plan, including budget estimates, to rebase the costs used to establish the per resident amount for DME payments and report to the JCHC by September 2016. Include estimates for rebasing up to 100 percent of Medicaid's portion of a hospital's GME cost.

2. Introduce a budget amendment (language and funding) for DMAS to amend the State Plan to establish an additional Medicaid health professional training supplemental payment. Funds would be based on an average per resident amount of $140,000.
   - Criteria developed by DMAS would set aside half of the available funds to support expansion of primary care training programs and the remainder for other needed specialties (e.g. psychiatry).

   Preference would be given to programs that extend their training to community settings, especially in rural or underserved areas.

3. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, contact hospitals that have never had residency programs to determine which ones may be interested in developing such programs and what support, including seed money, might be

needed to develop successful programs. The VHWDA shall report to the Commission by September 2016.

4. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the Virginia Community Healthcare Association and the stakeholder Graduate Medical Education Advisory Group, assess whether it is prudent to develop residency programs based on the Teaching Health Center GME Program Model in Virginia and, if so, what would be needed to develop successful programs, with a report to the Commission by September 2016.

5. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, assess whether it is prudent to develop a Virginia Sole Community Hospital Residency Fund and, if so, what would be needed to develop successful programs, with a report to the Commission by September 2016.

6. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, assess the effectiveness of the State Loan Repayment Program and the potential benefits of expansion of the program, with a report to the Commission by September 2016.

7. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, develop a plan for a GME governing body in Virginia, whose responsibilities would include:
   - Guide workforce and GME data collection
   - Provide policy recommendations and oversee policy implementation
   - Assure that the GME system is meeting the needs of the state and each of its regions.

   A report on the proposed plan will be presented to the JCHC by September 2016.

Legislative Action

Budget Amendment 306#19c - This amendment provides $1.25 million from the general fund and an equivalent amount of federal matching funds to increase the number of medical residency slots funded through Medicaid. The average supplemental payment for each new slot will be $100,000 a year minus any Medicare residency payment for which the hospital is eligible. Thirteen of the 25 slots will be dedicated to primary care and the remainder for high-need specialties. Preference will be given to residency programs in communities and rural areas that are underserved.

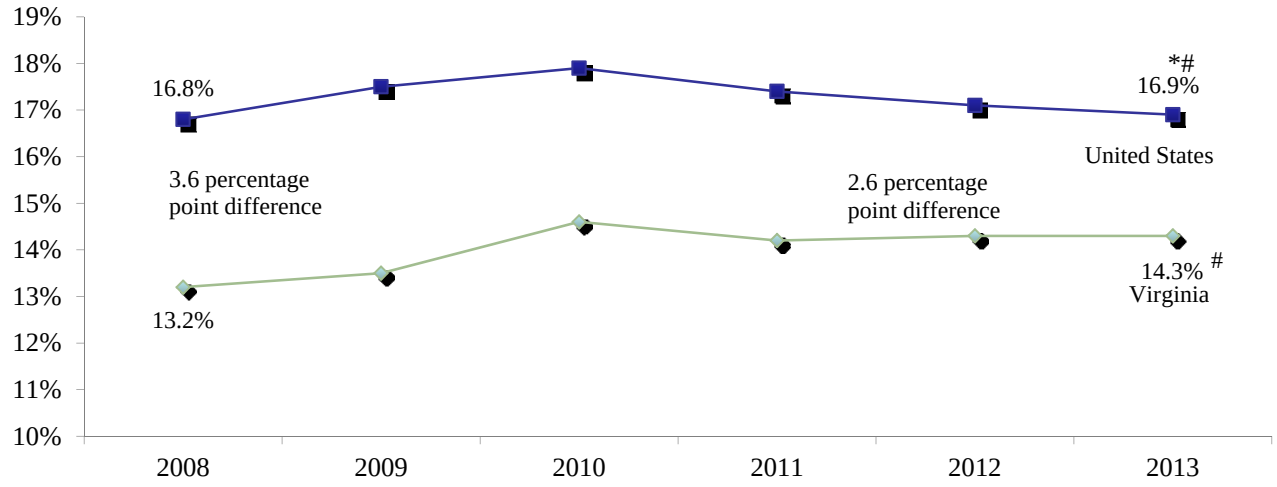
RESOURCES FOR UNSERVED AND UNDERSERVED POPULATIONS

During the 2015 General Assembly Session, House Joint Resolution 596 (Delegate Marshall) directed the Joint Commission on Health Care to conduct a study to: (i) identify unserved or underserved regions and populations in the Commonwealth; (ii) examine existing health care services for unserved and underserved individuals provided by free or charitable clinics; and (iii) in considering new models of health care provision, address concerns regarding civil liability protection for health care professional volunteers in free or charitable clinics.

The Uninsured in Virginia

Approximately one million individuals are uninsured in Virginia and uninsured rates are typically lower than the rates in the nation as a whole. The difference in the rates of uninsured between the U.S. and Virginia narrowed slightly between 2008 and 2013. Specifically, the number of uninsured in Virginia increased among adults and decreased among children during this time.

Uninsurance Rates Among the Nonelderly in Virginia and the U.S., 2008 - 2013

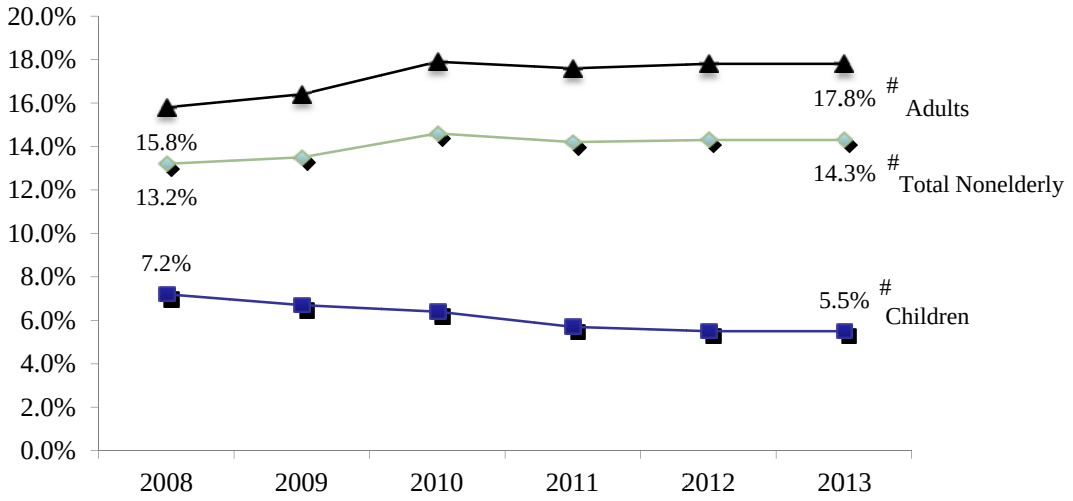


Note: * indicates the 2012 uninsured rate is statistically different from 2013 at the .10 level. # indicates the 2008 uninsured rate is statistically different from 2013 at the .10 level.

The estimates reflect Urban Institute adjustments for potential misreporting of coverage, based on a simulation model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation.

Source: Urban Institute, May 2015. Based on the 2008, 2009, 2010, 2011, 2012, and 2013 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) via the Virginia Health Care Foundation's *2015 Profile of the Uninsured in Virginia* Report

Percent Uninsured in Virginia; Adults, Children and Total Nonelderly, 2008 - 2013



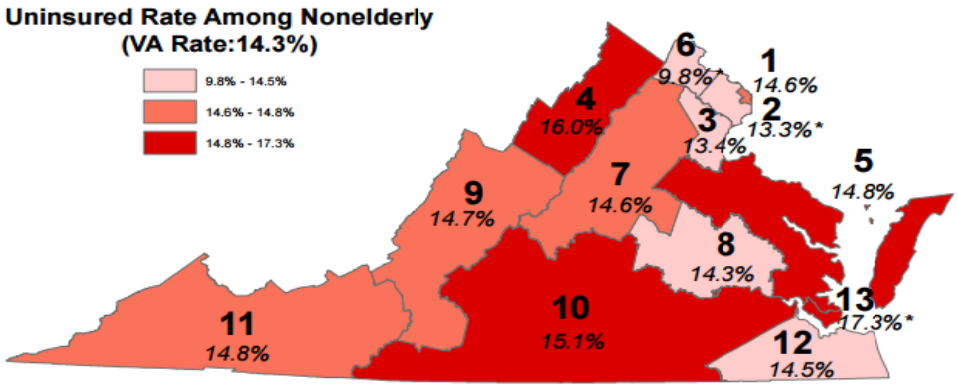
Note: * indicates the 2012 uninsured rate is statistically different from 2013 at the .10 level. # indicates the 2008 uninsured rate is statistically different from 2013 at the .10 level.

The estimates reflect Urban Institute adjustments for potential misreporting of coverage, based on a simulation model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation.

Source: Urban Institute, May 2015. Based on the 2008, 2009, 2010, 2011, 2012, and 2013 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) via the Virginia Health Care Foundation's 2015 Profile of the Uninsured in Virginia Report

69.5 percent of uninsured Virginians (684,000) live in families with income at or below 200 percent of the federal poverty level (FPL) and uninsured adults in Virginia are much more likely than insured adults to have unmet needs and less likely to receive preventive services.

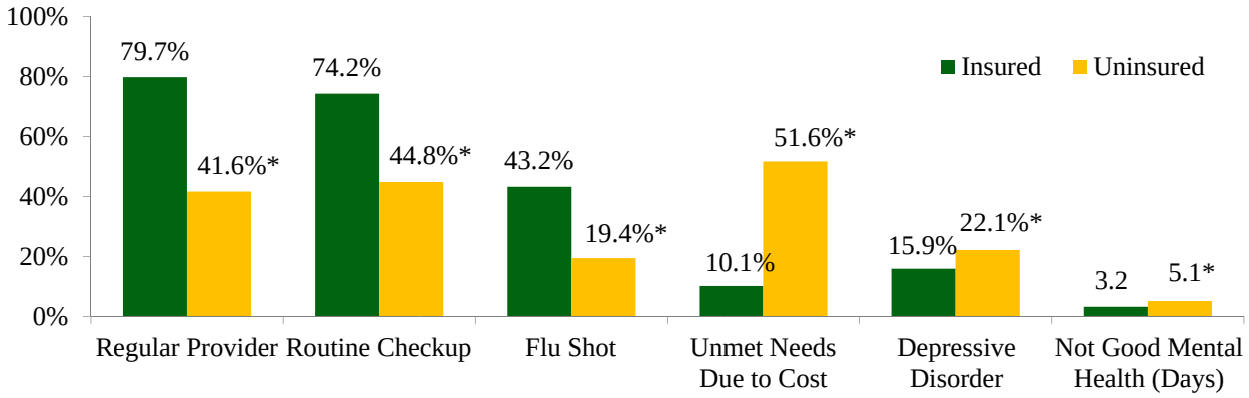
Uninsured Rate Among Nonelderly (0-64) in Virginia by Area, 2013



Source: Urban Institute, July 2015. Based on the 2013 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) of the Minnesota Population Center.
1 Shaded areas represent regions of Virginia which are defined in terms of counties or a combination of counties (see "Guide to Regions in Virginia").
Notes: The estimates reflect Urban Institute adjustments for potential misreporting of coverage, based on a simulation model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation.
* indicates that the uninsured rate for the region is statistically different from the uninsured rate for the areas in the rest of the state at the 0.1 level.

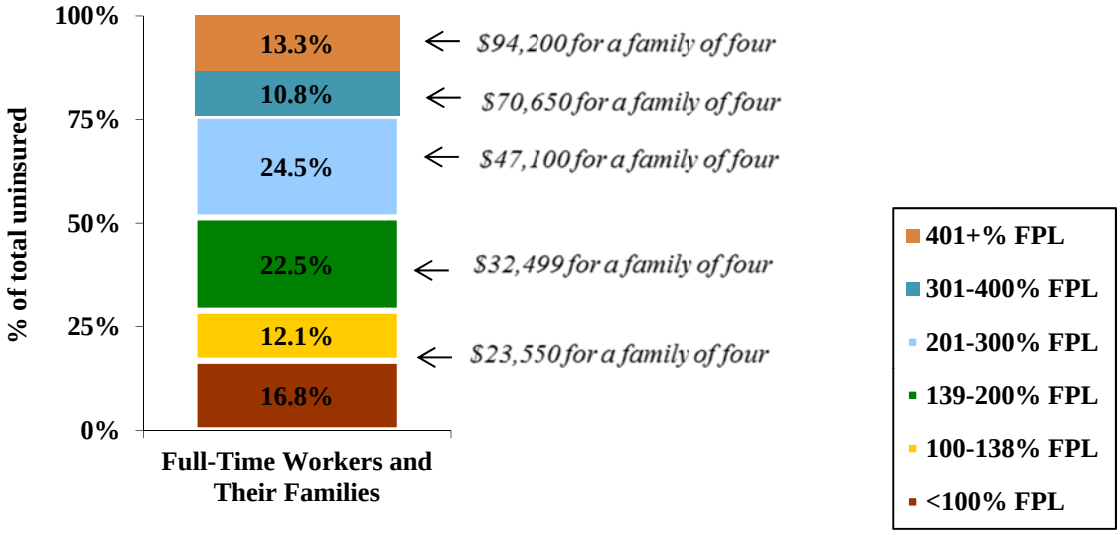
Source: The Virginia Health Care Foundation's 2015 Profile of the Uninsured in Virginia Report

Level of Need Comparison of Insured and Uninsured Virginians



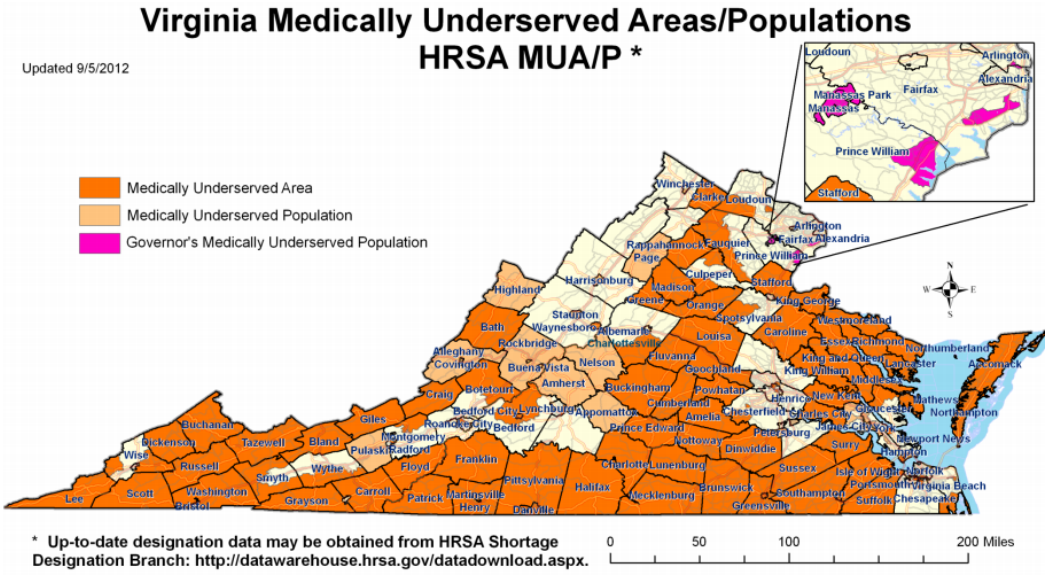
Note: Adults are age 19-64. Measures refer to access or utilization over the past 12 months.
Estimates marked with * indicate the difference between the insured and uninsured estimates is significant at the .01 percent level.
Source: The Virginia Health Care Foundation's *2015 Profile of the Uninsured in Virginia* Report

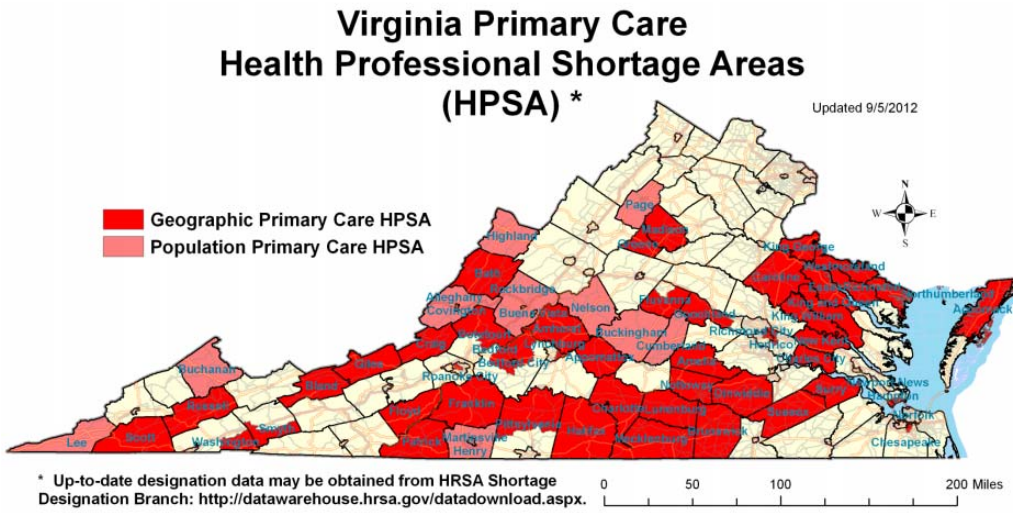
Full-time workers and their families make up 50.5 percent of the uninsured in Virginia and are distributed over all income levels



Notes: Family poverty level estimates are based on health insurance unit gross income and use the 2013 Federal Poverty Levels (FPLs) defined by the U.S. Census Bureau. Family work status is based on the highest level of employment among the adults in the health insurance unit. Estimates may not sum to 100% due to rounding.

Source: Urban Institute, May 2015. Based on the 2013 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). The estimates reflect Urban Institute adjustments for potential misreporting of coverage, based on a simulation model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation via the Virginia Health Care Foundation's *2015 Profile of the Uninsured in Virginia* Report





Sources: Virginia Department of Health website at http://www.vdh.virginia.gov/OMHHE/primarycare/shortagedesignations and U.S. Department of Health and Human Services, Health Resources and Services Administration website at http://bhpr.hrsa.gov/shortage/index.html.

Access to Services

The Virginia Association of Free and Charitable Clinics have 60 member clinics with patients at or below 200 percent of the federal poverty level (FPL). In 2014 a total of 12,288 individuals volunteered their services.

- 7,316 health care professional volunteers
- 4,972 lay volunteers

71,916 patients were served by member clinics and 699,071 unduplicated prescriptions were dispensed.

All member clinics combined had total annual operating expenses of $34,906,586 in CY 2014 with a wide variation in the operating expenses of individual clinics ranging from $52,500 to $2,726,856 per year.

Health Care Visits to Free and Charitable Clinics in Virginia, CY 2014

	Medical Visits	Dental Visits	Mental Health Visits	Specialty Visits	Grand Totals
Total # Visits	224,840	37,567	22,946	5,596	290,949
Value per Visit	$126	$207	$161	$192	
Total Value	$28,329,840	$7,786,136	$3,690,405	$1,074,208	$40,880,590

Example of Free and Charitable Clinics in Virginia, CY 2014 Data

Clinic	# Health Care Volunteers	# Physician Volunteers	# Unduplicated Patients	# Patient Visits	Annual Operating Budget
Cross Over Health Care	291	70	6,609	26,589	$2,629,969
Fan Free Clinic	50	7	3,970	9,750	$2,305,976
Health Wagon	40	5	3,575	8,789	$1,615,769
Charlottesville Free Clinic	380	149	3,089	9,555	$1,677,289
Reddy Tri County Health	47	21	219	533	$99,543
Free Clinic of Powhatan	24	6	217	1141	$201,536
Roanoke Valley Mental Health Care	43	0	209	1254	$73,452
Surry Area Free Clinic	3	1	100	340	$72,810

Volunteer Health Care Professionals and Civil Liability Protections

In 1997, Congress adopted the Volunteer Protection Act (VPA), which provides all volunteers of government entities and not-for-profit organizations protection from liability for harms caused by their acts or omissions while serving as volunteers.

Under the VPA, two types of organizations qualify as not-for-profit organizations:

- A 501(c)(3) organization as defined by the Internal Revenue Code and exempt from tax under 501(a)
- Any not-for-profit organized for the public benefit and operated primarily for charitable, civic, educational, religious, welfare or health purposes

The statute defines a volunteer as an individual performing a service for a not-for-profit organization or governmental entity who does not receive compensation for his or her services, other than reasonable reimbursement for expenses actually incurred, or anything of value, in lieu of compensation, in excess of $500 per year.

Four requirements must be met for the VPA law to apply:

- The volunteer is acting within the scope of his or her responsibilities
- The volunteer is properly licensed, certified or authorized by the state to practice
- The harm was not caused by willful or criminal misconduct, gross negligence, reckless misconduct or conscious indifference to the rights/safety of the person injured
- The harm was not caused while the volunteer was operating a motor vehicle or other vehicle for which a license or insurance is required

The VPA preempts any conflicting state law, although states may enact broader protections.

Federal Tort Claims Act (FTCA)

Under the FTCA, enacted in 1946, the federal government acts as a self-insurer and recognizes liability for the negligent or wrongful acts or omissions of its employees acting within the scope of their official duties. The United States is liable to the same extent an individual would be in like circumstances. The statute substitutes the United States as the defendant in such a suit and the United States—not the individual employee—bears any resulting liability.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) extended the eligibility for FTCA protection to volunteer health professionals at qualifying free clinics, deeming them federal employees for such purposes. Funds to support the program were appropriated in 2004, and the first free clinic volunteers were deemed in 2005.

The FTCA enables free clinics to invest more in health care services and quality improvement activities by freeing funds that would have been used on medical malpractice insurance premiums. To be eligible, the volunteer's sponsoring free clinic must be operated by a nonprofit private entity meeting the following requirements:

- Does not, in providing health services through the facility, accept reimbursement from any third-party payor - including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program--but may accept voluntary donations for the provision of services
- In providing health services through the facility, either does not impose charges on the individuals to whom services are being provided, or imposes a charge according to the ability of the individual involved to pay the charge
- Is licensed or certified in accordance with applicable law regarding the provision of health services

An eligible clinic health professional providing a health service to an individual must be sponsored by a free clinic, provide services to patients at a free clinic or through offsite programs or events carried out by the clinic, and must be licensed or certified at the time of service provision in accordance with applicable law. The health professional may not receive compensation from patients directly or from any third-party payor. However, he/she may receive repayment from a free clinic for reasonable expenses incurred in service provision to patients.

Under the FTCA, a claimant may not file suit before presenting an administrative claim to the Department. The administrative claim must be presented to the Department of Health and Human Services (HHS) Office of the General Counsel (OGC). If the claim is denied or an administrative settlement is not reached within six months of such presentment, the claimant can sue the United States in the appropriate Federal district court.

State Volunteer Liability Protections

According to Virginia Code § 54.1-106 no person who is licensed or certified by the Boards of/for Audiology and Speech-Language Pathology; Counseling; Dentistry; Medicine; Nursing; Optometry; Opticians; Pharmacy; Hearing Aid Specialists; Psychology; or Social Work or who holds a multistate licensure privilege to practice nursing issued by the Board of Nursing who renders at any site any health care services within the limits of his license, certification or licensure privilege, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge or any clinic for the indigent and uninsured that is organized for the delivery of primary health care services as a federally qualified health center designated by the Centers for Medicare & Medicaid Services, shall be liable for any civil damages for any act or omission resulting from the rendering of such services unless the act or omission was the result of his gross negligence or willful misconduct.

In addition, the Division of Risk Management (DRM) administers risk management plans and programs to protect Virginia's state government, political subdivisions, some non-profit organizations, and certain individuals serving in the public interest from financial loss. Pursuant to § 54.1-106, *Code of Virginia,* DRM offers medical malpractice coverage for health care practitioners who volunteer their services at Virginia's free clinics and federally-qualified health

centers. This coverage is available regardless of whether the clinic itself is covered through DRM. The premium for coverage of volunteers under the plan is paid by the Department of Health, and free clinics and volunteers report being very satisfied with the program. In over ten years, only three claims have been brought against a free clinic, and all three were dismissed.

Conclusion

The VPA and Virginia Code § 54.1-106 provide health care professional volunteers working in free and charitable clinics protection from civil liability. While these laws do not provide volunteers liability protection in all possible settings, due to regulation and licensure requirements, it is unlikely that a volunteer would be providing services in a setting not covered by the law. Although these federal and state laws make it more difficult for a plaintiff to win a liability suit (i.e. the volunteer health care provider would use the affirmative defense of the VPA or state law to request dismissal), they do not bar volunteers from being sued.

The statutes seek to balance protecting a volunteer from personal liability, thereby increasing volunteerism, and maintaining a tort system that provides incentives for volunteers to exercise appropriate and reasonable care. If a suit is brought against a health care professional volunteer, both the FTCA and the VaRISK program provide liability coverage and protection from financial loss.

The Advisability of Establishing a Midlevel Provider License

An approved policy option from the JCHC staff-study, *Update on the Virginia Physician Workforce Shortage* House Document No. 2 – 2014, requested that the Department of Health Professions (DHP) convene a workgroup to review and report to the JCHC regarding the advisability of establishing a midlevel provider license.

Department of Health Professions Review of Midlevel Providers

In response to a JCHC letter-request, DHP convened a workgroup representing stakeholder associations, medical schools and state agencies. The resulting DHP report, *The Advisability of Establishing a Midlevel Provider License*, noted that midlevel providers are "licensed non-physician health care providers who have received less extensive training and have a more restrictive scope of practice than physicians."[1] Nurse practitioners and physician assistants are examples of well-established midlevel providers. In fact, funding is provided under the Affordable Care Act (ACT) to encourage the use of nurse practitioners and physician assistants practicing in underserved areas and within team-based care. The DHP report notes: "Full utilization of midlevel providers, however, could require changes in scope of practice laws and payment reform to allow midlevel providers to perform expanding roles."[2]

Missouri Midlevel Provider Law. In 2014, Missouri established a midlevel assistant physician license which allows medical students, who have graduated from medical school within the previous three years, to apply for licensure. Licensure allows for entering into an "assistant physician collaborative practice arrangement" with a physician; thereby, enabling the assistant physician to provide primary care services in medically underserved rural and urban areas. Furthermore, the licensed assistant physician is allowed to "practice somewhat autonomously and have the authority to prescribe Schedule III, IV, and V drugs."[3]

Department of Health Professions - Convened Workgroup Recommendations

The workgroup met in September 2014 to consider establishing a midlevel provider license and determined that "a midlevel provider license is not advisable at this time [but]… recommended the subject be revisited after enough time has passed for data to be gathered on Missouri's experience with a mid-level provider license. In the meantime, Virginia should explore other approaches to address any physician workforce shortages, such as:

1. Increasing the number of Graduate Medical Education (GME) residency slots.

[1] *The Advisability of Establishing a Midlevel Provider License*, Department of Health Professions, July 1, 2015, p. 5.
[2] Ibid, p. 6.
[3] Ibid, p. 7.

2. Ensuring state methods and organizational structures target GME positions toward state health workforce needs.
3. Leveraging emerging technology and telemedicine to reach the underserved and address geographical mal-distribution of physicians.
4. Utilizing a team-based approach to health care delivery with integration of nurse practitioners and physician assistants.
5. Ensuring Virginia effectively utilizes currently regulated professions, such as nurse practitioners and physician assistants, to address access to care issues before establishing a new level of provider.
6. Considering an increase in the licensure fee to fund rural physicians.
7. Ensuring the sustainability of any solution to address physician shortages.
8. Ensuring any solution to address workforce issues does not compromise patient care and safety."[4]

A number of these approaches have been studied and supported by the Joint Commission including promoting technology and telemedicine, team-based approaches, and the use of nurse practitioners and physician assistants; as well as the policy options addressing graduate medical education proposed this year. In several years, members may wish to include in the JCHC work plan, a staff-review of Missouri's experience in licensing physician assistants.

Action Taken by the Joint Commission on Health Care

JCHC members voted to introduce legislation *to amend Code of Virginia Title 32.1 to establish a midlevel provider license for medical school graduates who have not completed a residency as well as for veterans as they leave the military consistent with their care-related experience.*

Legislative Action

House Bill 900 – Delegate Christopher P. Stolle

HB 900 authorizes the Board of Medicine to issue a two-year license to practice as an associate physician to an applicant who is 18 years of age or older, is of good moral character, has successfully completed a course of study approved by the Board, has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination, and has not completed a medical internship or residency program. The bill requires all associate physicians to practice in accordance with a practice agreement entered into between the associate physician and a physician licensed by the Board and provides for prescriptive authority of associate physicians in accordance with regulations of the Board.

Continued to 2017 in the Senate Education and Health Committee

[4] Ibid, p.1

Meeting Agendas 2015

Joint Commission on Health Care

May 28, 2015	**Welcome New Members** Delegate John M. O'Bannon III, Chair **2015 Work Plan Proposals** Kim Snead Executive Director
June 17, 2015	**State Innovation Models (SIM) Update** Beth A. Bortz President and CEO Virginia Center for Health Innovation **Cancer Projections for Virginia** Qian Cai, Ph. D. Director Meredith Strohm Gunter, Ph.D. Outreach Director Demographics Research Group Weldon Cooper Center for Public Service **STAFF REPORT:** **Allowing Certain Minors to Receive Inpatient Mental Health Treatment Without Parental Consent** Stephen Weiss Senior Health Policy Analyst
October 7, 2015	**Consideration of Nominee for Virginia Health Information Board** Delegate John M. O'Bannon III **Review of Public Comments and Additional Updates** Kim Snead **Virginia Health Information: Annual Report and Strategic Plan** Michael T. Lundberg VHI Executive Director **STAFF REPORTS:** **Review of Graduate Medical Education** Michele L. Chesser, Ph.D. Senior Health Policy Analyst **Resources for Unserved and Underserved Populations** **House Joint Resolution 596 (Delegate Robert G. Marshall)** Michele L. Chesser, Ph.D.

November 4, 2015

Recognition of Departing Members
Delegate John M. O'Bannon III

Report by Virginia's Conversion Health Foundations
Kim Snead

Update on the Hancock Geriatric Center
Jack W. Barber, M.D.
Interim Commissioner
Department of Behavioral Health and Developmental Services

Decision Matrix: Review of Policy Options and Legislation for 2016
JCHC Staff

Behavioral Health Care Subcommittee

June 17, 2015

Suicide in Virginia: 2003 - 2012
Marc Leslie
Virginia Violent Death Reporting System Coordinator
Office of the Chief Medical Examiner
Virginia Department of Health

Youth Suicide Prevention Program
Anya Shaffer
Suicide and Violence Prevention Coordinator
Virginia Department of Health

Suicide Risk in Long-Term Care in Virginia: 2003 – 2011
Briana Mezuk, Ph.D.
Assistant Professor
Division of Epidemiology
Department of Family Medicine and Population Health
Virginia Commonwealth University School of Medicine

The Virginia Acute Psychiatric and CSB Bed Registry
Cleopatra L. Booker, Psy.D.
Acute Care Services Consultant
Virginia Department of Behavioral Health and Developmental Services

September 9, 2015

Civil Commitment Practices in Virginia
Richard J. Bonnie. L.L.B.
Harrison Foundation Professor of Law and Medicine
Professor of Public Policy
Director, Institute of Law, Psychiatry and Public Policy
University of Virginia School of Law

Update on the Center for Behavioral Health and Justice
Victoria H. Cochran
Deputy Secretary of Public Safety and Homeland Security
Office of the Governor

Healthy Living/Health Services Subcommittee

September 9, 2015	**Department for Aging and Rehabilitative Services Update** Robert H. Brink Deputy Commissioner James A. Rothrock Commissioner Department for Aging and Rehabilitative Services **Impact of Childhood Trauma on Health** Allison Jackson, Ph.D., LCSW Trauma Informed Care Operations Manager Richmond Department of Social Services **Staff Report:** **Review of Certain Health-Care System Characteristics in States with and without Certificate of Need** Stephen Weiss
October 7, 2015	**Core Population Health Measures and Related Issues** Marissa Levine, M.D., MPH State Health Commissioner Virginia Department of Health **Report on the Provider Tax Assessment Work Group** K. Joseph Flores Deputy Secretary of Health and Human Resources Office of the Governor **Update: Activities of the Certificate of Public Need Work Group** Joseph J. Hilbert Director of Governmental and Regulatory Affairs Virginia Department of Health **Recommendations of the Governor's Task Force on Prescription Drugs and Heroin Abuse** Jodi L. Manz, MSW Policy Advisor Office of the Secretary of Health and Human Resources

Statutory Authority

§ 30-168. (Expires July 1, 2018) 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, 2018) 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, 2018) 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, 2018) 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, 2018) 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, 2018) 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, 2018) 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, 2018) Sunset.
The provisions of this chapter shall expire on July 1, 2018.
(1992, cc. 799, 818, § 9-316; 1996, c. 772; 2001, cc. 187, 844; 2006, cc. 113, 178; 2009, c. 707; 2011, cc. 501, 607.)
2014, cc. 280, 518.

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