JOINT COMMISSION ON HEALTH CARE

2019 ANNUAL REPORT

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2019 Annual Report
Joint Commission on Health Care

To the Governor and the
General Assembly of Virginia

Report Document #280

Commonwealth of Virginia
Richmond
2020

JOINT COMMISSION ON HEALTH CARE

Senator George L. Barker, Interim Chair

September 8, 2020

The Honorable Ralph Northam
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

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

Dear Governor Northam 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, 2019.

This report includes a summary of the Joint Commission's activities including legislative recommendations to the 2020 Session of the General Assembly. In addition, staff studies are submitted as written reports, published and made available on the General Assembly's website and the Joint Commission on Health Care's website.

Respectfully submitted,

George L. Barker

Michele Chesser, PhD, Executive Director
Joint Commission on Health Care
P.O. Box 1322/Richmond, VA 23218

JOINT COMMISSION ON HEALTH CARE

LEGISLATIVE MEMBERS

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Senator George L. Barker
Senator Charles W. Carrico, Sr.
Senator Siobhan S. Dunnavant
Senator John S. Edwards
Senator L. Louise Lucas
Senator Glen H. Sturtevant, Jr.
Senator David R. Suetterlein

Delegate T. Scott Garrett (Vice Chair)

Delegate David L. Bulova
Delegate C.E. Cliff Hayes, Jr.
Delegate Patrick A. Hope
Delegate Riley E. Ingram
Delegate Kaye Kory
Delegate Robert D. Orrock, Sr.
Delegate Christopher K. Peace
Delegate Christopher P. Stolle
Delegate Roslyn C. Tyler

EX OFFICIO MEMBER

The Honorable Daniel Carey, MD
Secretary of Health and Human Resources

COMMISSION STAFF

Michele L. Chesser, PhD
Executive Director

Paula R. Margolis, PhD, MPH
Senior Health Policy Analyst

Andrew D. Mitchell, ScD
Senior Health Policy Analyst

Stephen G. Weiss, MPA
Senior Health Policy Analyst

Agnes Dymora
Executive Assistant/Office Manager

OFFICE LOCATION

Main Street Centre Building
600 East Main Street
3rd Floor, Suite 301
Richmond, Virginia 23219

Mailing Address:
P. O. Box 1322
Richmond, Virginia 23218

804.786.5445
804.786.5538 fax

Website: http://jchc.virginia.gov

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 tare he most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care." The 2017 General Assembly extended the Commission's sunset date to July 1, 2022, during the Session (Senate Bill 1043 and House Bill 1736).

The Joint Commission on Health Care is comprised of 18 legislative members. Eight members are Senators appointed by the Senate Committee on Rules, and ten members are Delegates appointed by the Speaker of the House. Senator Rosalyn R. Dance served as Chair in 2019 and Delegate T. Scott Garrett was the Vice Chair.

Thank you for your service:

After contributing years of time and effort to improve the health care services provided to Virginians, the following members completed their tenure at the Joint Commission on Health Care in December of 2019. Through the acquisition and sharing of health policy information, the creation of sound recommendations, and patronage of JCHC legislation, these individuals upheld the mission of the Commission. Members and staff thank them for their invaluable service and dedication. They will be missed.

Senator Charles W. Carrico, Sr. represented the 40th district in the Senate since 2012. Before that time, he was a member of the House of Delegates, starting in 2002. Appointed to the Joint Commission on Health Care in 2012, he served one two-year term as the Chair beginning in 2016.

Senator Rosalyn R. Dance began her service to the Commonwealth as a member of the House of Delegates from 2005 to 2014. Then she was elected to represent the citizens of the 16th district in the Senate. Appointed to the JCHC in 2009, she was the Vice Chair in 2016 and 2017 and became the Chair in 2018.

Delegate T. Scott Garrett was elected to the House of Delegates in 2010, representing the 23rd district, and was appointed to the Commission that same year. Prior to serving as Vice Chair in 2018 and 2019, he was the Co-Chair of the Healthy Living/Health Services Subcommittee in 2014 and 2015, and the Co-Chair of the Behavioral Health Care Subcommittee in 2016 and 2017.

Senator L. Louise Lucas has represented the people of the 18th district since 1992. Appointed to the Commission in 2008, she served as the Vice Chair in 2014 and 2015 and was the Co-Chair of the Behavioral Health Care Subcommittee from 2008 through 2014.

Delegate Christopher P. Stolle represented the 83rd district since 2010. Appointed to the Commission in 2012, he served as the Co-Chair of the Behavioral Health Care Subcommittee from 2012 to 2015 and the Co-Chair of Healthy Living/Health Services Subcommittee in 2016 and 2017.

Delegate David L. Bulova has represented the 37th district since 2006. He was appointed to the Joint Commission on Health Care in 2010.

Delegate Riley E. Ingram represented the 62nd district in the House for eighteen years and was appointed to the Joint Commission on Health Care in 2012.

Delegate Kaye Kory represents the 38th district since 2010. She was appointed to the Joint Commission in 2014.

Delegate Christopher K. Peace was elected to represent the 97th district in 2006 and appointed to the Joint Commission on Health Care in 2010.

Senator Glen H. Sturtevant, Jr. became a member of the Senate, representing Virginians in the 10th district, in 2016. That year, the Senate Rules Committee appointed him to the Joint Commission on Health Care.

Delegate Roslyn C. Tyler has represented the 75th district since 2006. She was appointed to the Joint Commission on Health Care in 2015.

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ACTIVITIES

In keeping with its statutory mandate, the Joint Commission received reports from state agencies and other health-related groups; conducted and presented staff studies; considered comments from public and private organizations, advocates, industry representatives, citizens and other interested parties; and made policy recommendations to advance the quality of health and health care services in the Commonwealth.

The full Commission met five times in 2019. These meetings were held in Senate Room A of the Pocahontas Building on May 8, June 24, September 4, October 3, and November 14. The Executive Subcommittee met on the first of May in Senate Subcommittee Room 3 of the Pocahontas Building to discuss the Commission's work plan for the year.

Seven staff reports were presented during the 2019 Joint Commission on Health Care meetings:

- Language Development Milestones and Parent Resources for Young Deaf/Hard of Hearing Children
- Increased Prescription Delivery Options at Same Price for Health Plan Members
- Naloxone Public Access & Storage
- The Dispensing of Drugs and Devices Pursuant to Pharmacy Collaborative Practice Agreements, Standing Orders and Statewide Protocols
- Prescription Drug Price Gouging
- Forensic Nursing in the Commonwealth
- Supported Decision-Making for Individuals with Intellectual and Developmental Disabilities (IDD)

In addition to the staff reports, invited guests delivered the following presentations at the June 24 meeting:

- *Virginia Maternal Mortality Data* presented by Melanie J. Rouse, PhD, Maternal Mortality Projects Coordinator at the Virginia Department of Health
- *Governor's Goal on Eliminating Racial Disparity in Maternal Mortality* presented by Gena Boyle Berger, MPA, Deputy Secretary of Health and Human Resources
- *Update on Creation of Standardized Release of Information Form* presented by Michael Schaefer, PhD, Assistant Commissioner at Virginia Department of Behavioral Health and Developmental Services
- *VHI 2018 Annual Report and Strategic Plan Update* presented by Michael Lundberg, Executive Director, Virginia Health Information, Inc.

The above reports and presentations are available at http://jchc.virginia.gov on the meetings and reports pages.

Additional Staff Activities

Memberships:

- Academy Health
- American Public Health Association (APHA)
- Children's Health Insurance Program Advisory Committee (CHIPAC)
- Early Periodic Screening Diagnosis and Treatment (EPSDT) Project
- Graduate Medical Education (GME) Grant Review Committee, Virginia Health Workforce Development Authority
- Hospital Payment Policy Advisory Council (HPPAC), Department of Medical Assistance Services (DMAS)
- Virginia Values Veterans (V3)

External Presentations, Interviews and News Reports:

- *Introduction to Health Care Policy*. Guest lecture in HCPR 601, Introduction to Health Policy; Department of Health Behavior and Policy; Virginia Commonwealth University
- *Forensic Nursing in the Commonwealth*. Presentation to the Virginia Crime Commission on October 15, 2019
- Virginia Quality Health Network's Breakfast with the Experts. Invited panelist
- Virginia Health Law Legislative Update and Extravaganza. Invited panelist
- VPM NPR *This Week in Richmond*. Host David Bailey interviews Senator L. Louise Lucas, Delegate C.E. (Cliff) Hayes, Jr. and Executive Director Michele Chesser from the Joint Commission on Health Care; September 9, 2019. https://vpm.org/watch/articles/6803/this-week-in-richmond-michele-chesser-del-cliff-hayes-sen-louise-lucas
- News Reports on JCHC's Forensic Nursing in the Commonwealth Study:
    - *Forensic nurse shortage means Virginia sex assault victims travel hours for exams*. WHSV Channel 3; Stanton, VA; by Associated Press, Autumn Childress; October 16, 2019 at 9:17 PM EDT
    - *Nursing, hospital shortage means Virginia sex assault victims travel hours for exams*. WTOP News; northern Virginia, by The Associated Press; October 15, 2019, 4:41 AM EDT
    - *Forensic Nurse Shortage in VA Means Sexual Assault Victims Jump Through Hoops to Resolve Cases*. VPM NPR News; by Whittney Evans; October 16, 2019
    - *Study: Shortage of nurses qualified to provide sexual assault exams in Va. is further hardship for some victims*. Richmond Times-Dispatch; Richmond, VA; by Frank Green; Oct 14, 2019

- *Sexual Assault Examinations Lacking in VA*. WZRV 95.3, from the AP Wire, October 15, 2019
- *Why a new study reveals Virginia is short on sex assault exam providers*. WJLS Channel 7; D.C. and Maryland; by Associated Press; October 15, 2019
- *Study finds state is short on sex assault exam providers*. Virginia Lawyers Weekly; by Associated Press; October 15, 2019
- *Shortage of nurses certified to perform sexual assault exams in Virginia, new study finds*. WTKR Channel 3; coastal VA and northeast Carolina; by Web Staff; October 16, 2019, 12:44 PM EDT
- *Forensic nurse scarcity means Virginia intercourse assault victims journey hours for exam*. fooshya.com
- *Study Finds Virginia is Short on Sex Assault Exam Providers*. WRDT Coast TV; by Associated Press; October 15th, 7:36 AM EDT

Conferences, Seminars and Workshops Attended:

- Academy Health - National Health Policy Conference; Washington D.C.
- Academy Health - Health Data Leadership Institute (HDLI) Conference; Washington D.C.
- American Public Health Association (APHA) Conference; Washington D.C.
- Mid-Atlantic Telehealth Summit (MATRC); Williamsburg, Virginia
- National Academy for State Health Policy (NASHP) Conference; Chicago, Illinois
- V3 (Virginia Values Veterans) Conference; Richmond, VA
- Virginia Health Care Foundation's Mental Health Roundtable

Other Staff Activities:

- Participated in determination of awardees for the following
  - Virginia Association of Free and Charitable Clinics' (VAFCC's) grant to help clinics become hybrids (i.e., allow Medicaid billing), conduct outreach, and educate/enroll eligible patients into Medicaid
  - Medicaid GME Residency Slot Grant as part of VHWDA's GME Grant Review Committee
- Attended health-related meetings, such as those listed below
  - Department of Medical Assistance Services' (DMAS) Medallion 4.0 Capitation Rate Setting
  - Health Insurance Reform Commission
  - Joint Subcommittee to Study Mental Health Services in the Twenty-First Century

- Governor's Advisory Commission on Opioids and Addiction
- Joint Subcommittee on Health and Human Resources
- The Hemophilia Foundation’s Presentation on Accumulator Adjusters
- Virginia Health Information, Inc. (VHI) Board of Directors

- Provided health care information to constituents and legislatures who contacted the Commission
- Active Shooter Response Training

EXECUTIVE SUMMARIES

During 2019, Commission staff conducted studies in response to mandates or 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.

Language Development Milestones and Parent Resources for Young Deaf/Hard of Hearing Children

Study Mandate

Senate Bill 1741 (Senator Edwards, 2018) would have required the selection of language development milestones for Deaf or hard of hearing (D/HH) children 0-5 years old, creation of parent and educator resources, and implementation of annual language milestone assessments with results reporting for D/HH children 0-5 years of age. During the 2019 Virginia General Assembly session, the bill was Passed By Indefinitely in the Senate Education and Health Committee, with a letter sent to Joint Commission on Health Care by the Senate Rules Committee requesting a report.

Background

Childhood hearing loss is a low incidence condition that historically has adversely affected language acquisition and development. Approximately 100-200 children born each year in Virginia are diagnosed with hearing loss, with an estimated 95 percent born to hearing parents. Any degree of hearing loss raises risks of delays in language acquisition and literacy, and historically, most D/HH children arrive at kindergarten language-delayed. There is a consensus that acquisition of any language is foundational to literacy in any language and broader social-cognitive development, and that it must begin early in life for full potential to be realized. Main communication options for D/HH children include sign language (e.g., American Sign Language [ASL]), spoken (oral-aural) language with or without visual supplements, and written language. No consensus exists on which communication approaches are optimal for language development/literacy.

In Virginia, six state agencies support D/HH children through screening and diagnosis, developmental and education services, and family support. The following are the three primary services and supports.

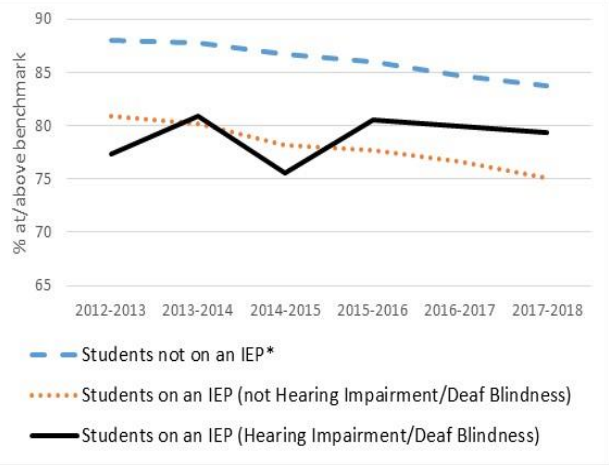
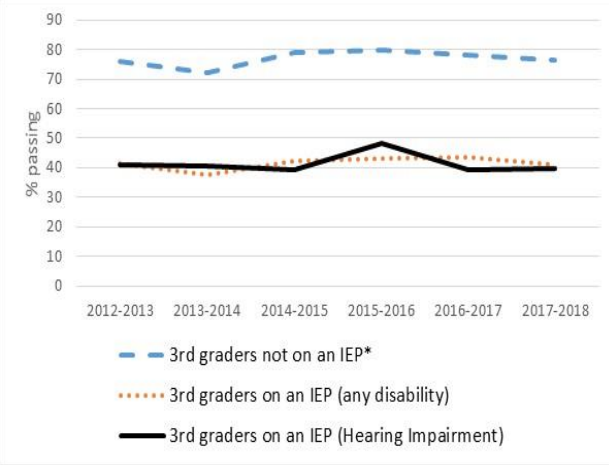
- The **Early Hearing Detection and Intervention (EHDI) Program** – overseen by the Virginia Department of Health (VDH) – which provides information/referral to families on newborn hearing screening, follow-up testing, and early intervention services. Ninety-eight to 99% of

live births annually in Virginia are screened for hearing loss, although a definitive diagnosis remains unknown for a significant percentage of children who fail their hearing screening.

- The "**Infant & Toddler Connection of Virginia**" – overseen by the Department of Behavioral Health and Developmental Services (DBHDS) – provides **Early Intervention (EI) services** to children up to three years old who are not developing as expected or have a medical condition that can delay normal development. EI services are funded by the Individuals with Disabilities Education Act (IDEA) "Part C" federal grant program for children with disabilities and families. EI services and supports are determined through an **Individual Family Service Plan (IFSP)**, which outlines developmental goals/services to be accessed by the child. In Virginia, children with hearing loss are automatically eligible for Part C services. Annually, up to 200 children zero to three years old have hearing loss as an eligibility reason.
- **Early Childhood Special Education (ECSE)** services – overseen by the Virginia Department of Education (VDOE) – are specially designed instructions to meet unique needs of children with disabilities. ECSE services and supports are funded by the Individuals with Disabilities Education Act (IDEA) "Part B" federal grant program. ECSE services and supports are determined through an **Individualized Education Program (IEP)** which outlines educational goals/services to be accessed by the child. In contrast to EI services, children with hearing loss are not automatically eligible for Special Education services. Instead, eligibility is based on the presence of a disability necessitating special education and related services.[1] Annually, up to 300 children two to five years old have deaf or hard of hearing as an eligibility disability category. However, the percentage of D/HH children transitioning from EI to ECSE services is unknown due to DBHDS EI data system limitations.

Language development among D/HH children 0-5 years old in Virginia is not directly measured. However, beginning in preschool, achievement in *literacy* is measured by VDOE through Phonological Awareness Literacy Screening (PALS) and SOL tests. Although PALS does not include all D/HH children (e.g., those who cannot and/or do not make use of hearing technologies), around two-thirds of D/HH children on IEPs take the PALS beginning in kindergarten. Trends in PALS/SOL results are presented below.

[1] To determine IEP eligibility, 34 C.F.R. § 300.304 requires education agencies to: use a variety of assessment tools and strategies to gather information and not use any single measure or assessment as sole criterion for determining eligibility; use technically sound instruments; and administer assessments: 1) in child's native language/mode of communication unless it is not feasible; 2) by trained personnel; 3) in accordance with producer's instructions; and use assessments for purposes for which measures are valid/reliable. 34 C.F.R. §300.324(a)(2)(iv) requires education agencies to consider "special factors" that include: the child's language/communication needs; opportunities for direct communication with peers/professional personnel in child's language and communication mode; academic level; and the full range of needs including opportunities for direct instruction in child's language and communication mode.

Phonological Awareness Literacy Screening (PALS) Kindergarten Results	3rd Grade Standards of Learning (SOL) English Reading Test Results
	

* May include children ever diagnosed with hearing loss but not in need of IEP-based accommodations

Report recommendations on Senate Bill 1741

A stakeholder workgroup was convened to discuss issues raised in Senate Bill 1741. Although there were some points of consensus (e.g., early language acquisition is critical for full language and cognitive development, including literacy; parents of D/HH children should be able to choose preferred language(s) and mode(s) of communication), points of disagreement persisted relating to most aspects of the bill. Based on workgroup input and research conducted for the study, the following summarizes JCHC staff recommendations related to Senate Bill 1741 (please note that these recommendations do not reflect workgroup consensus).

Recommendation	Rationale
• Key terms should be defined, including language, communication modality, forms of English, Deaf	• Several terms used in SB 1741 are subject to varying interpretations and some terms have "industry" meanings
• Change agency assigned to lead the implementation of SB 1741 from DBHDS to the Virginia School for the Deaf and the Blind (VSDB)	• Whereas expertise of DBHDS staff is not specific to deafness and programming is limited to children 0-3 years old, VSDB staff expertise is directly relevant to D/HH children and its mission is to provide education to D/HH persons 0-21 years old • Note: VSDB's estimated fiscal impact is ~$155K for Years 1 and 2, ~$23-$35K ongoing (DBHDS' estimated fiscal impact for SB 1741 was ~$200K for Years 1 and 2, ~$33K ongoing)

Recommendation	Rationale
• Change requirements for constitution of Advisory Committee by stipulating that VSDB will: 1) determine *size* of Advisory Committee and 2) ensure *balanced membership*	• Legislating exact committee size/composition risks omitting relevant perspectives • Similar legislation in other states has evolved to provide greater state agency authority over determining committee specifics
• Stipulate that the Parent Resource should be based on pre-existing resource guides	• VDH and VDOE currently support production by VCU of two parent-oriented resource guides which provide much of the information stipulated in SB 1741
• Change basis of milestones away from "standardized norms" to currently available assessments that are appropriate for evaluating progress toward age-appropriate language	• Requiring milestone selection based solely on standardized and/or norm-referenced instruments may unduly limit choice of appropriate milestones given that multiple non-standardized and/or non-norm-referenced instruments exist that may be appropriate for selecting milestones
• Require that milestone data include additional characteristics of assessed children	• Collecting data on characteristics of children assessed (e.g., by geographic region or communication approaches) could more directly inform agency programming • Note: VDOE's estimated fiscal impact for data collection is ~$95K for Year 1, ~$45K ongoing; DBHDS' estimated fiscal impact is unknown due to current procurement process for new EI data collection system

Alternative approaches to Senate Bill 1741

The study explored alternative approaches to addressing issues raised in SB 1741. The following summarizes JCHC staff recommendations for action the Commission members may wish to consider in place of or in addition to Senator Edward's bill.

Using existing literacy data to track language development outcomes:

Current initiatives to integrate agency data may provide an opportunity to longitudinally track literacy outcomes of *all* children ever diagnosed with hearing loss before the age of three and who are part of the Virginia public schooling system. English literacy may be considered an outcome/proxy indicator for language acquisition since literacy cannot develop in the absence of language development. Additionally, written English is the sole form of communication shared by the great majority of D/HH children and is tracked by VDOE through PALS and SOL assessments. The Virginia Longitudinal Data System (VLDS) currently links data from 6

participating agencies – including VDOE – and VDH is currently in the process of onboarding Early Hearing Detection and Intervention (EHDI) Program data on children 0-3 years old diagnosed with hearing loss. When VDH EHDI data are onboarded to the Virginia Longitudinal Data System, literacy outcomes tracked by VDOE at the kindergarten and early grade school levels (via PALS) and later grade school levels (using SOL testing) can be linked to all children ever diagnosed with hearing loss – including those who, through Cochlear Implants and/or hearing aids, participate in school without the use of an Individualized Education Program (IEP) – to measure progress in literacy.

Recommendation:

Use the Virginia Longitudinal Data System (VLDS) as a basis for reporting on literacy outcomes of children diagnosed with hearing loss beginning at the kindergarten level, by linking literacy-related data from VDOE and hearing loss-related data from VDH's Early Hearing Detection and Intervention (EHDI) program.

Building on existing informational resources:

The anticipated revision of existing "Green" Parent Resource Guide – provided to families of children 0-3 years of age diagnosed with hearing loss by VDH's EHDI program – can serve as a basis on which to integrate information on milestones. The revision process could include stakeholder input on language milestone selection and/or the provision of information on milestones developed in other states.

In addition to printed Resource Guides, information provided by state agencies relevant to D/HH children could be better aligned. Multiple workgroup participants highlighted difficulty in knowing where to turn for information when a hearing loss diagnosis first is received. Additionally, how each agency fits into the system of services and supports is complicated and not always entirely evident to the public. Improved public understanding of roles of state agencies involved with D/HH children and families could be beneficial.

Recommendation:

Request that relevant state agencies a) incorporate language milestones into existing parent resource guides, and b) ensure that provision of information to families of D/HH children is consistently messaged, easily accessible and user-friendly.

Building on Existing Agency Initiatives Addressing Provider-Side Barriers to Accessing Services:

Geographic barriers to accessing Early Intervention (EI) services could be addressed through Medicaid reimbursement for telehealth-delivered services. DBHDS maintains a list of Teachers of the Deaf and Hard of Hearing (ToDHH) qualified to deliver EI services. According to DBHDS, although the total number of ToDHH statewide is adequate to serve the EI needs of the state's D/HH children, their geographic placement constitutes a barrier to accessing services outside of metropolitan areas. Although DBHDS is currently seeking DMAS approval to cover EI services delivered by telepractice, a recent DMAS memo that clarifies existing telehealth policy does not provide a process to include new/changed coverage (e.g., EI services).

Recommendation:

Strengthen existing agency initiatives to identify opportunities for Medicaid reimbursement of telehealth-delivered Early Intervention (EI) services.

Exploring Opportunities for Early Exposure of Families to Deaf Role Models:

Because childhood hearing loss is a low incidence condition, hearing parents often have had little previous contact with D/HH persons. The potential positive impact of involvement of D/HH persons in systems of services and supports is widely recognized, and several states support programs in which D/HH adults provide information and/or Early Intervention (EI) services to families. In particular, the "Deaf Mentor" program model emphasizes instruction in ASL and exposure to Deaf culture. Virginia currently does not support mentoring programs involving D/HH adults.

Recommendation:

Identify opportunities to connect families of D/HH children with D/HH adults through mentoring programs to increase uptake of Early Intervention (EI) services and assistance to families in sign- and non-sign-based communication.

Policy Options Approved by the Commission

The commission voted to take no action.

JCHC Staff:
Andrew Mitchell, ScD
Senior Health Policy Analyst

Increased Prescription Delivery Options at Same Cost for Health Plan Members

Study Mandate

House Bill 2223 (Delegate O'Quinn) would have required every carrier to permit a plan-covered person the option of filling a mail order-covered prescription at an in-network retail community pharmacy if the pharmacy agrees to accept a price that is comparable to that of the mail order pharmacy (calculated to reflect all drug manufacturer's rebates, direct and indirect administrative fees, costs and any remuneration). In addition, the Pharmacy Benefits Manager (PBM) or carrier cannot impose a differential copayment, additional fee, or other condition on the person; and the PBM must utilize the same benchmark index (including the same average wholesale price, maximum allowable cost, and national prescription drug codes) to reimburse all pharmacies participating in the health benefit plan regardless of whether a pharmacy is a mail order pharmacy or a retail community pharmacy. The bill was Passed By Indefinitely in the Senate Committee on Education and Health and sent to the JCHC for consideration.

Background

House Bill 2223 is a type of "Any Willing Provider" (AWP) law focused on channel of distribution (i.e., mail order vs. retail). Virginia Code contains two sections relevant to the bill. First, Virginia's "Freedom of Choice" Act (§§ 38.2-3407.7, 38.2-4209.1, 38.2-4312.1) allows patients to select any non-network pharmacy to receive pharmacy benefits – with the same patient-side conditions as when receiving benefits from network pharmacies – as long as the non-network pharmacy signs a contract that insurer requires of all network pharmacies (the insurer must reimburse the non-network pharmacy at the network rate). However, insurers are permitted to select a single mail order provider as their exclusive provider of mail order pharmacy services. Second, retail pharmacies are allowed to dispense by mail order on limited basis/as an "ancillary service" (§ 38.2-3407.15:4). Determination of what constitutes an ancillary service vs. something more than ancillary is made via contract between the PBM/carrier and pharmacies.

In the context of Pharmaceutical Benefit Manager (PBM) services, HB 2223 is focused on addressing potential conflicts of interest. Direct pharmacy dispensing – by mail order and/or specialty services – is a common part of services provided by PBMs. PBM-affiliated mail order dispensing may create a conflict of interest, such as by incentivizing the use of mail order pharmacies regardless of benefit to plan sponsor or patient. While a 2005 study by the Federal Trade Commission (FTC) found that mail order pharmacy ownership by PBMs "generally did not disadvantage plan sponsors," the applicability of those findings in current markets is not known. In 2014, the FTC commented on the "need for continued analysis of potential

misalignment of incentives or conflicts of interest" in pharmacy plan design as part of a letter to the Center for Medicare & Medicaid Services (CMS).

Key Considerations on House Bill 2223

Potential cost and quality impacts

The impact of House Bill 2223 on future prescription costs is likely to depend on changes in mail order market concentration and inherent cost differentials between mail order/retail pharmacy-filled prescriptions. In a highly concentrated market – such as when there is an exclusive provider of mail order services – economies of scale may help contain costs, such as by giving PBMs leverage to negotiate larger rebates from manufacturers and price concessions from pharmacies due to a high and/or predictable volume of prescriptions. Opening up the mail order market to any willing pharmacies could fracture the market and drive up prices, through either reduced manufacturer rebates or higher fees paid to pharmacies. However, there are reasons that the impact of opening up the mail order channel on market concentration/prices may be limited. First, there may be very little, if any, demand for additional options to receive mail order-covered services. Members of many health plans can already fill mail-order covered prescriptions for the same patient contribution at brick-and-mortar pharmacies through "Retail 90" networks, and, since 2018, the Bureau of Insurance has received no complaints of any kind from consumers related to pharmacy benefits. Second, other states' experiences with AWP laws focused on mail order channel suggest that there are limited changes in market concentration when retail pharmacies are required to meet mail order terms and conditions. Likely many retail pharmacy owners determined that the costs associated with meeting the mail order requirements negated the benefits.

House Bill 2223 could also impact quality of pharmaceutical benefits. Contracts between PBMs and pharmacies lay out both reimbursement price schedules and "terms and conditions" required for reimbursement. The terms and conditions are generally different between retail and mail order pharmacies and omission of a requirement for retail pharmacies to adhere to mail order "terms and conditions" could adversely impact quality of some mail order covered services. For example, specialty drugs, e.g. chemo-therapy pills, are required to be dispensed by mail order to ensure a) patient has 24/7 telephone access to pharmacists; b) adherence to storage, shipping and handling standards; and c) tracking of patient outcomes (Khandelwal et al., 2011). In House Bill 2223, there is no requirement for retail pharmacies to meet mail order terms and conditions.

Recommendation:

If legislation similar in intent to House Bill 2223 is considered, include provision requiring retail pharmacies to adhere to the same terms and conditions as pharmacies providing mail order services.

Compliance

Ensuring compliance of the bill's provisions would require substantial changes in how the Bureau of Insurance (BOI) currently conducts oversight, and – without additional legislation – that oversight could be substantially limited. In particular, implementation of PBM/pharmacy-focused provisions by the BOI would require changes to its existing business practices because the BOI does not currently conduct contract and/or claims comparisons focused on PBM reimbursement prices and basis of costs. Additionally, PBMs are not currently required by law to provide information directly to the BOI because the BOI regulates carriers (not PBMs). Without additional legislation requiring that all relevant PBM records be provided to the Bureau, the BOI would be limited in its ability to ensure enforcement. Other states (e.g., Maine) addressing similar issues have passed legislation that could serve as a model for creating a stronger regulatory framework around PBMs. That approach requires that carriers have the ability to access – and make available to BOI – all data related to prescription benefits provision that would be needed to ensure that the BOI could obtain relevant data for enforcement (e.g., PBM drug transaction/pricing data). Such an approach would provide the BOI the necessary authority to ensure compliance with the provisions of HB 2223. To address potential legal challenges, legislation to this effect should also ensure confidentiality of data provided by the PBM to the BOI to address anti-trust concerns or other legal challenges.

Recommendation:

If legislation similar in intent to House Bill 2223 is considered, include provisions to license PBMs and require carriers to have the ability to access/make available to BOI all data related to the provision of prescription drug benefits.

Additional Considerations

Vagueness in terminology and ambiguity in how certain sections of the bill relate to each other should be addressed. First, a key component of the bill is to require retail pharmacies to be reimbursed at a "comparable" price to mail order, with that price calculated on the same basis between retail and mail order. Determining whether a retail reimbursement price is "comparable to" mail order price could be difficult. Second, the bill includes drug manufacturer rebates as a required component in determining that basis of the reimbursement price (along with direct and indirect administrative fees, costs and any remuneration). Although manufacturer rebates may indirectly affect reimbursement prices for mail order pharmacies – if those pharmacies are vertically integrated with PBMs – rebates are generally not passed on by the PBM or plan sponsor to pharmacies and therefore are not a direct input into prices. Finally, the bill contains a section requiring the same benchmark index to be used to reimburse all pharmacies. As it is written, that section is not tied to the bill's provisions on determining whether the price is comparable and could be interpreted as requiring all pharmacies across all networks to be reimbursed in a uniform way.

Additionally, as noted in the bill's Fiscal Impact Statement, HB 2223 is in conflict with the mail order exclusivity provision of Pharmacy Freedom of Choice Act, and there are certain prescriptions prohibited by federal law from dispensing from retail pharmacies (45 CFR 156.122). The bill would need to be amended to address those issues.

Recommendation:

If legislation similar in intent to House Bill 2223 is considered, (1) require that retail pharmacies be reimbursed a price "identical to" that of mail order, calculated to reflect all *direct* price inputs and based on the same benchmark index; 2) eliminate mail order exclusivity provision from the Pharmacy Freedom of Choice Act; and 3) exempt from provisions all prescriptions federally prohibited from retail channel dispensing.

Other Approaches to Addressing Possible PBM Conflicts of Interest

While House Bill 2223 focuses narrowly on addressing potential PBM conflicts of interest related to mail order vs retail channels, other states are increasingly addressing potential PBM conflicts of interest. These include:

- anti-steering provisions, which prohibit PBMs from incentivizing in various ways the use of PBM-affiliated or –owned pharmacies;
- prohibiting reimbursement of non-PBM-owned/-affiliated pharmacies less than PBM-owned/-affiliated pharmacies for same service; and
- including ownership-related factors in PBM reporting requirements (e.g., annual audits must report on differential payments to pharmacies based on ownership differences).

Recommendation:

JCHC members may wish to consider other or additional approaches focused on possible PBM ownership-related conflicts of interest, including legislation related to incentivizing patient choice, reimbursement differentials to pharmacies, and transparency reporting provisions.

Policy Options Approved by the Commission

The commission voted to take no action.

JCHC Staff:
Andrew Mitchell, ScD
Senior Health Policy Analyst

Naloxone Public Access and Storage

Study Mandate

House Joint Resolution 653 (Delegate Gooditis) requested the Virginia Department of Health (VDH) study barriers and corresponding solutions to co-locating naloxone in Automatic External Defibrillators (AEDs) and then propose and implement an education program. The resolution was tabled in House Rules Committee with an understanding that the Joint Commission on Health Care would consider a study in its 2019 workplan. A subsequent letter from Delegate Gooditis requested that the JCHC study focus on: (a) whether removing barriers to administering naloxone is likely to save lives without causing significant damage to public health, and (b) whether, and if so how, naloxone can be positioned in publicly accessible places, such as alongside AEDs.

Background

Naloxone hydrochloride is a short-acting opioid antagonist that has a high rate of success in reversing effects of opioid overdoses. Although naloxone is a Schedule VI Controlled Substance in Virginia, it is not scheduled federally by the Drug Enforcement Agency, is not psychoactive, has no effect in the absence of opioids, and has no abuse potential. Two FDA-approved formulations for community use include Narcan nasal spray and EVZIO auto-injector.

Recent legislation and agency initiatives in Virginia have focused on increasing public accessibility to naloxone. In the context of over 1,200 opioid overdose fatalities occurring annually in Virginia, legislation from the 2019 session eliminated a requirement that substance abuse-focused organizations obtain a Controlled Substance Registration for naloxone dispensing, as well as expanded the list of professionals authorized to possess, administer and dispense naloxone under a statewide Standing Order. (Currently, any individual may obtain naloxone from a pharmacist or one of 10 categories of professionals identified in § 54.1-3408(X).) Board of Pharmacy protocols require authorized dispensers to provide some form of naloxone instruction and/or the Department of Behavioral Health and Developmental Services' (DBHDS') naloxone training REVIVE! brochure to lay individuals at the time of dispensing. In terms of agency initiatives, over 23,000 naloxone kits have been procured by VDH for community-based distribution and, to date, around 35,000 individuals have received DBHDS REVIVE! training in opioid overdoses. Additionally, a recent VDOE Superintendent's Memo requires local school divisions to develop naloxone policies.

Naloxone Training and Education

While the act of administering naloxone is straightforward – studies have found high rates of successful administration of naloxone by untrained lay rescuers – and there are no special requirements for the storage or handling of naloxone, layperson training still may be necessary. Training and education on opioid overdose *recognition and response* – which usually accompanies training in naloxone administration – can be important to both improving patient outcomes (e.g., taking steps to avoid vomit-induced aspiration; calling 911 to ensure medical assistance) and ensuring lay rescuer's safety (e.g., being prepared for patient agitation from opioid withdrawal). In Virginia, DBHDS' REVIVE! training is the primary channel that the public can access naloxone/opioid overdose training. While its current lay rescuer module takes 1 – 1.5 hours to complete, the Department has recently developed an abbreviated (7-10 minute) "Rapid REVIVE" in-person training model that targets high-volume events, high-risk groups, and treatment centers. The DBHDS is also exploring a 10-15 minute online version for lay rescuers.

Lesser known channels of information on opioids include 911 call centers and regional Poison Control Centers (PCCs). In acute situations, 911 call centers with Emergency Medical Dispatch (EMD) services are potential sources of guidance/information on opioid overdose and/or naloxone administration. While some 911 call centers are currently integrating opioid overdose and/or naloxone administration protocols into Emergency Medical Dispatch (EMD) services, others are not yet doing so, and around one-third of 911 call centers don't offer EMD services. In acute or non-acute situations, PCCs – a confidential call-in resource staffed 24/7 by medical professionals – have expertise in opioid overdose response. However, PCCs are not widely known to the public as sources of information. Opportunities may exist to both build EMD capacities and leverage existing PCC capacities.

Recommendations:

If JCHC members consider legislation authorizing the placement of naloxone in public places[2], retaining the training requirement may alleviate concerns of the naloxone administrator and the public entity in which it occurs.

Commission members also may wish to request that stakeholders investigate opportunities to strengthen emergency communications capacities in opioid overdose/naloxone administration and leverage existing capacities of regional Poison Control Centers in non-acute and/or acute situations.

[2] For purposes of this study and resulting legislation, "public place" is defined as any enclosed location that is used or held out for use by the public, whether owned or operated by public or private interests, and regularly staffed.

Naloxone Accessibility in Public Places

Beginning in 2017, a limited number of other states and localities have experience with positioning naloxone in public places to provide opportunities to lay rescuers to respond to opioid overdose emergencies. These include the Rhode Island "NaloxBox" program – in which organizations establish Memoranda Of Understanding with the state's Disaster Medical Assistance Team/Medical Reserve Corps – and positioning of naloxone in municipal or other buildings in three other states. As of November 14, 2019, no instances of naloxone administration have been reported through these new programs. At this time it is difficult to determine whether the lack of use is due to the newness of these programs or other factors.

Co-locating Naloxone with AED Units

Co-locating naloxone with AED units may not be the most effective approach to expanding public accessibility of naloxone, especially given that there is no comprehensive database of AED locations in Virginia. Pros of co-located naloxone/AED units include public familiarity with AED units, the possibility of sudden cardiac arrest due to an opioid overdose, and existence of AED-related software/apps linking AEDs to first responders. Conversely, a program to co-locate naloxone with AED units may not be cost-effective, there may be a higher potential for theft of naloxone kits compared to AEDs, and there may be liability concerns with positioning naloxone – a Schedule VI Controlled Substance in Virginia – in a publicly accessible place without staff supervision.

Positioning Naloxone in Public Places

While 60 percent of opioid overdose fatalities take place inside the home (based on data collected between 2016 and 2018) and urban areas with the highest concentration of public places are also likely to have other sources of rapid access to naloxone (e.g., 911-dispatched first responders), positioning naloxone in public places could increase opportunities for lay rescuers to respond to opioid overdose emergencies occuring outside of a private residence. This may be an effective strategy when bystanders are hesitant to call emergency services (e.g., when illicit drugs are present), in rural areas in which first responders would arrive too late, or when opioid overdoses are consistently clustered in certain areas (e.g., hotels).

In Virginia, data collected for this study indicate that approximately 50 percent of opioid overdose fatalities that occurred outside of the home between 2016-2018 in three metropolitan areas took place within one-tenth of a mile from a public place. Percentages of fatalities occurring most frequently in proximity to different types of public places is indicated in the table below.

% overdose fatalities outside of home occurring within 1/10th mile of:

Location Type**	Richmond (n=260)	Hampton Roads (n=278)	Roanoke (n=55)
Eating establishment	15%	16%	16%
Gas station/convenience store	15%	13%	9%
Hotel	10%	20%	16%
Religious establishment	14%	13%	15%
Municipal/government building	9%	1%	0%
Pharmacy	7%	5%	5%

Availability of Naloxone in Community Pharmacies

Although VDH's Standing Order is intended to facilitate access by the public to naloxone – including through retail pharmacies – media reports and previous research indicate variability in the public's ability to obtain naloxone through the pharmacy channel. In a survey of a statewide representative sample of ~300 community pharmacies, 77 percent of pharmacies accurately indicated that a patient-specific prescription was not required to purchase naloxone. However, only 50 percent of *independent* pharmacies provided accurate information on obtaining naloxone without a patient-specific prescription (compared to 87 percent of chain pharmacies). Overall, ~65 percent of pharmacies had naloxone in stock at the time of contact for the survey.

Recommendations:

If JCHC members consider legislation on positioning naloxone in public locations, focusing on co-location with AED units may not be the most effective strategy.

Instead, members could consider legislation adding persons acting on behalf of public places who have completed a training program to the list of individuals *explicitly* authorized to *possess and administer* intranasal/intramuscular formulations of naloxone.

Lastly, the Commission may wish to request that the Board of Pharmacy re-emphasize in communications with licensed pharmacists that Virginia law permits dispensing of naloxone without a patient-specific prescription.

Supply-/Demand-Side Considerations

A variety of no-pay and discounted options exist to purchase naloxone. While typical cash prices for naloxone range from ~$120/kit (Narcan) to >$4,000/kit (EVZIO), the public can obtain VDH-procured naloxone at no-cost and/or through most health insurers for a co-pay. Narcan/EVZIO manufacturers currently have community/public pricing programs for qualifying organizations (e.g., Narcan: $75 for non-profit organizations; 2 kits at no cost for schools, YMCAs and libraries; EVZIO: $178/kit for government agencies, first responders, and "other qualifying groups"). However, survey data collected for this study suggest hesitancy by locality-

managed public places to stock naloxone. In a survey of 58 locality/county administrators[3], only 30 percent indicated that their local government would be somewhat or very likely to consider stocking naloxone if authorized by Virginia Code. Major concerns expressed related to liability, employee training, costs and naloxone security/theft.

Additionally, current Virginia law related to naloxone possession and administration may be a deterrent to willingness to use naloxone in certain circumstances. Although Virginia Code provides Good Samaritan (civil) liability protections for naloxone administration by individuals who are dispensed naloxone under authorized channels, individuals may come to possess and administer naloxone in other ways. Possession through unauthorized channels is a Class 4 misdemeanor – up to $250 fine – and administration would not be covered by Good Samaritan liability protections. The limited applicability of liability protections could deter willingness of naloxone administration by individuals (e.g., in opioid overdose events involving illicit substances) and public places/organizations (e.g., to develop on-premise naloxone policies due to liability concerns stemming from individual-level liabilities). Broadening civil/criminal liability protection could diminish those deterrents.

Recommendation:

JCHC members may wish to consider legislation broadening criminal and civil liability protections for possession and administration of naloxone (e.g., regardless of the channel through which naloxone was obtained).[4]

> Illustrative language: A person who is (1) not otherwise authorized to administer naloxone or other opioid antagonist used for overdose reversal and (2) acting in good faith, and in the absence of gross negligence or willful and wanton misconduct, may administer an opioid antagonist to another person who appears to be experiencing an opioid related drug overdose. The person administering naloxone or other opioid antagonist used for overdose reversal shall not be considered to be engaged in the unauthorized practice of medicine or the unlawful possession of an opioid antagonist. A person who administers an opioid antagonist pursuant to this article is personally immune from civil or criminal liability for any act or omission resulting in damage or injury.[5]

[3] Response rate for all counties/localities was around 30 percent

[4] In the public comments from the Virginia Association of Counties (VACo), Executive Director Dean Lynch stated that: "Clear liability protections for an individual who administers naloxone, including local government staff, as well as for the entity making the naloxone available, would be essential prerequisites for localities to consider stocking naloxone in public facilities."

[5] This language was developed with input from representatives of the Virginia Association of Commonwealth's Attorneys, Virginia Criminal Justice Conference, and Virginia Trial Lawyers Association

Policy Options Approved by the Commission

- Introduce legislation authorizing persons acting on behalf of public places who have completed a training program to *possess and administer* intranasal / intramuscular formulations in case of suspected overdose
- Introduce legislation broadening criminal and civil liability protections for naloxone *administration*
- By letter of the JCHC Chair, request that the Board of Pharmacy include information about Virginia laws making naloxone available without a patient-specific prescription in the next pharmacy profession license renewal communication.
- By letter of the JCHC Chair, request that the HHR Secretary convene a task force to study current roles of Public Safety Answering Points (911 call centers) and regional Poison Control Centers in providing information/assistance to the public on opioid overdoses and naloxone in both acute and non-acute situations. A written report – submitted to the JCHC by October 31, 2020 – should provide recommendations on any necessary enabling legislation or funding that may be required to enhance their respective roles

Legislation Enacted

HB 908 (Hayes), SB 836 (Suetterlein) , and SB 566 (Edwards). Acts of Assembly - Chapters 92, 302 and 1095, respectively.

The purpose of these bills is to provide greater access to naloxone, or other opioid antagonists, to reduce the number of deaths due to opioid overdose. House Bill 908 is the most extensive, allowing trained employees of a public place to *possess and administer* (except in needle or syringe form) and any by stander to *administer* the drug with liability protection for civil damages, unless the personal injury was the result of gross negligence or willful and wanton misconduct.

House Bill 908.

§ 54.1-3408. Professional use by practitioners.
X. …*Notwithstanding any other law or regulation to the contrary, an employee or other person acting on behalf of a public place may possess and administer naloxone or other opioid antagonist, other than naloxone in an injectable formulation with a hypodermic needle or syringe, to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose if he has completed a training program on the administration of such naloxone and administers naloxone in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.*
For the purposes of this subsection, "public place" means any enclosed area that is used or held out for use by the public, whether owned or operated by a public or private interest.

Z. A person who is not otherwise authorized to administer naloxone or other opioid antagonist used for overdose reversal may administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose.

§ 8.01-225. Persons rendering emergency care, obstetrical services exempt from liability.
A. Any person who:
21. In good faith administers naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose in accordance with the provisions of subsection Z of § 54.1-3408 shall not be liable for any civil damages for any personal injury that results from any act or omission in the administration of naloxone or other opioid antagonist used for overdose reversal, unless such act or omission was the result of gross negligence or willful and wanton misconduct.

Senate Bill 836 allows trained employees of a public place to *possess and administer* (except in needle or syringe form).

Senate Bill 566 allows any person to *administer* the drug with liability protection for civil damages, unless the personal injury was the result of gross negligence or willful and wanton misconduct.

JCHC Staff:
Andrew Mitchell, ScD
Senior Health Policy Analyst

Dispensing of Drugs and Devices Pursuant to Pharmacy Collaborative Practice Agreements, Standing Orders, and Statewide Protocols

Background

House Joint Resolution 662 (Delegate Stolle) directs the Joint Commission on Health Care (JCHC) to study the current laws and regulations, and roles and responsibilities of pharmacists and other providers, pertaining to prescribing, dispensing and administering drugs and medical devices. The study focus should include pharmacy collaborative practice agreements, standing orders, and statewide protocols; as well as the legal liability of pharmacists and other health care providers who prescribe, dispense, and/or administer medications and devices. Commission staff should identify changes in Virginia Code or regulations "that would enhance patient access to health care in the Commonwealth."[6]

Pharmacy Workforce and Education

Eighty-one percent of 478 respondents to the Department of Health Professions Workforce Data Center's most recent survey who indicated that they participate in a collaborative practice agreement (CPA) reported that they earned a PharmD degree while 16 percent reported having earned a Bachelor's degree. The Virginia Commonwealth University (VCU) School of Pharmacy no longer confers Bachelor's degrees; all degrees are doctoral level. This is a national trend.

The Accreditation Council for Pharmacy Education determines key elements for PharmD programs, which includes skills in patient assessment and history taking, drug allergies, identifying risk for prevalent diseases, establishing and follow up of a care plan, minimize risk for adverse drug events and errors, and knowing when a patient needs a referral to a physician. The VCU pharmacy program requirements include 73 credit hours of prerequisites including biology, chemistry, physiology, anatomy, microbiology, biochemistry, genetics and immunology. The pharmacy curriculum includes 155.5 credit hours over 4 years that include in-depth training on all body systems, patient assessments, and ordering and interpreting laboratory tests.

[6] House Joint Resolution 662, 2019 Virginia General Assembly Session.

Laws and Regulations

Parties to an Agreement

The *Virginia Administrative Code* Chapter 18. Sections 110–70 addresses CPAs. The code defines *practitioners* and *pharmacists* who may be parties to a CPA. Currently, the code references the definition of practitioners that includes nurse practitioners (NP) and physician assistants (PA) who practice under a practice agreement with a medical doctor, doctor of osteopathy or podiatry. It does not reference the code section that defines NPs and PAs that may practice independently without an agreement with a physician, osteopath or podiatrist. Board of Pharmacy staff indicated that this was an oversight.

Reimbursement for Pharmacist Services

VAC 38.2-3408, which went into effect October 1, 2019 states that:

> "B. If an accident and sickness insurance policy provides reimbursement for a service that may be legally performed by **a licensed pharmacist**, **reimbursement under the policy shall not be denied** because the service is rendered by the licensed pharmacist provided that (i) the service is performed for an insured for a condition under the terms of a collaborative agreement, as defined in § 54.1-3300, between a pharmacist and the physician with whom the insured is undergoing a course of treatment or (ii) the service is for the administration of vaccines for immunization. Notwithstanding the provisions of § 38.2-3407, the **insurer may require the pharmacist, any pharmacy or provider that may employ such pharmacist, or the collaborating physician to enter into a written agreement with the insurer as a condition for reimbursement** for such services. In addition, reimbursement to pharmacists acting under the terms of a collaborative agreement under this subsection shall not be subject to the provisions of § 38.2-3407.7." (Pharmacies; freedom of choice). C. **This section shall not apply to Medicaid, or any state fund**.

The Department of Medical Assistance Services (DMAS) does not include pharmacists in their definition of *practitioner* due to the fact that pharmacists are not included in the definitions of provider under the Social Security Act regarding Medicare Part B, and under the Family Medical Leave Act. Therefore, DMAS does not have a mechanism in place that would allow pharmacists to bill for services other than drug acquisition cost and dispensing fee. Despite this, DMAS does require that Medicaid Managed Care Organizations (MCOs) reimburse pharmacists for activities provided under Medication Therapy Management programs that is over and above the drug cost and dispensing fee.

CPA Protocols

CPAs must include the condition or disease state that the pharmacist will manage and a protocol for that management which is clinically accepted as the standard of care. The parties to an agreement wishing to use a protocol that is not a clinically accepted standard of care must submit the protocol to the Boards of Pharmacy and Medicine for approval. The application fee is $750. Board of Pharmacy (BoP) members indicated that the criteria for which to judge a non-standard protocol is the existence of evidence published in a peer-reviewed journal that supports the protocol. To date, the Boards have not received any applications for non-standard protocols. In addition, the BoP does not receive copies of CPAs using standard protocols. Some policy advocates recommend eliminating any requirements for Board approval for CPAs.

Liability

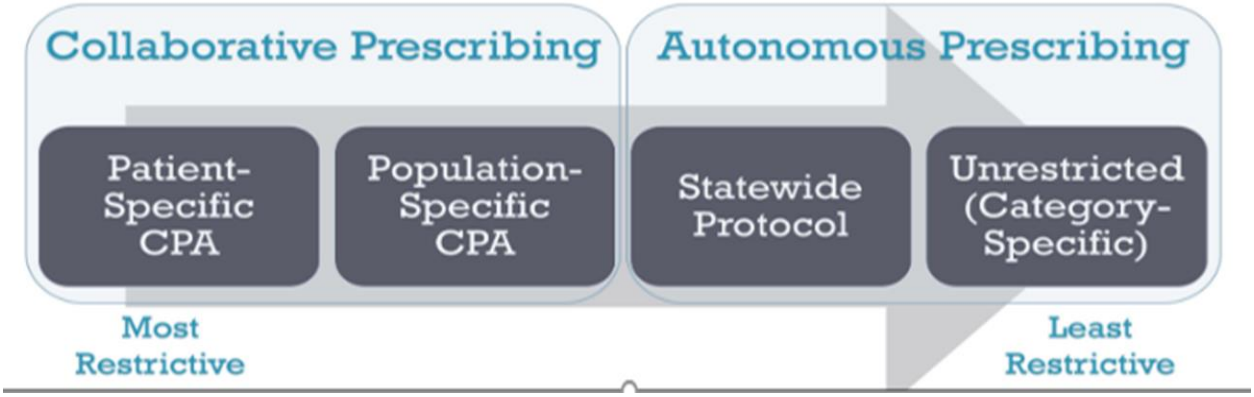
The Code of Virginia, Title 8.0. Civil Remedies and Procedures Chapter 21.1 Medical Malpractice, defines the term *health care provider* and includes pharmacists in the definition. Section 8.01.581.15 specifies a schedule of the dollar amount of required liability insurance that a health care provider must maintain. The amount increases periodically, and the schedule goes through 2031. None of the individuals consulted for this study (including key stakeholders) indicated that liability was an issue for CPAs and did not feel it was a barrier to CPA participation.

Scope of Pharmacists' Practice

Prescriptive Privileges

The continuum of scope of practice goes from the most restrictive (patient-specific CPAs) to the least restrictive (autonomous prescribing). Virginia's laws fall in the middle of the continuum. Federal programs, including the Indian Health Service and Veterans Administration allow unrestricted authority to clinical pharmacists. Two laws enacted in the last two years, one in Idaho and one in Oregon, have expanded prescriptive authority for pharmacists through statewide protocols. In Idaho, pharmacists can now prescribe and dispense drugs for a long list of conditions, such as cold sores, seasonal influenza, strep throat, uncomplicated UTIs, and diabetic conditions. In Oregon, pharmacists can now prescribe and dispense drugs that appear on a state-authorized formulary, which will continue to grow upon request and approval. Potential items on the formulary include diabetic testing supplies, smoking-cessation aids, epinephrine auto-injectors, albuterol inhalers, rapid strep tests, and spacers for inhalers.[7]

[7] https://www.pbahealth.com/is-pharmacist-prescribing-authority-on-the-rise/



Standing Orders and Statewide Protocols

The terms *protocol* and *standing order* almost are almost used interchangeably; both allow someone other than the provider to enter, modify, or stop an order on the provider's behalf. A *standing order* is an order conditioned upon the occurrence of certain clinical events. The important characteristic of a standing order is that all the patients who meet the criteria for the order receive the same treatment. For example, during an outbreak of influenza, unimmunized individuals who present to a pharmacist with flu symptoms may be tested for the flu using a CLIA Waved test, and if they test positive, they could receive an antiviral medication without having to see a physician. Having to see a physician may delay treatment beyond the window of drug efficacy and result in duplicate testing. A common use of standing orders is in public health clinics that treat specific diseases. *Medical protocols* are sets of predetermined criteria that define appropriate interventions and describe situations in which judgments are made relative to a course of action for effective management of common patient problems, such as nurses' standing orders for dispensing medications or starting intravenous fluids for hospital inpatients.

The *Code of Virginia* allows the Commissioner of Health, or his/her designee, to issue standing orders for naloxone for opioid overdose and for routine vaccines. There may be conditions that could be identified for which the Commissioner could issue a standing order, such as influenza, urinary tract infections, strep throat and others that could enhance public health, increase timely access to services and perhaps reduce unnecessary health care expenditures, such as visits to an emergency department or urgent care center.

Several states allow pharmacists to dispense certain drugs under statewide standing orders, such as prescription tobacco cessation products, hormonal birth control, anti-viral drugs for influenza, antibacterials for strep throat, and drugs for urinary tract infections.

Policy Options Approved by the Commission

- Introduce legislation to amend the definition “collaborative agreement” in § 54.1-3300 to read:

  "Collaborative agreement" means a voluntary, written, or electronic arrangement between one pharmacist and his designated alternate pharmacists involved directly in patient care at a single physical location where patients receive services and (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided that such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; (iv) ***any licensed independent physician assistant****; or* ~~*(iv)*~~ *(v)* any licensed nurse practitioner working in accordance with the provisions of § 54.1-2957 ***including a licensed independent nurse practitioner***, involved directly in patient care which authorizes cooperative procedures with respect to patients of such practitioners. Collaborative procedures shall be related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. A collaborative agreement is not required for the management of patients of an inpatient facility.

  and

  Amend § 54.1-3300.1 to read:

  (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided that such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; (iv) ***any licensed independent physician assistant;*** *or* ~~*(iv)*~~ *(v)* any licensed nurse practitioner working in accordance with the provisions of § 54.1-2957 ***including a licensed independent nurse practitioner***, involved directly in patient care which authorize cooperative procedures related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. However, no person licensed to practice medicine, osteopathy, or podiatry, ***and licensed independent physician assistants and independent nurse practitioners,*** shall be required to participate in a collaborative agreement with a pharmacist and his designated alternate pharmacists, regardless of whether a professional business entity on behalf of which the person is

authorized to act enters into a collaborative agreement with a pharmacist and his designated alternate pharmacists.

- By letter from the JCHC Chair, request that the Boards of Pharmacy and Medicine convene a workgroup of expert stakeholders to determine if statewide standing orders can be expanded to other conditions (e.g., those for which there are CLIA Waived tests).

Legislation Enacted

SB 565 (Edwards) and HB 517 (Bulova). Acts of Assembly - Chapters 232 and 46, respectively

Collaborative practice agreements; nurse practitioners (NPs) and physician assistants (PAs).

These identical bills provide *two technical amendments* to the Virginia Code § 54.1-3300.1 regarding pharmacy collaborative practice agreements (CPAs). The first amendment updates the section to reflect the 2019 change in Code that redefined how licensed PAs may work from 'practicing under a supervising physician' to 'practicing as part of a patient care team that includes at least one physician or podiatrist'. The second addresses an inconsistency in the section. While NPs and PAs are listed as practitioners that may form a CPA with a pharmacist, they were excluded from the list of practitioners who are not *required* to participate in a CPA.

JCHC Staff:
Paula Margolis, PhD
Senior Health Policy Analyst

Prescription Drug Price Gouging

Study Request

Senator John Edwards introduced Senate Bill 1308 to prohibit unconscionable price increases of essential off-patent or generic drugs in the 2019 General Assembly session. The legislation was Passed By Indefinitely by the Senate Education and Health Committee chaired by Senator Newman with a letter to the Joint Commission on Health Care requesting they study the issue. Commission members approved the study during the May work plan meeting.

Drug Spending Increases

The PIRG Education Fund reported in March of 2019 that drug unit price increases, rather than increased utilization, is driving drug spending. From 2012 - 2016, the price of drugs rose approximately 25 percent while utilization increased by approximately 2 percent.[8] A common perception is that the high price of drugs is justified by the cost of research and development, including drugs that do not make it to market, but a Thomson Reuters study found that drug companies spend far more on marketing and advertising than they do on research and development.[9]

Drugs are sold at a variety of prices, depending on where in the supply chain a transaction occurs, manufacturers' rebates, coupons, and clawbacks, and whether the rebates and other discounts are included in published prices.[10] For example, the federal government requires that manufacturers pay rebates for single-source, brand-name drugs that are provided to Medicaid recipients. Also, there are supplemental rebates (beyond the federally-required rebates) that PBMs and carriers negotiate in exchange for inclusion in a preferred drug list and favorable tier placement (which determine preauthorization requirements and patient co-payment amounts).

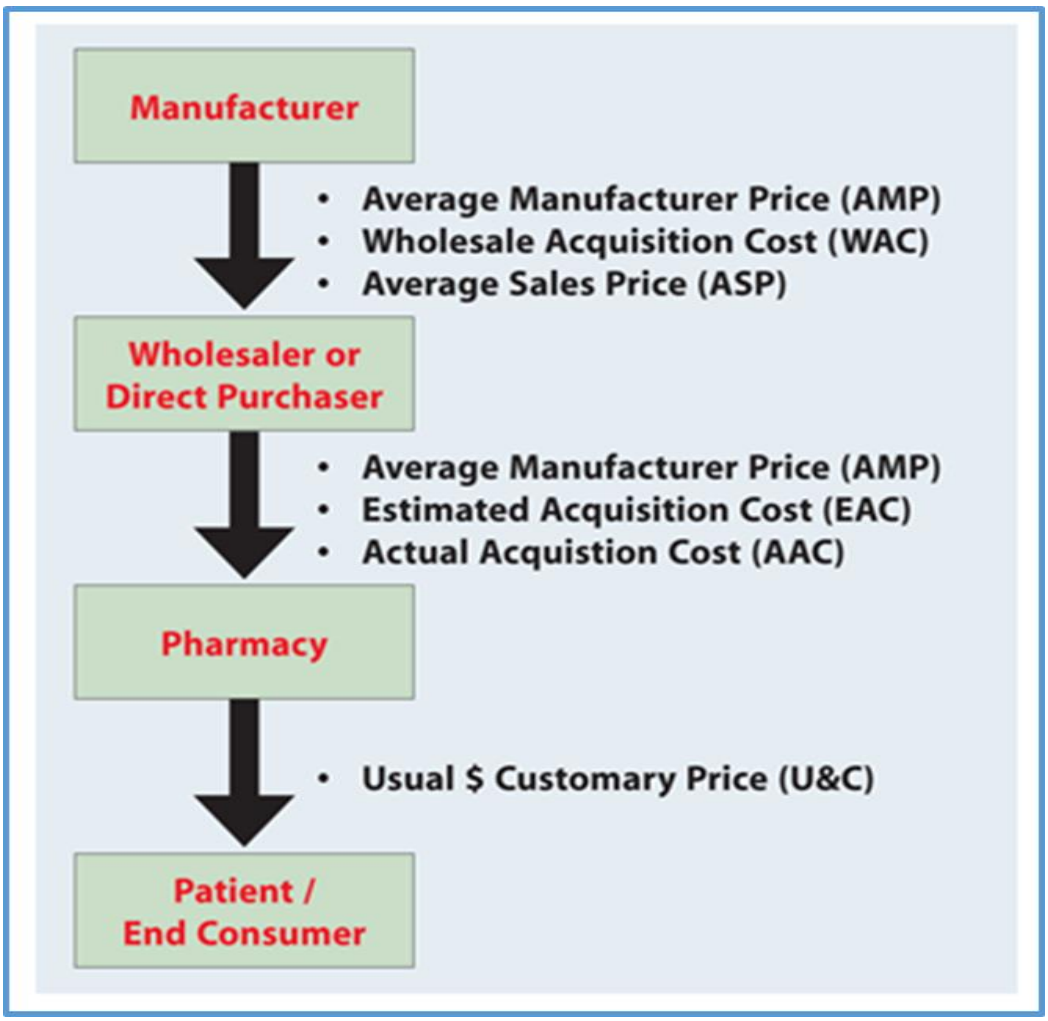
[8] The Real Price of Medications - A Survey of Variations in Prescription Drug Prices. Reuben Mathew, Lance Kilpatrick & Adam Garber. U.S. PIRG Education Fund, March 2019.
[9] https://nurses.3cdn.net/e74ab9a3e937fe5646_afm6bh0u9.pdf
[10] Excluding rebates in the published price is used to keep prices charged to non-Medicaid plans higher than if the rebates were factored into the price, as an incentive for manufacturers to provide Medicaid rebates.

Drug Pricing Terms

Term	Explanation[11]
Average Manufacturer Price (AMP)	A measurement of the price a wholesaler pays for products from the manufacturer after rebates or discounts.
Average Wholesale Price (AWP)	A measurement of the price paid by pharmacies to wholesalers. This is an estimate based on reporting to data vendors.
Wholesale Acquisition Cost (WAC)	An estimate of the manufacturer's list price to wholesalers, it does not include discounts/rebates.
Average Actual Cost (AAC)	The final cost paid by pharmacies to their wholesalers after all discounts have been deducted and is derived from actual audits of pharmacy invoices.
Average Sales Price (ASP)	Derived from the sales from manufacturers to all purchasers and includes most discounts, but is limited in that it is only available for Medicare Part B covered drugs.
Estimated Acquisition Cost (EAC)	An estimated price that state Medicaid programs use to reimburse pharmacies for the cost of the drug plus a reasonable dispensing fee.
Best Price (BP)	The lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, HMO, nonprofit entity, or government entity, excluding prices charged to certain federal programs, (Medicaid, 340B covered entities, Medicare Part D plans, and certain other purchasers)
Usual and Customary Price (U&C)	The amount charged at a retail pharmacy. It reflects the cost to the consumer without insurance.
Federal rebates	Manufacturers must provide rebates to states in order to sell brand name drugs to Medicaid patients.
Supplemental rebates	Paid in exchange for placement on a Preferred Drug List (PDL) and result in market share shifts to the preferred drug[1], even if the list price is greater than an available alternative.
Price Spread	The difference between the PBM cost and the price the PBM charges the insurer.

[11] https://masspirg.org/sites/pirg/files/reports/MAP%20Rx%20Price%20Report%20March%205.2019.pdf

Drug Pricing Along the Distribution Pipeline

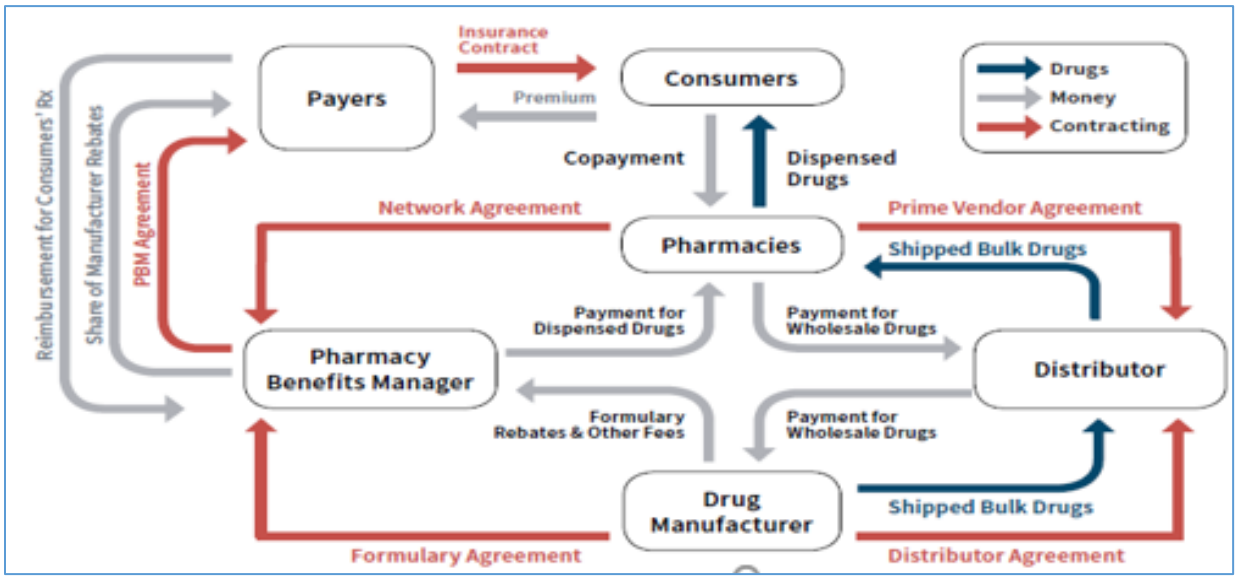


The Drug Distribution and Payment Pipelines

The drug distribution and payment pipelines are extremely complex and lack transparency. Parties in the pipeline include manufacturers, wholesalers/distributers, pharmacy benefit managers, insurers, pharmacies and consumers. Contractual terms between parties, such as the price of a drug or the amount of rebates, may not be revealed to other parties in the pipeline, which may contribute to arbitrage. Some agreements favor the use of brand-name drugs, despite the availability of less expensive generic drugs, because one or more of the parties derives higher profits from selling the more expensive brand name product[12] (e.g., PBMs derive profits in the form of manufacturer rebates).

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4357353/

Drug Distribution and Payment Pipelines



Pharmacy Benefit Managers (PBM)

Insurance companies often hire PBMs to manage their pharmacy benefit. Ninety-five percent of insured individuals have drug coverage managed by a PBM, and the three largest PBMs control 80 percent of the market. In addition, several of the largest PBMs are owned by insurance companies.

PBMs receive manufacturer rebates in exchange for placing a drug on the health insurance plan's list of covered drugs, especially if listed as a preferred drug (i.e. having no or low co-payments and/or no pre-authorization requirements). The difference between the payments made by insurance companies to PBMs and the rebates PBMs receive from the manufacturer or wholesaler/distributor is known as *the spread.* The amount of the spread is often unknown by the insurance company.

Some states require that PBMs and insurance companies use *pass-through contracts* rather than spread pricing. Pass-through contracts separate PBM fees paid by the insurer into separate components, for example drug acquisition costs, administrative costs (e.g., pre-authorization and claims adjudication), and PBM profit. Pass-through contracts are more transparent than spread priced contracts as all components of transactions, including profit, are spelled out in the contract. Also, several states are requiring that PBMs work in the best interest of patients and the insurance companies (i.e. *fiduciary duty*).

Virginia insurance industry representatives assert that spread pricing is an appropriate method of ensuring PBM's profitability; however, several states that performed analyses of their Medicaid PBMs found that PBMs using spread pricing contracts were keeping hundreds of millions of dollars a year in rebate money (see table below). Spread price contracts can encourage the use of drugs that provide rewards to PBMs versus the use of the lowest cost

drugs. Profit levels written into PBM pass-through contracts can ensure PBM profitability while also ensuring that the state is acting as a responsible steward of tax-payer funds (for Medicaid plans). For example, the Medallion 4.0 Medicaid managed care organization contracts in Virginia specify that managed care organizations with profits over 8.5 percent in a contract year must return excess profits to the state.

State findings of Audits of Medicaid Managed Care Contracts with PBMs

State	Findings
Ohio	From 4/1/17 – 3/31/18 the spread on drugs in the Medicaid MCO program ranged from 0.8 percent for branded drugs, 31.4 percent for generics, and 1.1 percent for specialty drugs with a total average spread of 8.9 percent[1]. The average price spread represented **$224.8M** on 39.4 million drug claims. **In 2018, Ohio announced that its Medicaid MCO programs would switch to a pass-through model.**
Kentucky	PBMs that contracted with Kentucky Medicaid MCOs reported being paid $957.7M for spread pricing contracts, **$123.5M of which was kept by the PBMs** in CYs 2018 and 2019 [2].
Mass	Drug spending in 2012 grew twice as fast as other MassHealth spending. The state noted its concern of the use of spread pricing for generic drugs by PBMs [3]. **In 2014, spread pricing covered 22 percent of all PBM compensation, but in 2016 that number rose to 54 percent.** For SFY 2020, Massachusetts officials have proposed a requirement for PBMs to be transparent about pricing and to limit PBM margins under MCO and accountable care organization contracts. **The government projects savings of $10 million.**

[1] Ohio's Medicaid Managed Care Pharmacy Services Auditor of State Report, August 16, 2018.
[2] Medicaid Pharmacy Pricing. Kentucky Cabinet for Health and Family Services Office of Health Data Analytics, 2/19/2019.
[3] https://www.fiercehealthcare.com/payer/massachusetts-puts-transparency-demands-pbms-as-drug-spend-jumps-41

Methods for Addressing High Drug Prices

States are using a variety of methods for slowing the increase in drug costs and are saving money by implementing strategies that target various points in the drug distribution and payment pipelines. Methods include the following.

- Increasing state authority to regulate PBMs through insurance contracts
- Requiring transparency reports from manufacturers and PBMs
- Subscription-based contracts with manufacturers
- Spending limits and caps
- Requiring notification in advance of price increases over a certain amount and/or for the highest priced and most utilized drugs

- Requiring that PBMs work in the best interest of insurance companies and plan members
- Banning pay-to-delay agreements for creating generic drugs
- Creating drug affordability review boards
- Importing drugs from Canada
- Establishing within-state and across-state purchasing compacts
- Value-based drug payments

Some of these methods require significant amounts of state resources to implement, (e.g., foreign importation) while others are more easily implemented (e.g., PBM requirements).

Pros and Cons of Options to Consider

Option	Pros	Cons
Take No Action	• Implementation of some strategies could require significant work and budget allocations. • New strategies could take a year or more to implement. • New federal laws may make state action less necessary.	• It is uncertain if any of the proposed federal legislation will become law, or if they do, what the final language will be.
Authorize the Bureau of Insurance to license and regulate PBMs through insurance companies (Option 2)	• Would allow the state to mandate elements of PBM activities (e.g., requiring pass-through contracts, transparency reports, prohibit clawbacks and conflicts of interest, etc.).	• May require additional staff and a budget appropriation to fund new positions and administrative functions.
Prohibit the use of manufactures' coupons	• May increase price transparency. • The use of coupons can drive shifting from generics to brand name drugs and result in higher insurance premiums.	• Coupons may be used by uninsured individuals, or when the coupon lowers the price paid by the consumer to below the insurance copay amount. So patients may perceive this as a price increase, as the use of coupons lowers the cost to the patient at the point of sale.

Option	Pros	Cons
Require pass-through contracts between PBMs and insurance companies with audit rights (along with option 2)	• Pass-through contracts require that PBMs charge insurers the net price of a drug. • Increases transparency and eliminates spread pricing. • Discourages the use of brand-name drugs when cheaper, generic drugs are available.	• The administrative portion of insurers' payments to PBMs could increase to compensate for lower revenue related to the reduction of the use of higher priced brand-name drugs. • May change an insurers' medical loss ratio if previous contracts classified *all* components of PBM payments as medical costs. • If cost-plus reimbursement is used, manufacturers may set higher prices.
Require PBMs to submit transparency reports (along with option 2)	Reports would include: • Break-out of administrative expenses, drug costs and profits • Financial assistance provided • Rebates • Costs of coupons • Wholesale acquisition cost • 5-year history of increases • Marketing and advertising costs	• May add to administrative costs that are then passed on to employers. • If the information is not confidential could enable tacit collusion. • May give unfair insights into competitors. • May require audits. • May reduce margins on generics undermining incentives to encourage generic utilization.
Develop a program to import drugs from Canada	• Imported drugs would be less expensive. • Supported by the Trump Administration and CMS. • Imported drugs would be safe. The drug market is already a global market.	• Canada has released statements of opposition, citing concern about drug shortages in their country. • Would take significant state resources and time to craft/pass legislation and implement a program. • A budget appropriation may be needed for administrative costs.

Option	Pros	Cons
Require PBMs to act in the best interest of insurers and their members (along with option 2)	• Would provide transparency and discourage hidden arbitrage. • Increased bargaining power of health plans and pharmacies to level the playing field. • Discourage the use of brand name and authorized generics and increase the use of lower cost generic drugs. • Disallow PBMs using lower cost MAC lists to pay pharmacies, higher cost MAC lists to bill insurance companies, and keeping the difference.	• Could require increased monitoring.
Introduce legislation modeled after CA to ban pay-to-delay. (Regulation signed into law Oct. 2019)	• Could accelerate the pipeline for generic drugs.	• Would require resources of the Office of the Attorney General and possible budget appropriation for the increased resource need.
Develop a subscription model for purchasing Hepatitis C and other drugs for Medicaid members and incarcerated individuals	• Could expand access to treatment and lower the price of Hepatitis C drugs. • Could help prevent the spread of Hepatitis C. • Could be expanded to include diabetes and other appropriate drugs.	• The model only works if there is unmet need. • The lack of providers trained in treating Hepatitis C would need to be addressed (Project Echo may be a solution). • Hepatitis C testing costs would increase. • Significant state resources and time to craft/pass legislation and implement a program. • May need budget appropriation to pay administrative costs.

Option	Pros	Cons
Implement a Drug Affordability Board and Upper Payment Limits, such as Maryland, Maine, New York and Vermont	• Imposes transparency. • Would help set fair, affordable prices.	• Would take significant state resources and time to craft/pass legislation and implement a program. • A budget appropriation to pay administrative costs would be needed.

Policy Options Approved by the Commission

The commission chose to take no action.

JCHC Staff:
Paula Margolis, PhD
Senior Health Policy Analyst

Forensic Nursing in the Commonwealth

Study Information

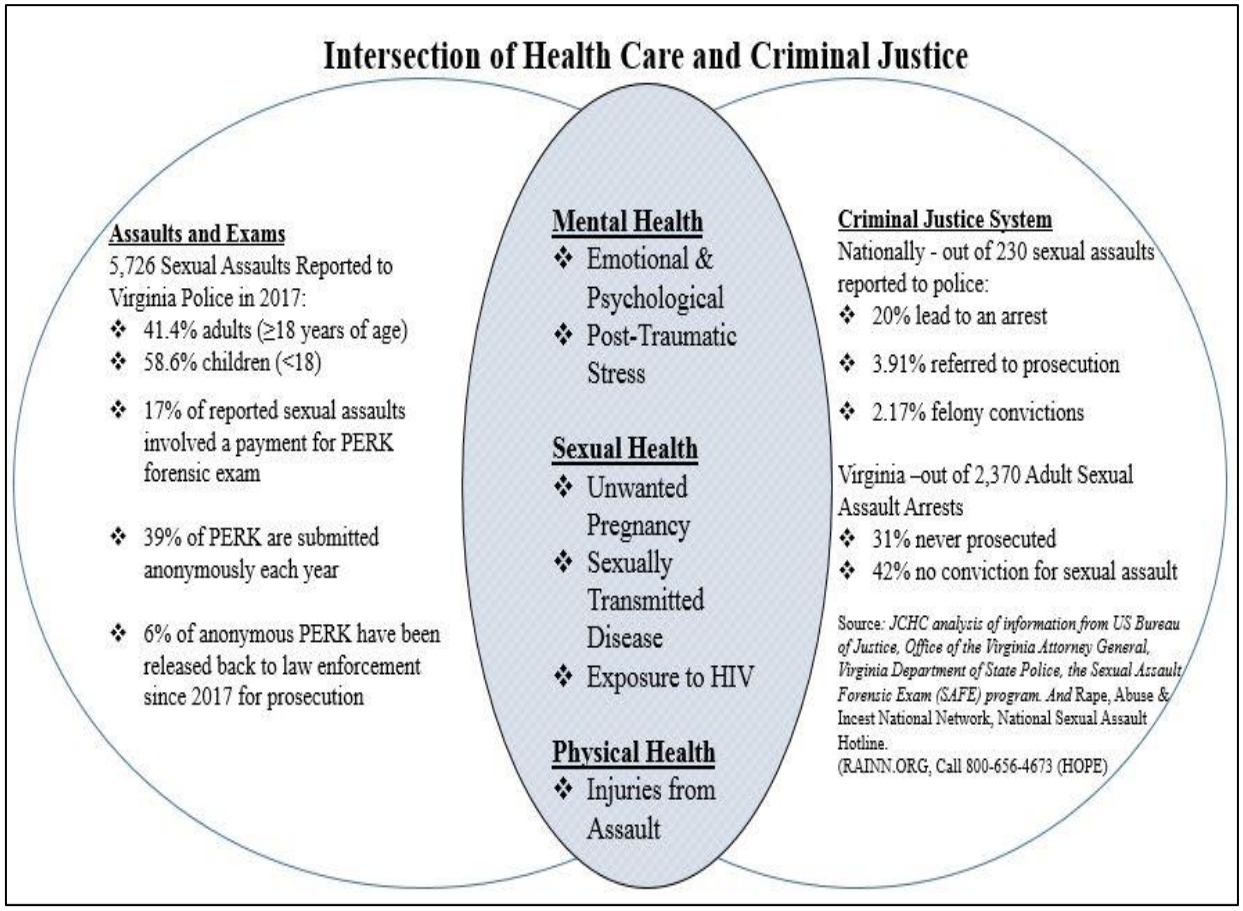
House Joint Resolution 614 (Delegate Delaney) requested that the Virginia State Crime Commission do a Forensic Nursing study. Due to time constraints, and with Crime Commission member approval, the director asked the Joint Commission on Health Care (JCHC) to conduct the study. During the May work plan meeting, JCHC members approved the transfer of HJR 614 from the crime commission to the health care commission. Per Delegate Delaney's request, as written in the resolution, the JCHC study included: (i) a review of existing forensic nursing (FN) programs in Virginia; (ii) identification of regions of the state with no FN programs or nurses and the closest locations where FN services are provided; (iii) the current funding sources for existing FN programs, the cost to create new programs, including potential funding sources; (iv) the actual cost of evidence collecting and court testifying, identification of potential funding sources to cover the costs for FN testimony; (v) the current FN workforce and ways to increase availability of FN certifications to nurses; (vi) possible insurance reimbursement for FN services; and (vii) best practices in other state FN programs, including telehealth.

Background

Forensic nursing is a specific practice of nursing where the health and legal systems intersect. According to the International Association of Forensic Nurses (IAFN), "victims of violence and abuse require care from a health professional who is trained to treat the trauma associated with the wrong that has been done to them—be it sexual assault, domestic/intimate partner violence, neglect, or other forms of intentional injury." In addition, forensic nurses collect evidence and give testimony that can be used in the criminal justice system to apprehend and prosecute those who commit violent and abusive acts against others.[13]

Forensic nurses work in a variety of fields, including sexual assault (as Sexual Assault Nurse Examiners or SANEs), domestic/intimate partner violence, child abuse and neglect, elder abuse, death investigation, and corrections. The overwhelming majority of forensic nurses in Virginia work for hospitals in forensic nurse examination programs. The nurses are specially trained registered nurses credentialed to treat and examine victims of sexual assault. The JCHC study found that advocacy groups, law enforcement agencies, and the Commonwealth's Attorneys ask the forensic nurses for additional assistance with examinations of victims of the other types crimes, e.g. domestic/intimate violence, etc. These requests often lead to an expansion of the original forensic nurse examination program from sexual assault examinations to the other types of examinations related to violence and abuse. The study focuses on both forensic nurse examination issues and general issues related to forensic nursing programs.

[13] International Association of Forensic Nurses website (https://www.forensicnurses.org/page/WhatisFN)



Findings

Training – Needs to be standardized

Forensic nurse examiners (FNE) are registered nurses (RN) who are required to have two or more years of experience as an RN before they can become credentialed and/or certified as FNEs.[14] There are no recognized national standards for FNE training. The IAFN, US Department of Defense and the American Nurse Credentialing Center offer guidelines for FNE training. The guidelines include 40 hours of online course work that results in a certificate of completion followed by 40 hours of supervised clinical training with experienced forensic nurses. The supervised clinical training can last between 2 months to a year, or longer. While the online course work is available through several websites (e.g. Tribal Forensic Healthcare, IAFN), the supervised clinical training is only available where forensic nurse examiner programs exist.

The length of time to complete the clinical training depends on if the RN is full time, part time or PRN (as needed). In addition, each FNE program in Virginia has different supervised clinical

[14] FNE are credentialed as Sexual Assault Nurse Examiners for Adults (A) and/or Pediatrics (P). The credentials are recognized by the American College of Emergency Physicians, Emergency Nurses Association, American Nurses Association, United States Department of Justice, State prosecutors, and Law Enforcement. In addition, a FNE can be certified in adult and/or pediatrics by the International Association of Forensic Nurses.

requirements. Some require 10 pelvic exams while others require 50; some require the RN to attend court while others require RNs to accompany law enforcement officers as they respond to sexual assault calls. A JCHC survey of nurses and hospitals found that of the 93,902 licensed RNs in Virginia only 96 to 155 are recognized as FNEs. The lack of national standardized FNE training has led to at least seven states adopting their own standards by state law or administrative rule.[15]

Location of FNE Programs is Unclear – Require hospital referral protocols and identification of FNE programs

Knowledge of FNE programs in Virginia is based on an informal network of forensic nurses, Commonwealth's Attorneys and a list posted on the IAFN website. JCHC surveys and reviews of data indicate that only 16 of 122 hospitals, plus one mobile FNE program, provide FNE services in the Commonwealth. The lack of FNE programs in the state results in sexual assault victims driving for hours for a FNE exam and could involve traveling to 2 or 3 hospitals before locating one with an FNE available to provide the service. In addition, JCHC staff found that law enforcement and EMS providers also are turned away by hospitals that do not provide FNE services.

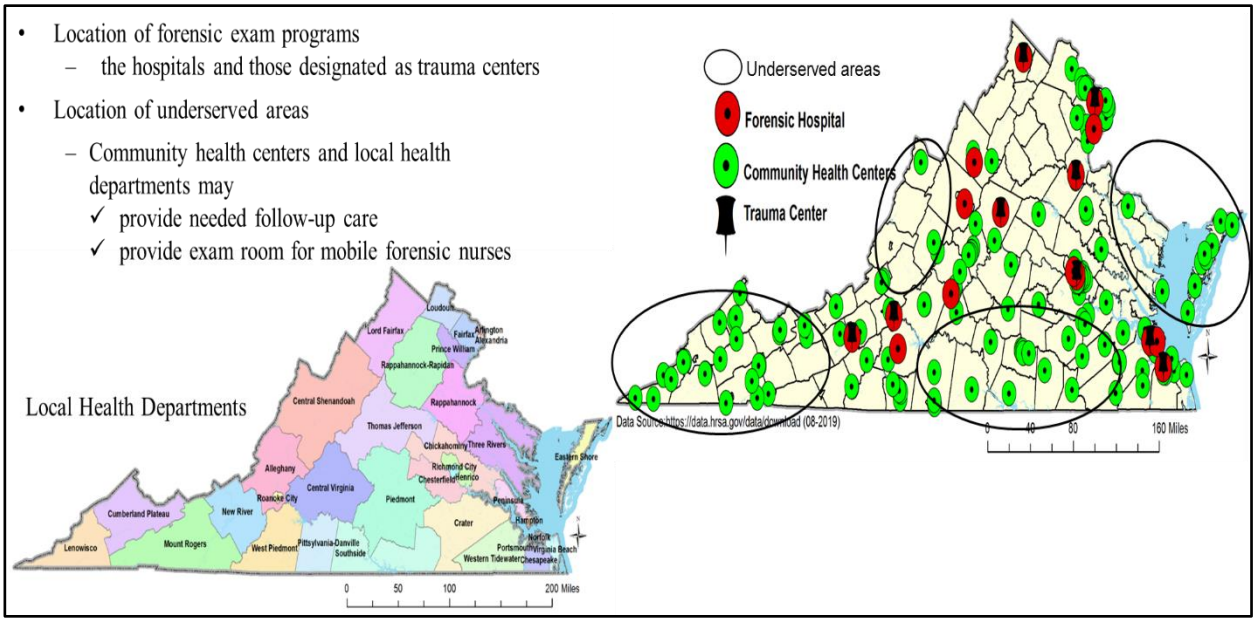
Follow-up exams – Other local and community health care providers should be involved in sexual assault response plans and included on the Sexual Assault Response Teams (SART)

Follow-up exams are an important and necessary part of any health care treatment plan, especially ones involving trauma, injuries, prevention of unwanted pregnancies and the possible existence of sexually transmitted diseases. For some patients, transportation back to the hospital where the initial exam was performed is not feasible. However, study findings indicate that follow-up referrals to a sexual assault victim's primary care physician often result in patient privacy concerns and confusion over the purpose of the appointment. The use of safety-net clinics is also problematic given that FNEs report difficulty locating these clinics and there appears to be a lack of knowledge about all of the different safety-net clinics in their area.

These issues could be partially addressed by including a range of providers, especially primary care physicians and providers from safety-net clinics, on SARTs. SARTs are created by Virginia Code § 15.2-1627.4 and led by Commonwealth's Attorneys. They are required to meet annually to develop a comprehensive and trauma-informed response for sexual assault victims within the Commonwealth's Attorney's jurisdiction. SART team members are listed in Virginia Code and include forensic nurse examiners or health care providers that perform Physical Evidence Recovery Kits (PERK), if any of those health care providers exist within the Commonwealth's Attorney's jurisdiction. The current Virginia Code does not include local hospital administrators, local health department district directors, representatives of safety-net clinics, or other local

[15] Illinois, Kentucky, Maryland, Massachusetts, New Jersey, North Carolina, Texas.

health care providers. As a result, even though these entities may be available to provide health care services, and/or sexual assault exams, they may not be included in the local response plan, or aware of the issues that need to be addressed, e.g. providers available to perform follow up care, etc.



Payments for sexual assault exams and all other health care services should be available to sexual assault victims that receive a sexual assault forensic exam

Under the current system, the state, through the Sexual Assault Forensic Exam (SAFE) program, covers all costs directly associated with a sexual assault forensic exam. However, for patients to qualify, the exam has to occur within 120 hours of the assault, the assault must occur in Virginia, and a PERK must be included. Patients have a choice about whether to file a police report and can submit the PERK anonymously. Patients are not responsible for the cost to store an anonymous PERK. In addition, patients do not have to pay for follow-up exams *if* they are directly related to the initial exam.

On the other hand, a patient is responsible for all costs if the exam is performed after 120 hours of the assault or the exam does not include a PERK (both *may* be eligible for SAFE program reimbursements but only if the assault is reported to the police and authorized by a Commonwealth's Attorney). A patient is also responsible for any medical costs associated with the assault that are not part of the sexual assault forensic exam, e.g. treatment of injuries that occurred as a result of the assault (e.g. a broken arm), treatment of existing medical conditions made worse by the assault, and any follow-up appointments, medications, and/or lab work not directly related to the initial forensic exam. Finally, a patient also is financially responsible for mental health counseling and any medications filled after a sexual assault forensic exam. A patient with medical or mental health costs not covered by the SAFE program can file claims for reimbursement with the Virginia Victim Fund (VVF) administered by the Workers Compensation

Commission (WCC). However, in order to submit claims to VVF the patient must file a report to the police and cooperate with the investigation.

JCHC analysis of SAFE payment data, and data provided by the Department of Consolidated Labs where the anonymous PERKs are stored, found that 39 percent of all sexual assault forensic exams are done anonymously each year. As a result, patients that do not file a police report but obtain a sexual assault forensic exam cannot submit any of their health or mental health care claims to VVF for reimbursement and the patient is responsible for medical bills not covered by the SAFE program. Of the 968 unique patient claims paid by the SAFE program (2018), only 77 (8 percent) of the patients filed a claim for reimbursement with VVF.

Billing Third Parties and Dependent Coverage – Explanation of Benefit (EOB) laws need to be updated

HIPAA provides patients with a right to *request* restrictions on protected health information for treatment, payment, or use and disclosure.[16] However, the law is less clear on whether providers and health plans have to accommodate a request and the law provides them with the authority to deny a request. HIPAA law allows states to be more restrictive than federal law in order to protect patient privacy of health information, and some states require carriers to accept patient requests and provide health care providers and patients with a standard form that patients can complete at the time health care services are sought.[17] Virginia's EOB law currently does not protect patients who are adult dependents, victims of sexual assault or domestic/intimate partner violence. Adult dependents include children through age 26, a spouse, or a partner. Victims of sexual assault or domestic/intimate partner violence often do not want anyone, let alone the perpetrator who may be the owner of the health insurance policy, to know that they received health care services after an assault. To protect their privacy many dependents (including college students) may refuse exams and other health care services or may only request prevention services (e.g., to prevent sexually transmitted diseases, unwanted pregnancy, etc.).

Current SAFE program reimbursements do not cover actual costs

JCHC staff found that a majority of hospital administrators did not appear to support forensic nurse examiner programs because of the high cost to operate the programs, low patient volume, and inadequate reimbursements that do not cover the costs. The current rates have not been increased since 2010 when they were established and do not include reimbursement for the time a forensic nurse spends preparing for, and appearing in, court when subpoenaed during a trial. Increasing the reimbursements to cover *all* of the *actual* costs involved in the program may encourage hospitals and other health care providers to operate forensic nurse examination programs and to provide the necessary follow-up care for patients

[16] 45 CFR § 164.522

[17] California, Massachusetts and Maryland updated their EOB laws to further protect patient privacy.

Current SAFE Program Reimbursement Rates	
Description of Current Program	SAFE Payment
Acute medical forensic exam – within first 120 hours with PERK	$1,200
Non-Acute medical forensic exam – after 120 hours, authorized by Commonwealth Attorney	$800
Follow-up forensic exam	$300
Transportation covered for travel to the initial forensic exam (but not any follow-up appointments), medications for STI, unwanted pregnancy and HIV post prevention covered at time of exam	Memo. of Agreement with providers / vouchers

Increase Reimbursement to Estimated Actual Cost	
Description of Current Program	Recommended Payment
Acute medical forensic exam – within first 120 hours with PERK	$2,823
Non-Acute medical forensic exam – after 120 hours, authorized by Commonwealth Attorney	$1,560
Follow-up forensic exam	$1,046
HIV Follow-up forensic exam (if necessary)	$913
Court Requirements if Subpoenaed	$1,641
Source: JCHC analysis of data provided by INOVA Ewing Forensic Assessment and Consultation Teams (FACT); Bureau of Labor Statistics compensation reports, American College of ER Physicians fact sheet and MarketRealist.com hospital data.	

With the Workers Compensation Commission approval, the SAFE administrators pursued rate increases with the Department of Planning and Budget on August 27, 2019. The following are the proposed new rates.

- Acute medical forensic exam – within first 120 hours with PERK: $2,900
- Non-Acute medical forensic exam – after 120 hours, authorized by Commonwealth Attorney, non-acute (no PERK): $1,800
- Follow-up forensic exam: $1,500

The estimated fiscal impact of these changes is $6 million. The SAFE program administrators also are reviewing a proposal to provide payments for injuries that occur during an assault and five trauma-informed counseling sessions consistent with VVF mental health treatment guidelines.[18] A third option to increase rates may be to increase the current SAFE program rates by inflation. However, neither the SAFE program administrator's proposal nor an inflation adjustment applied to the current rates would cover the costs associated with court appearances as a result of subpoenas.

[18] Counseling expenses must be reasonable and appropriate, crime-centered, time-limited, and for Trauma- and Stressor-Related Disorders. **(**http://www.cicf.state.va.us/content/mental-health-treatment-request)

An implementation work group should be created to modernize forensic nurse exam claims processing and to determine the feasibility of moving the SAFE program to DMAS

The SAFE program is administered by the Virginia Victims Fund (VVF) as part of the Workers Compensation Commission (WCC). SAFE program reimbursement claims are not processed like traditional health care claims and reimbursement rates are not set by rule or publicly posted. Filing claims to the SAFE program is labor intensive and cumbersome (e.g. fax, mail and email) and the majority of FNE nurses do not understand follow-up care reimbursement procedures. FNE nurses train each other on how to bill the SAFE program, and other health care providers may not be aware that they can be reimbursed for providing follow-up care for patients.

SAFE program claims and other medical expenses incurred by patients should be patient and provider friendly and use standard health care claims procedures for reimbursements. For example, claims should be filed electronically, a modifier designating the claim as a forensic nurse examine should be created in order to appropriately bill, suppress EOBs and coordinate benefits among the different state funds and other sources of reimbursements that may be available to patients. There should be comprehensive provider training to insure that all health care providers are aware of the process and procedures related to reimbursements for follow-up care. An implementation work group could examine all of these issues and make recommendations to improve claims processing and determine if moving the SAFE program to DMAS is feasible. DMAS has all of the systems necessary to improve SAFE payment program claims processing and procedures.

Policy Options Approved by the Commission

- Introduce legislation to amend § 15.2-1627.4 of the Code of Virginia by adding the following: In addition, the attorney for the Commonwealth shall invite other individuals, or their designees, including: local health department district directors; hospital administrators from each licensed hospital within the jurisdiction; safety-net provider clinic directors from each clinic within the jurisdiction (including those created by 42 CFR 491.1 and the free and charitable clinics); and any other local health care providers to participate in the annual meeting. Attendance shall be encouraged but is not required. Attorneys for the Commonwealth are authorized to conduct the sexual assault response team annual meetings using other methods to encourage attendance, including conference telephone calls and videoconferencing as provided by Title 2.2 (§ 2.2-3708.2) Chapter 37.
- Introduce legislation to amend the Code of Virginia to allow victims of sexual assault to access victim funds for all medical expenses regardless of whether a victim chooses to report a sexual assault to law enforcement or chooses to have an exam without a PERK.
- Introduce legislation to amend the Code of Virginia to require the Bureau of Insurance to establish regulations, and the Department of Medical Assistance Services to require in its

contracts with managed care companies, that covered individuals receiving health services can choose a preferred method of receiving the explanation of benefits (EOB) from their insurer, as permitted by 45 CFR § 164.522, and restrict descriptions of sensitive services in the EOB. Authorize the Bureau of Insurance--in consultation with experts on infectious disease, reproductive and sexual health, domestic violence and sexual assault, mental health, and substance use disorders--to define sensitive health care services.

- Introduce a budget amendment, amount to be determined, if any, creating an Implementation Work Group (IWG) led by the Office of the Secretary of Health and Human Resources to determine the feasibility of transferring the SAFE program and all related claims for medical expenses related to sexual assault, strangulation, domestic/intimate partner violence, human trafficking, and adult or child abuse from the Virginia Workers Compensation Board to the Department of Medical Assistance Services.

  The Implementation Work Group should also include members from the Office of the Attorney General, the Office of the Secretary of Public Safety and Homeland Security, the Office of the Executive Secretary of the Supreme Court, the Workers Compensation Commission, Department of Medical Assistance Services, Department of Criminal Justice Services, and Department of Planning and Budget.

  The IWG shall make a recommendation regarding whether to increase reimbursement rates for sexual assault examinations to the actual costs of the exams and to include reimbursements for the costs associated with preparing for, and appearing in, court when a forensic nurse is subpoenaed during a trial.

  If not feasible to move to DMAS, the work group shall create an efficient, seamless electronic medical claim processing system for hospitals and health care providers that coordinates payments from all fund sources, suppresses EOBs and removes patient from the medical billing and reimbursement process.

  The Implementation Work Group shall present a report with any necessary statutory changes and budget requirements to the Governor, the House Appropriations and Senate Finance and Appropriations Committees, and the Joint Commission on Health Care by September 1, 2020, for consideration in the Executive Budget for SFY-2021.

Legislation Enacted

SB 949 (Lucas) and HB 806 (Delaney). Acts of Assembly -Chapters 1073 and 1072, repsectively

Criminal Injuries Compensation Fund; uncompensated medical costs; victims of sexual assault.

Adds to those persons invited to participate in the annual meeting of the sexual assault response team (SART) led by the attorney for the Commonwealth, to coordinate the multidisciplinary response to criminal sexual assault, in his/her political subdivision (i) local health department district directors; (ii) the administrator of each licensed hospital within the

jurisdiction; (iii) the director of each health safety net clinic within the jurisdiction; and (iv) any other local health care providers, or their designees; and authorizes the Commonwealth attorney to conduct the annual meeting using other methods, such as electronic communication means, to encourage attendance.

The bill also directs the Secretary of Health and Human Resources to establish a work group to evaluate (i) the feasibility and cost of expanding the type of services for which the Criminal Injuries Compensation Fund will make awards to include claims or portions of claims based on the claimant's *actual* expenses and indebtedness associated with or attributable to the sexual abuse upon which such claim is based and (ii) the feasibility of transferring responsibility from the Virginia Workers' Compensation Commission to the Department of Medical Assistance Services (DMAS) for the Sexual Assault Forensic Examination program (the SAFE program) and all related claims for medical expenses. If the work group finds that it is not feasible to move responsibility for the SAFE program and related claims from the Virginia Workers' Compensation Commission to DMAS, the work group shall develop recommendations for creation of an efficient, seamless electronic medical claim processing system for hospitals and health care providers that coordinates payments from all available sources, suppresses explanations of benefits (EOBs), and removes the patient from the medical billing and reimbursement process.

The work group also must provide recommendations related to (a) increasing the reimbursement rates for sexual assault forensic examinations to cover the actual cost of such examinations and (b) including reimbursement of costs associated with preparing for and participating in a criminal trial when a sexual assault forensic nurse is subpoenaed as a cost that is reimbursable through the SAFE program. The work group's report shall include specific legislative, regulatory, and budgetary changes necessary to implement the work group's recommendations. The work group shall report its findings and recommendations to the Governor and the Chairmen of the House Committee on Appropriations, the Senate Committee on Finance and Appropriations, and the Joint Commission on Health Care by September 1, 2020.

SB 766 (Barker) and HB 807 (Delaney). Acts of Assembly -Chapter 716 and 715, respectively

Health care services; explanation of benefits.

Authorizes the State Corporation Commission to adopt regulations that establish alternative methods of delivery of the explanation of benefits, provided that such alternative method is in compliance with the provisions of federal regulations regarding the right to request privacy protection for protected health information.

JCHC Staff:
Stephen Weiss, MPA,
Senior Health Policy Analyst

Supported Decision-Making for Individuals with Intellectual and Developmental Disabilities

Study Information

House Joint Resolution 729 (Delegate Kory) requested the Secretary of Health and Human Resources study supported decision-making (SDM) for individuals with intellectual and developmental disabilities (IDD). The study was approved by JCHC members at the May 8, 2019 work plan meeting. The study topics include the uses of SDM, policies and practices used in other states, whether SDM can be an appropriate alternative to guardianship, stakeholder opinions, recommended strategies to insure that individuals with intellectual and developmental disabilities are informed of SDM, and whether legislation is necessary, and if so, legislative recommendations.

Previous Study and Other Activity Related to SDM in Virginia

The topic was studied in 2015 by the Secretary of Health and Human Resources and a report, House Document 6, was issued to the Governor and the Virginia General Assembly. The report indicated that Virginia had no official position on SDM, with no defined policies or practices, and recommended (a) adding SDM to the guardianship and DBHDS authorized representatives code sections, (b) requiring SDM and Person Centered Planning training for guardians and authorized representatives, and (c) standardizing procedures for capacity evaluations that determine the need for guardianship. No actions were taken by the General Assembly following the report.

As a result of a 2012 code change requiring person-centered practice procedures for public guardians,the Department of Aging and Rehabilitation Services (DARS) implemented an inclusive decision-making process by rule in 2016 that was focused on the expressed preferences, personal values, and needs of the individual with the goal of empowering and supporting individual decision-making as much as possible.[19] Prior to this , in 1997, the private guardianship code was amended to encourage participation in decisions and consider the expressed desires and personal values of a person by guardians.

What is SDM for individuals with IDD?

SDM is based on the understanding that everyone needs help making decisions at times and persons with IDD differ only in degree and/or frequency of assistance needed. SDM can be an informal agreement or a valid contract recognized by law between one IDD adult and at least one supporter. It may be used in lieu of, or in combination with, a guardianship. Under SDM the

[19] VA Code § 51.5-150 and 22VAC30-70-30.F

supporter is not the decision-maker.[20] SDM can be used to preserve individual rights that are often lost due to the current guardianship process. SDM, when legally recognized in Code, may be the least restrictive alternative for a disabled person that can be used to both provide a person with the dignity to assume risk and to provide legal protections against abuse.

Delaware, Indiana, and Texas SDM laws are profiled in the JCHC study. All three states consider SDM as a less restrictive substitute to guardianship for disabled adults. These states recognize SDM as a way of supporting and accommodating an adult in the decision making process without impeding self-determination. The states provide guidance in establishing agreements and contracts between the IDD individual and the person(s) he/she chooses to provide decision-making assistance when needed. Supporters are usually family members or friends that the IDD individual trusts and can contact to provide recommendations on matters such as legal, financial, health care, employment, and housing issues.

What is Adult Guardianship?

Adult Guardianship is the result of a judicial determination that an adult person lacks the capacity to make decisions for him or herself. A person under guardianship loses a variety of decision making rights including the right to vote; make medical decisions; bank and make financial decisions; file lawsuits in their own name; sign a power of attorney and an advanced directive; choose where to live and work; obtain a drivers license; and own a gun.[21]

Virginia guardianship can be private or public, limited or full. The process is the same regardless of the type of guardianship. A person petitions the ciruit court of jurisdiction where the person of concern lives. The ciruit court judge appoints a guardian ad litem to review the petition and follow an extensive process to determine if the person of concern needs a guardian and what decision-making rights might be removed or retained based on the person's demonstrated level of capacity. A hearing is held where the circuit court judge considers a report from the guardian ad litem as well as information presented at the hearing. Guardianship may be approved if the judge finds that the person lacks decision-making capacity. The judge also may determine what decision-making rights a person may lose and retain. When a person retains decision-making rights the guardianship may be considered a "limited guardianship". Each guardianship case is different and the final determinations are tailored to the needs of the person of concern. People who are indigent and/or have no other proper and suitable person willing and able to serve as a guardian, may be appointed a public guardian through the public guardianship program operated by DARS. Otherwise the judge will appoint a private guardian who may be a family member, friend, or other interested person. All guardians, regardless of type, are

[20] SDM can also be an informal agreement between the IDD and others but does not provide the legal protections that a contract can provide.

[21] Article II, Section 1 of the Constitution of Virginia, VA Code § 64.2-1601 et. seq., and VA Code § 54.1-2981 et. seq.

required by law to file annual reports to local department(s) of social service. The reports are then submitted to the Circuit Court Clerk.[22]

Public guardianship compared to private guardianship

The public guardianship program administered by DARS operates in collaboration with the Department of Behavioral Health and Developmental Services (DBHDS). The program is regulated and publicly funded. Public guardians are required to have face-to-face visits at least once a month with their ward, provide an annual review to determine if guardianship remains appropriate, utilize person-centered planning, maintain client files that are subject to audit, and attend trainings. The public guardianship program limits the staff-to-client ratio to 1-to-20. According to DARS, 13 organizations serve as public guardian through contracts with the state.[23] There are approximately 12,000 private guardians and 1,049 state funded public guardians in Virginia.[24]

Private guardians, on the other hand, are not regulated. Private guardians are required to file annual reports with the local department(s) of social services. The local department(s) of social services turn the annual reports over to the circuit court clerk.

DBHDS - "authorized representatives"

In addition to the guardianship process outlined in code, DBHDS uses "authorized representatives" in lieu of guardianship. A determination of capacity is made by the director of a local DBHDS or CSB program based on an evaluation of the person of concern by a licensed professional. If the program director determines that a person in treatment is not capable of making health and mental health care decisions for themselves the director will appoint a substitute decision maker, usually a family member. However, the authorized representative does not automatically transfer when a person moves to an area served by a different program or CSB and, under the DBHDS rules, capacity determinations are reviewed regularly.[25]

[22] Private guardianship, VA Code § 64.2-2000 et. seq.; Public guardianship, VA Code § 51.5-149 et. seq.; Limited guardianship, VA Code § 64.2-2009

[23] 22VAC30-70-10 et. seq.

[24] The estimated number of private guardians is based on the number of annual reports filed with local departments of social services. DARS reports that of the 1,049 public guardians, 454 slots are reserved for the ID/DD referred by Community Service Boards, 98 are reserved for individuals coming out of state mental health inpatient facilities, and 497 are unrestricted, generally individuals with dementia or a traumatic brain injury.

[25] VA Code § 37.2-400 et. seq. and 12VAC35-115-146 et. seq.; The need for authorized representatives is reviewed every 6 months, upon the request by the person in treatment, at discharge; and annually by the program if still in effect.

Findings

Authorized representative designations should be reported to the state

Authorized representatives are appointed by local mental health program directors after a person is formerly evaluated by an independent "licensed professional" and determined to lack decision-making capacity "to consent to treatment, services, or research or {when the ability} to authorize the disclosure of information is in doubt."[26] Currently, the DBHDS is able to identify IDD clients who have guardians, conservators and/or powers of attorneys. [27] The Department, however, does not collect data to determine how many individuals served by the mental health system have a "program-director-appointed" authorized representative, what decision-making rights the person has lost, or how long those appointments are in effect. The Department should report data on the number of authorized representatives appointed in the mental health system so that the data can be included in information on how many people in the state are formally considered to lack decision-making capacity.

SDM should be legally recognized in Virginia for the IDD and Guardians Ad Litem should consider SDM as a viable option in their report to the circuit court

Adding SDM to the VA Code makes clear to the courts and others that SDM is a viable alternative to guardianship and will provide a legal framework for IDD individuals that physicians, hospitals, banks, landlords and others can rely on when doing business with those who have entered into an SDM contract. Once added to the code, guardians' ad litem should review SDM as an option or alternative to guardianship. The guardian ad litem report should include information to the court on whether a person may benefit from SDM in lieu of a guardian. Recognizing SDM by law does not change current guardianship laws or remove the ability of a person to petition the circuit court for guardianship.

Annual Report and Circuit Court data additions can improve reporting and evaluating guardianship determinations

Annual reports are submitted by guardians to local department(s) of social services and then submitted to the court clerks where the guardianship orders originate. The annual report form is prepared by the Office of the Executive Secretary of the Supreme Court (OES). Virginia code lists seven items that are covered on the form.[28] However, the annual report form does not include the age of the incapacitated person at time of initial guardianship appointment, what type of guardianship was ordered (limited, temporary or full), the reason for guardianship (IDD, dementia, mental illness), the relationship to person or profession of the guardian.

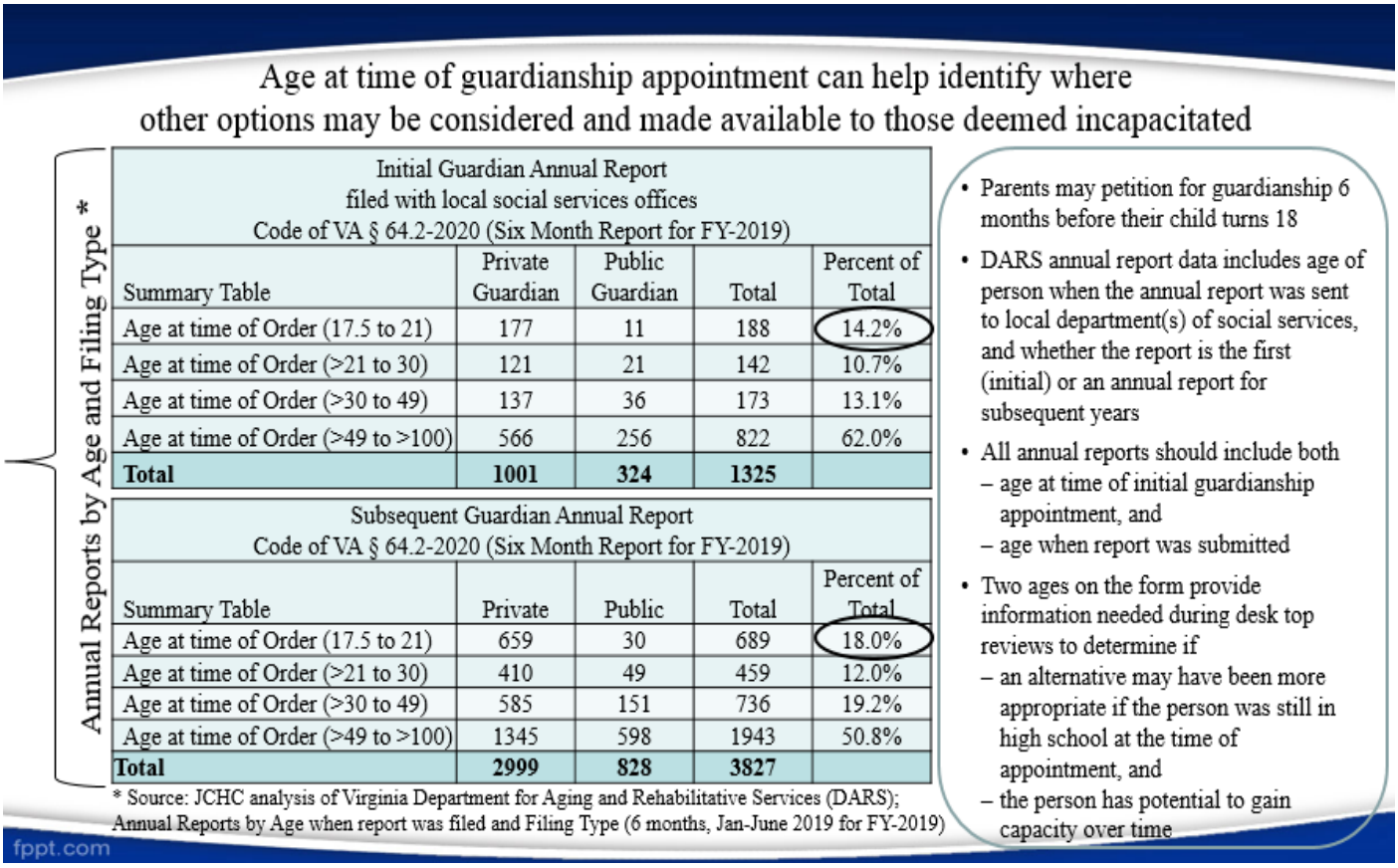
[26] 12VAC35-115-146

[27] 8,800 of the 27,000 DBHDS clients who are either enrolled (~14,000) or on the wait list (~13,000) for IDD Medicaid Waiver services have a guardian, conservator or powers of attorney.

[28] VA Code § 64.2-2020 - medical and mental health condition; living arrangements; services provided to meet needs; visits by guardian; guardian statement on agreement with treatment and habilitation plan; need for continued guardianship with possible proposed changes; whether the guardian incurred expenses; requests for reimbursement and from whom; and amount of compensation.

In addition, OES maintains the Circuit Case Management System (CCMS). Of the 120 circuit courts, only Fairfax and Alexandria do not report data to the CCMS. The code permits OES to aggregate the circuit court data for statewide reporting purposes.[29] CCMS fields currently do not include date of birth or age at time of initial guardianship appointment or the reason for the guardian appointment.

Adding items to the annual report and to the CCMS will improve data collection and reporting. In addition, if the annual reports and CCMS data fields include age and reason for determination they can be reviewed periodically to determine if there is a change in capacity that may influence a change of the guardianship order.



Age at time of guardianship appointment can help identify where other options may be considered and made available to those deemed incapacitated

Annual Reports by Age and Filing Type *

Initial Guardian Annual Report
filed with local social services offices
Code of VA § 64.2-2020 (Six Month Report for FY-2019)

Summary Table	Private Guardian	Public Guardian	Total	Percent of Total
Age at time of Order (17.5 to 21)	177	11	188	14.2%
Age at time of Order (>21 to 30)	121	21	142	10.7%
Age at time of Order (>30 to 49)	137	36	173	13.1%
Age at time of Order (>49 to >100)	566	256	822	62.0%
Total	**1001**	**324**	**1325**	

Subsequent Guardian Annual Report
Code of VA § 64.2-2020 (Six Month Report for FY-2019)

Summary Table	Private	Public	Total	Percent of Total
Age at time of Order (17.5 to 21)	659	30	689	18.0%
Age at time of Order (>21 to 30)	410	49	459	12.0%
Age at time of Order (>30 to 49)	585	151	736	19.2%
Age at time of Order (>49 to >100)	1345	598	1943	50.8%
Total	**2999**	**828**	**3827**	

* Source: JCHC analysis of Virginia Department for Aging and Rehabilitative Services (DARS); Annual Reports by Age when report was filed and Filing Type (6 months, Jan-June 2019 for FY-2019)

- Parents may petition for guardianship 6 months before their child turns 18
- DARS annual report data includes age of person when the annual report was sent to local department(s) of social services, and whether the report is the first (initial) or an annual report for subsequent years
- All annual reports should include both
  - age at time of initial guardianship appointment, and
  - age when report was submitted
- Two ages on the form provide information needed during desk top reviews to determine if
  - an alternative may have been more appropriate if the person was still in high school at the time of appointment, and
  - the person has potential to gain capacity over time

[29] VA Code § 17.1-502 and VA Code § 17.1-208.

Virginia Department of Education (DOE) should update special education transition materials for students and parents; and Guardians Ad Litem should consider the person's Individualized Education Program (IEP) when preparing reports for those between 17.5 through 21 years of age

People find out about guardianship in a variety of ways. For parents with IDD children one way is through the school system. During the JCHC study, many of those interviewed indicated that parents with IDD children often pursue guardianship based on a suggestion from someone at the child's school. A small anonymous survey through VCU's Partnership for People with Disabilities found that 9 of 28 (32 percent) respondents were told to pursue guardianship by school personnel. A 2015 national study of parents and the disabled found that 20 percent of the responses to a survey indicated that guardianship was "suggested" by school personnel.[30]

A child with a developmental disability who is in school and found eligible for special education services will have an "Individualized Education Program" (IEP; 20 U.S. Code § 1400, et. seq.). The IEP is updated annually and includes individual goals, progress, and age appropriate transition from school to post graduation that may begin when the child turns 14, or when entering post-secondary school. The IEP transition plan developed when the child turns 16 must include information about services that can be put into place when the child is 18 years old. Finally, one year before the child turns 18, students and parents are informed of education rights that are transferred to the student when the child reaches the age of 18. Parents are encouraged to get a Power of Attorney for education-related decisions. The VDOE material provided to school divisions and parents mentions guardianship but does not explain what happens when a guardian is appointed, e.g. loss of rights. In addition, some of the material is dated and needs to be updated.

Guardians Ad Litem play a pivotal role in guardianship proceedings. The review and report by guardians' ad litem for those aged 17 through 21 should include a review and report on the person's IEP if the disabled student was in special education. This will provide the judge with information on how well the person learned and advanced in school and whether or not the person has the opportunity or ability to gain a certain level of decision-making capacity over time. Guardianship appointments may be better tailored to the young person's actual needs, e.g. limited or temporary, retention of certain decision-making rights, etc.

[30] JCHC analysis of Table 1. Q.5. Jameson, J. Matt., et. al. Guardianship and the Potential of Supported Decision-Making with Individuals with Disabilities. Research and Practice for Persons with Severe Disabilities. June 29, 2015.

Virginia's Guardianship Code can be difficult to follow and should be updated and clarified

Parents, family members and others may seek information about guardianship directly from the VA Code. The code should be "user" friendly. Definitions should be added, cross references to other sections of code should be linked directly to the references, and sections providing information on what the responsibilities of a guardian are should be clarified.

Judicial orders for guardians should include standard language to provide clear guidance to guardians and others

The guardianship order is the document used by all guardians as the legal guide in working with a person. Guardianship orders are written by petitioning attorneys. A JCHC staff review of different orders found that some lacked basic information, such as whether the order was a full or limited guardianship, what rights a person retained and lost, requirements to file annual reports, basic responsibilities of guardians, and that guardianship can be changed or reversed.

Policy Options Approved by the Commission

- Introduce legislation to add a new section to the VA Code, Title 37.2 (Behavioral Health and Developmental Services) and/or Title 59.1 (Trade and Commerce) creating SDM for Individuals with Developmental Disabilities and/or all disabled adults as an option for the DBHDS and to formalize a supported decision-making contract in code that provides protections for private individuals that want to use a contract (e.g. use Delaware law as model: 80 Del. Laws, c. 427; Code § 9401A, et. seq.).
- Introduce legislation to amend VA Code § 64.2-2003.C. by adding a requirement that guardian ad litems consider whether supported decision-making is a viable option when reviewing and reporting on the extent of the duties and powers of the guardian or conservator.
- Introduce legislation directing VDOE to update special education transition materials for students and parents; directing school divisions to use the VDOE material to the fullest extent possible and include more information about transition for students and parents during the annual IEP meetings related to health care and other options available, including supported decision making.
- Introduce legislation to amend VA Code § 64.2-2003 to include a requirement that a person's IEP be part of the GAL's review and report for those between 17.5 through 21 years of age.

- Introduce legislation to amend VA Code § 64.2-2000, et. seq. to clarify the code sections as follows

  § 64.2-2000, definitions should be more complete so prospective guardians, family members and others are aware of what is included in the Code. Definitions should be added for:

  - annual reports required by § 64.2-2020 (to indicate oversight)
  - guardian ad litem required by § 64.2-2003 (to clearly identify who will review and report to the judge at the hearing)
  - temporary guardian and conservator (clearly defined options to pursue, ask questions about)
  - power of attorney(s) to inform (clearly defined options to pursue, ask questions about)
  - Individual Education Plan (20 U.S. Code § 1414) that should be reviewed by guardian ad litem for persons between the ages of 17.5 through 21

  Code clarifications:

  - the advanced directive reference in the definition section currently refers to the short title of the health care decisions act and not to the definition of advanced directive, the reference should be directed to the actual definition in § 54.1-2982
  - "Guardian" definition should include a reference to the duties and powers section § 64.2-2019 of a guardian
  - § 64.2-2007.C. related on the petition hearing should include a reference to § 64.2-2019.E. to make it clear that, to the extent feasible, the respondent (the subject of the hearing) will be encouraged to participate in decisions, act on his or her own behalf, and to develop or maintain the capacity to manage personal affairs if the respondent retains any decision-making rights

- Introduce legislation to amend VA Code § 64.2-2007 by adding a requirement that the following language be included in all guardianship orders

  - Clearly state whether the order is a full order removing all rights, a limited order and what rights are removed from the respondent {incapacitated person}, and/or a temporary order indicating the time-frame that the order is in effect for.
  - A guardian, to the extent possible, should encourage the incapacitated person to participate in decisions, consider the expressed desires and personal values of the incapacitated person to the extent known, shall not unreasonably restrict an incapacitated person's ability to communicate with, visit, or interact with other persons with whom the incapacitated person has an established relationship pursuant to VA Code § 64.2-2019. E.

- Annual reports should be filed by the guardian with the local department of social services for the jurisdiction where the incapacitated person then resides pursuant to VA Code § 64.2-2020.
- Guardianship orders are subject to petition for restoration, modification, or termination pursuant to the provisions VA Code § 64.2-2012.

Legislation Enacted

SB 214 (Suetterlein). Acts of Assembly - Chapter 581

Guardianship; review of Individualized Education Plan.

Provides that if the respondent to a guardianship or conservatorship petition is between 17 and a half and 21 years of age and has an Individualized Education Plan, the guardian ad litem appointed to represent the respondent shall review the IEP and include the results of his review in the report required to be submitted to the court. The bill also requires that the local school division disclose or make available to the guardian ad litem, upon request, any information, records, and reports concerning the respondent that the guardian ad litem determines necessary to perform his duties.

SB 585 (Dunnavant). Acts of Assembly - Chapter 855

Guardianship for incapacitated persons.

- Requires the Superintendent of Public Instruction to "make available special education transitional materials for students and parents to be used during a student's annual Individualized Education Program meeting as required by the State Board of Education Regulations Governing Special Education Programs for Children with Disabilities in Virginia (8VAC20-81-118 and 20 U.S.C. § 1400 et seq.) and direct local school divisions to use the material to the fullest extent possible. Such materials shall be prepared and updated as necessary by the Department of Education and shall include information describing services that can be provided in the least restrictive environment possible; and the purpose and use of temporary guardianship, limited guardianship, and guardianship, as those terms are defined in § 64.2-2000."
- Requires, in § 64.2-2003 Appointment of guardian ad litem, the guardian ad litem, when investigating the petition, to consider "whether a less restrictive alternative to guardianship or conservatorship is available, including the use of an advance directive or durable power of attorney…[and] if the respondent to a guardianship or conservatorship petition "is between 17 and a half and 21 years of age and has an IEP [Individualized Education Plan] and transition plan, the guardian ad litem [appointed to represent the respondent] shall review the IEP and transition plan and include the results of his review in the report required [to be submitted to the court]."
- Adds "local school division" to § 64.2-2003.D that requires them to "disclose or make available to the guardian ad litem, upon request, any information, records, and reports

concerning the respondent that the guardian ad litem determines necessary to perform his duties."

- Requires the court, upon appointment of a guardian or conservator, to inform such person of his duties and powers and that, to the extent feasible, the respondent should be encouraged to participate in decisions, act on his own behalf, and develop or maintain the capacity to manage his personal affairs if he retains any decision-making rights. The bill sets out the following language to be included in all orders of appointment of a guardian.

  "1. Pursuant to § 64.2-2009 of the Code of Virginia, _____ (name of guardian), is hereby appointed as guardian of _____ (name of respondent) with all duties and powers granted to a guardian pursuant to § 64.2-2019 of the Code of Virginia, including but not limited to: (enter a statement of the rights removed and retained, if any, at the time of appointment; whether the appointment of a guardian is a full guardianship, public guardianship pursuant to § 64.2-2010, limited guardianship pursuant to § 64.2-2009, or temporary guardianship; and the duration of the appointment).

  2. Pursuant to the provisions of subsection E of § 64.2-2019 of the Code of Virginia, a guardian, to the extent possible, shall encourage the incapacitated person to participate in decisions, shall consider the expressed desires and personal values of the incapacitated person to the extent known, and shall not unreasonably restrict an incapacitated person's ability to communicate with, visit, or interact with other persons with whom the incapacitated person has an established relationship.

  3. Pursuant to § 64.2-2020 of the Code of Virginia, an annual report shall be filed by the guardian with the local department of social services for the jurisdiction where the incapacitated person resides.

  4. Pursuant to § 64.2-2012 of the Code of Virginia, all guardianship orders are subject to petition for restoration of the incapacitated person to capacity; modification of the type of appointment or areas of protection, management, or assistance granted; or termination of the guardianship."

- Requires DBHDS to "convene a group of stakeholders to study the use of supported decision-making agreements in the Commonwealth, including making recommendations as to the use of supported decision-making agreements as a less restrictive alternative to the appointment of a guardian or conservator for an incapacitated person. The Department shall report the findings and recommendations of the stakeholder group's study to the Chairmen of the Senate Committee on the Judiciary and the House Committee on Health, Welfare, and Institutions no later than November 1, 2020."

JCHC Staff:
Stephen Weiss, MPA,
Senior Health Policy Analyst

MEETING AGENDAS 2019

May 1, 2019	EXECUTIVE SUBCOMMITEE MEETING Introduction Senator Rosalyn R. Dance, JCHC Chair Discussion of Work Plan for 2019
May 8, 2019	Call to Order Senator Rosalyn R. Dance, JCHC Chair Discussion of 2019 Work Plan Proposal Michele L. Chesser, PhD, JCHC Executive Director
June 24, 2018	Call to Order Senator Rosalyn R. Dance, JCHC Chair *Virginia Maternal Mortality Data* Melanie J. Rouse, PhD, Office of Chief Medical Examiner, Virginia Department of Health *Governor's Goal on Eliminating Racial Disparity in Maternal Mortality* Gena Boyle Berger, MPA, Deputy Secretary of Health and Human Resources *Update on Creation of Standardized Release of Information Form* Michael Schaefer, PhD, ABPP, Assistant Commissioner, Virginia Department of Behavioral Health and Developmental Services *VHI Report on Virginia's ED Care Coordination Program & APCD* Michael Lundberg, Executive Director Virginia Health Information, Inc. JCHC Staff Study Updates
September 4, 2019	Call to Order and Introduction of New Member Senator Rosalyn R. Dance, JCHC Chair *Forensic Nursing in the Commonwealth* Stephen Weiss, MPA, JCHC Senior Health Policy Analyst *Language Development Milestones and Parent Resources for Young Deaf/Hard of Hearing Children* Andrew Mitchell, Sc.D., JCHC Senior Health Policy Analyst *Prescription Drug Price Gouging* Paula Margolis, Ph.D., MPH, JCHC Senior Health Policy Analyst

October 3, 2019	Call to Order Senator Rosalyn R. Dance, JCHC Chair *PCPA's, Standing Orders and Statewide Protocols* Paula Margolis, Ph.D., MPH, JCHC Senior Health Policy Analyst *Prescription Delivery Options* Andrew Mitchell, Sc. D., JCHC Senior Health Policy Analyst *Naloxone Public Access & Storage* Andrew Mitchell, Sc. D., JCHC Senior Health Policy Analyst *Supported Decision Making* Stephen Weiss, MPA, JCHC Senior Health Policy Analyst
November 14, 2019	Call to Order Senator Rosalyn R. Dance, JCHC Chair Presentation of Gifts for Departing Members Decision Matrix - Study-overviews with public comment results and review of policy options Adjourn

STATUTORY AUTHORITY

§ **30-168**. (Expires July 1, 2022) 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, 2022) 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, 2022) 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, 2022) 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, 2022) 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, 2022) 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, 2022) 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, 2022) Sunset.
The provisions of this chapter shall expire on July 1, 2022.
(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.

JOINT COMMISSION ON HEALTH CARE

600 EAST MAIN STREET, SUITE 301

RICHMOND, VIRGINIA 23219

Mailing Address:

P. O. BOX 1322

RICHMOND, VIRGINIA 23218

804-786-5445

http://jchc.virginia.gov