

**Joint Commission on Health Care**

# **Decision Matrix**

**Policy Options for 2011 General Assembly Session**

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November 3, 2010

# Membership

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Senator Patricia S. Ticer  
Senator William C. Wampler, Jr.

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

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*Policy Options for 2011 General Assembly Session*

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#### **Purpose of Document:**

- A. To review and discuss findings, public comments, and policy options regarding staff reports and other issues that came before the Commission and its subcommittees in 2010.
- B. To develop legislative recommendations for the 2011 General Assembly Session.



*Behavioral Health Care Studies*



## Health Reform 2010 and Beyond

Jill Hanken, Staff Attorney  
Virginia Poverty Law Center

Jill Hanken presented to the Behavioral Health Care Subcommittee regarding how the provisions of federal health reform will impact Virginia. The following remarks and options were submitted by Ms. Hanken for JCHC's consideration.

### Background

Virginia leads the nation

- In business: "the best state for business." (*Forbes*, 2006-2009)
- In education: the "state where a child will most likely have a successful life." (*Education Week*, 2007)
- In personal income: # 8 nationally in per capita personal income. (Bureau of Economic Analysis)

But not in healthcare

- Is among only 10 states with more uninsured children today than 15 years ago – 167,000.
- Has experienced the 4<sup>th</sup> largest drop nationally in worker health insurance coverage over the last 15 years.
- Ranks 43<sup>rd</sup> nationally in income eligibility for children's health coverage.
- Ranks 48<sup>th</sup> nationally in Medicaid per capita expenditures.

Over One Million Virginians Are Uninsured

- **They are employed:** 80% live in households with at least one full-time (65%) or part-time (15%) worker.
- **They work for small companies:** 46% live in households with a worker in a small company (100 or fewer employees) or with a self-employed worker.
- **Their employers don't offer health insurance:** 72.3% live in households where the worker(s) has no offer of employer-sponsored health insurance.
- **They are U.S. citizens:** The overwhelming majority of uninsured Virginians are U.S. citizens (81%).
- **The majority are white, non-Hispanic:** 50% are Caucasian/non-Hispanic, 20% are African-American, 20% are Hispanic, and 10% classify as "other."

Source: Virginia Health Care Foundation, *Profile of the Uninsured in Virginia*, 2010.

National Health Reform Legislation

- **Medicaid Expands to 133% FPL in 2014**
  - \$14,400 /individual; \$29,300/family of 4
  - 100% federal funding for 2 years; ↓90% thereafter
  - Coverage for ≈ 270,000 - 425,000 Virginians
  - Federal payments for primary/primary care, children's coverage

- **Insurance Exchanges** – for people without employer based coverage and small businesses
  - Standardized benefit packages
  - Sliding scale subsidies
  - Limits on out-of-pocket costs
  - Premiums = 2%-9.5% of income
- **Insurance Reforms**
  - Dependent coverage up to age 26
  - No pre-existing condition restrictions
  - No annual caps
  - No rescissions
  - Rate review
  - Medical-loss ratio requirements

### Policy Options\*

**Option 1:** Take no action.

**Option 2:** Introduce a budget amendment (language and funding) to offer coverage to legal immigrants who are Medicaid eligible pregnant women. (Estimated cost: \$898,275 GFs \$1.13 M NGFs)

**Option 3:** Introduce a budget amendment (language and funding) to offer coverage to legal immigrants who are FAMIS-eligible children. (Estimated cost: \$140,000 GFs \$280,000 NGFs)

**Option 4:** Introduce a budget amendment (language and funding) to offer coverage to legal immigrants who are FAMIS-eligible pregnant women. (Estimated cost: \$90,473 GFs \$168,021 NGFs)

**Option 5:** Introduce a budget amendment (language and funding) to offer coverage to “other qualified” legal immigrants. (Estimated cost: \$9.2 M GFs \$9.2 M NGFs)

\*Cost estimates were based on previous considerations of these Options, more precise estimates will be determined for all approved options.

Without considering all the offsets, the Kaiser Family Foundation estimates the federal government will pay 92.8%-95.1% of Virginia’s new costs from 2014-2019.

(Source: *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, Kaiser Family Foundation, May 2010.)

**Staff Report:  
Statutory Language on Barrier Crimes**

Kim Snead  
Executive Director

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

**Background**

In undertaking the study, it was determined that while barrier crime laws for employers caring for children, the elderly, and the disabled continued to become more restrictive, a different movement was underway in the mental health and substance abuse arena. The New Freedom Commission on Mental Health, established by President George W. Bush, focused on recovery and making mental health care more consumer- and family-driven. In Virginia, the System Transformation Initiative sought to transform the “services delivery system to one that truly embraces the concepts of recovery, self-determination and empowerment.” (Source: *The System Transformation Initiative*, DMHMRSAS 2007 website.) In keeping with the federal and State initiatives, representatives of CSBs and private providers indicated support for considering the circumstances surrounding criminal convictions of individuals in recovery from mental illness in evaluating their suitability to be considered for employment. Individuals who have experienced mental health concerns can be very effective peer counselors and employment supports their recovery while helping to address the workforce need for mental health staff. Moreover, a similar review process had been established in 2001, to consider criminal convictions for specific crimes typically related to the applicant’s substance use disorder, so convictions for those crimes would not serve as absolute barriers to employment in adult substance abuse treatment facilities.

In 2008, two bills were introduced on behalf of JCHC to ease some employment restrictions to allow a job applicant (in recovery from mental illness) who had a misdemeanor assault and battery conviction to be considered for employment in an adult behavioral health care treatment program. The Table on the next page describes the legislative history of those bills as well as subsequent legislation introduced to address barrier crimes and employment in adult behavioral health care facilities.

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

### Policy Options and Public Comments

Four comments were received regarding the barrier crime policy options; comments were submitted by:

- Mira Signer on behalf of the **National Alliance on Mental Illness (NAMI) Virginia**
- Mary Ann Bergeron on behalf of the **Virginia Association of Community Services Boards (VACSB)**
- Jennifer Fidura on behalf of the **Virginia Network of Private Providers, Inc. (VNPP)**
- Violet Taylor

	<b>Comments In Support</b>
Option 1	<b>2</b>
Option 2	<b>1</b>
Option 3	<b>0</b>
Other	<b>1</b>

 **Option 1:** Take no action.

Mary Ann Bergeron of the **Virginia Association of Community Services Boards** and Jennifer Fidura of the **Virginia Network of Private Providers** commented in support of **Option 1.**

**Option 2:** Introduce legislation to amend the *Code of Virginia* § 37.2-416.C to allow an individual with a conviction of assault and battery against a family or household member to be assessed for employment by providers licensed by DBHDS and to amend *Code* §§ 37.2-416.E and 37.2-506.E to make it clear that the provisions in subsection C do not affect the provision to allow hiring “persons who have been convicted of not more than one misdemeanor offense under §18.2-57 or §18.2-57.2, if 10 years have elapsed following the conviction, unless the person... [was] employed in a direct consumer care position.”

Mira Signer, Executive Director of **NAMI-Virginia** commented in support of **Option 2**

**Option 3:** Introduce legislation to amend the *Code of Virginia* § 37.2-506.C to remove the provision allowing an individual with a conviction of assault and battery against a family or household member to be assessed for employment by community services boards and to amend *Code* §§ 37.2-416.E and 37.2-506.E to make it clear that the provisions in subsection C do not affect the provision to allow hiring “persons who have been convicted of not more than one misdemeanor offense under §18.2-57 or §18.2-57.2, if 10 years have elapsed following the conviction, unless the person... [was] employed in a direct consumer care position.”

**Violet Taylor** commented without supporting a specific **Option**, indicating support of looking at each person “as an individual, and the realization of potential in recovery should be considered. Each person should have an Equal Employment Opportunity.”



*Healthy Living/Health Services Studies*



## Childhood Obesity

Elena L. Serrano, Ph.D., Associate Professor  
Human Nutrition, Foods, & Exercise  
Virginia Tech

HL/HS Subcommittee members included the issue of childhood obesity in their work plan for 2010. Dr. Serrano of Virginia Tech addressed this topic and provided the following remarks and policy recommendations for JCHC's consideration.

### Background

Childhood obesity is now considered a national epidemic. The National Survey of Children's Health found that 30.9 percent of Virginia youth (10-17 years old) are overweight or obese. The negative consequences for children who are overweight or obese include higher risks for

A recent study showed that the plaque buildup in the neck arteries of obese children is similar to those seen in middle-aged adults.

diabetes, high blood pressure, osteoarthritis, adult obesity, sleep disorders, absenteeism at school and lower levels of self-esteem and perceived quality of life. Overweight or obese children also are more likely to participate in more primary care sick visits and mental health related visits at a cost of approximately \$72 more per year than a healthy weight child.

### Findings

There are numerous contributing factors to childhood obesity, including the abundance of sugar sweetened beverages and junk foods available in schools, inadequate levels of physical activity during school hours, and a lack of nutrition and wellness education in schools.

*Sugar Sweetened Beverages and Junk Food.* Between 1991 and 2005, the percentage of schools with vending machines increased from 42% to 82% in middle schools and 76% to 97% in high schools; and the most common items sold at schools (outside of school meals) include candy, sugar-sweetened beverages, chips, cookies, and snack cakes. A new Virginia law requires nutrition standards for snacks and competitive foods sold in schools, but beverages were not included in the legislation.

*Physical Education.* Research conducted by the Centers for Disease Control and Prevention (CDC) indicates that regular participation in physical education classes helps reduce obesity in low-income teenagers; however, daily physical education courses are only offered by 3.8% of elementary schools, 7.9% of middle schools and 2.1% of high schools. Twenty-two percent of all schools do not require students to take any physical education. The national recommendation for physical education is 150 minutes per week for elementary school students and 225 minutes for middle and high school students.

*Nutrition and Wellness Education.* The Child Nutrition and WIC Reauthorization Act of 2004 required that each local school division participating in the USDA school breakfast and lunch program adopt a local (school) wellness policy to address school foods, physical education, physical activity, nutrition education and school wellness. While a number of schools have proposed or recommended policy changes in these areas, very few have adopted and implemented specific requirements.

### **Policy Options**

**Option 1:** Take no action.

**Option 2:** Require nutrition standards for beverages sold in schools, based on guidelines set by the Alliance for a Healthier Generation or the Institute of Medicine.

**Option 3:** *Introduce legislation to* require every student in grades K-8 to participate in ~~daily~~ **regular physical education activity** for the entire school year, including students with disabling conditions and those in alternative education programs.

- Students in the elementary schools shall participate in physical education for at least 150 minutes during each school week
- Students in middle schools shall participate for at least 225 minutes per week.

**Option 4:** Require local (school) wellness policies (that were mandated as part of the Child Nutrition & WIC Reauthorization Act of 2004) to contain language that “requires” policies in the following areas:

- School foods
- Physical education
- Physical activity
- Nutrition education
- School wellness.

## **Adult Obesity and Menu Labeling**

HL/HS Subcommittee members included the issue of adult obesity in their work plan for 2010. Dr. Serrano of Virginia Tech addressed this topic by providing information and recommendations on menu labeling for JCHC’s consideration.

### **Background**

Dramatic changes in the availability, purchase, and consumption of foods away from home have taken place over the past 30 years, aligned with increasing rates of obesity. In 2000, 41% of U.S. adults reported eating away-from-home foods at least weekly; and 25% of adults and 30% of children reported eating fast food at least daily.

## Findings

Several studies have shown strong associations between the frequency of eating away from home, particularly at fast food restaurants, and an increase in total calories, fat, saturated fat and weight status and a decrease in the consumption of fruit, vegetables and milk. Individuals who often eat outside of the home also are more likely to experience negative metabolic outcomes.

In addition to encouraging individuals to eat at home more often, a possible solution to the negative problems associated with dining out is providing nutrition information on menus and healthier options at restaurants. Most consumers underestimate the amount of calories and fat in foods away from home and public opinion surveys show that most consumers want nutrition information made available to them when dining out. Inclusion of nutrition information on restaurant menus has been found to result in lower caloric and fat purchases and, in one study, parents who received nutrition labeling on a McDonald's menu averaged 102 fewer calories for their children.

Effective January 1, 2011, a provision of federal health reform law will require restaurants with 20 or more locations nationwide to post "the number of calories contained in the standard menu item, as usually prepared and offered for sale...in a clear and conspicuous manner," as well as "a succinct statement concerning suggested daily caloric intake." Given the demonstrated success of menu labeling in improving food-related choices, increasing the number of restaurants required to post menu information could further help to alleviate the obesity epidemic in Virginia.

## Policy Options

**Option 1:** Take no action.

**Option 2:** Require restaurants with 5-19 locations to post calorie information (consistent with national mandate for 20+ locations) for recipes that do not change day-to-day and for all restaurants that use standardized menus, including children's menus.

**Staff Report:**  
**Consideration of FAMIS Eligibility Levels (SB 266)**

Jaime H. Hoyle  
Senior Staff Attorney/Health Policy Analyst

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

**CHIP Background**

The State Children's Health Insurance Program (CHIP) was created by the federal government in 1997 to provide health coverage to low-income families that earn too much to qualify for Medicaid but too little to afford private insurance. CHIP was originally authorized for 10 years from 1997 through 2007. (Virginia's CHIP is the FAMIS program.)

**Current Coverage/Eligibility Levels for Low-Income Children in Virginia**

<b>Ages</b>	<b>Medicaid (FAMIS PLUS)</b>	<b>CHIP Medicaid Expansion</b>	<b>FAMIS</b>
<b>&lt; 6</b>	≤ 133% FPL	N/A	>133% to ≤200% FPL
<b>≥6 to &lt; 19</b>	≤100% FPL	>100% to ≤133% FPL	>133% to 200% FPL

**Impact of CHIPRA on FAMIS**

In January 2009, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA) that formally reauthorized CHIP through the end of September 2013. Under CHIPRA, states pay a share of all CHIP expenditures, and that state funding is matched by federal CHIP dollars up to a capped allotment. Within the capped allotment, states receive an "enhanced" federal matching rate that is higher than the standard matching rate for their Medicaid programs. In Virginia, the standard matching rate for Medicaid is 50% and 65% for FAMIS. Under CHIPRA, states received a higher initial allotment. As such, Virginia received an allotment of \$175.6 million in FY 2009, an 81% increase over the previous year.

**Impact of Federal Health Reform on FAMIS**

The Patient Protection and Affordable Care Act (PPACA), known as federal health reform, requires states to maintain the eligibility levels and enrollment policies which were in place on March 23, 2010. The Act also extends CHIP through 2019, but only provides two years of federal funding through September 2015. PPACA calls for a 23% increase in federal funding for CHIP matching rates between 2016 and 2019, which will bring the federal matching rate to at least 88% for every state. However, in 2014, children with family incomes below 133%

of FPL will be eligible for Medicaid, meaning that some low-income children who are currently eligible for CHIP will become eligible for Medicaid.

### Increasing FAMIS Eligibility Levels as Outlined in SB 266

SB 266 would change the family gross income limits as follows:

	Monthly Gross Income 200% FPL	Monthly Gross Income 225% FPL
Family of 3	\$3052	\$3433
Family of 4	\$3675	\$4135

The fiscal impact statement for SB 266 indicated that approximately 6500 additional children would be enrolled in FAMIS in FY 2011, if the income limit had been increased to 225% FPL at a cost of \$2.7 million GFs and \$5.0 million NGFs. Beyond that, costs were estimated to increase based on a projected enrollment growth rate of 5% increasing to \$3.7 million GFs and \$6.9 million NGFs by FY 2015.

### Considerations in Raising the Eligibility Level

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

### DMAS Reported FAMIS Information

	SFY/FFY 2008	SFY/FFY 2009	SFY/FFY 2010
Expanded Federal Funds	\$120,419,421	\$141,318,450	\$162,555,292
Federal Grant Funding Received	\$90,860,630	\$175,860,300	\$184,454,740
<b>Difference</b>	<b>-\$29,558,791</b>	<b>\$34,541,950</b>	<b>\$21,899,448</b>
Expended State Funding*	\$64,611,667	\$75,631,052	\$85,402,089
Total FAMIS Expenditures	\$185,031,088	\$216,949,402	\$247,957,381
*State funding includes FAMIS Trust Funds of approximately \$14 million each year and GFs. Source: JCHC staff analysis of DMAS report: <i>Total Program Expenditures by State Fiscal Year</i> .			

## Policy Options and Public Comments

Eleven comments were received regarding the FAMIS eligibility policy options; comments were submitted by:

- Wade Corbit
- Deborah Corbitt
- Lisa Frick
- Pam Murphy, Executive Director  
Shenandoah County Free Clinic and Shenandoah Dental Clinic
- Mike Purdue
- Rhonda Seltz, Outreach Worker and Health Care Advocate for counties in Southwest Virginia
- Lisa Sutphin
- Ann Walker, Project Connect Outreach Advocate  
Martinsville and Henry County Coalition for Health & Wellness
- Richard P. Melia on behalf of the American Heart Association (AHA)
- Jill Hanken on behalf of the Health Care for All Virginians (HAV) Coalition which represents 54 organizations
- Rick Shinn on behalf of the Virginia Community Healthcare Association (VCHA)

**All** of the comments received **were in support of Option 2** for raising the FAMIS eligibility levels to 225% of the federal poverty level. **Seven** (Lisa Frick, Pam Murphy, Rhonda Seltz, Ann Walker, AHA, HAV, VCHA) **commented in support of an increase to 300% FPL.**

**Option 1:** Take no action.

**Option 2:** By letter of the JCHC Chairman, to the Health, Welfare and Institutions Committee, indicate support for SB 266 to increase the eligibility level for FAMIS to 225% of FPL *if it is possible to return to the lower threshold in the future if funding is no longer available.*

**(11 comments in support)**

**Staff Report:  
Prescription of Antibiotic Therapy for Lyme Disease (HB 512)**

Jaime H. Hoyle  
Senior Staff Attorney/Health Policy Analyst

House Bill 512 was introduced by Delegate Thomas D. Rust during the 2010 General Assembly Session in order to:

- allow licensed physicians to prescribe, administer, or dispense long-term antibiotic therapy to a patient diagnosed with Lyme disease
- specify that the Board of Medicine shall not initiate a disciplinary action against a licensed physician solely for prescribing, administering, or dispensing long-term antibiotic therapy to a patient clinically diagnosed with Lyme disease.

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

**Background**

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

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

There is a minority of physicians and patients who believe that Lyme Disease can be a persistent and relapsing infection, often referred to as Chronic Lyme Disease or post-Lyme syndrome. These physicians often treat their patients with combinations of antibiotics over a long period until symptoms resolve; a course of treatment that conflicts with the short-term treatment guidelines set forth by the Infectious Diseases Society of America (IDSA). Physicians who support the use of long-term antibiotics, offer alternative research and studies that suggest post-Lyme syndrome could result from an autoimmune reaction to the Lyme bacteria; or certain genetic traits, and finally that the Lyme bacterium is capable of surviving the short-term doses of antibiotics by hiding in the tissues of the body. As the debate continues, physicians who disagree with the short treatment recommendations of the IDSA sometimes find themselves investigated and tried by their state medical licensing board for

breaking with the IDSA. To date, there have been no disciplinary proceedings by the Virginia Board of Medicine against a physician for treating Lyme Disease with long-term antibiotics. The case of the Eastern Shore physician recently in the news, involves being disciplined for prescribing narcotics. The physician is still able to administer long-term antibiotic treatment to Lyme Disease patients.

**Policy Options and Public Comments**

One comment was received regarding prescription of antibiotic therapy for Lyme Disease. The comment was submitted by Michael Jurgensen on behalf of the Medical Society of Virginia (MSV).

	Comments	
	In Support	In Opposition
Option 1	1	0
Option 2	0	1
Option 3	0	1

**Option 1:** Take no action.

Michael Jurgensen commented on behalf of **MSV in support of Option 1.**

**Option 2:** By letter of the JCHC Chairman, to the Health, Welfare and Institutions Committee, indicate support for HB 512.

Michael Jurgensen commented on behalf of **MSV in opposition to Option 2.**

**Option 3:** Introduce a budget amendment (language and funding) to provide the Department of Health with additional funding for education and prevention efforts.

Michael Jurgensen commented on behalf of **MSV in opposition to Option 3.**

**Option 4:** *By letter of the JCHC Chairman to the Secretary of Health and Human Resources request a report on the findings and recommendations of the Governor’s Task Force on Lyme Disease. In addition, by letter of the JCHC Chairman to the Department of Health Professions and Board of Medicine request that JCHC be notified of any plans to take action or consider regulations to take action against physicians related to prescribing antibiotics over an extended period to treat Lyme Disease, Chronic Lyme Disease, or post-Lyme Syndrome.*

**Staff Report:  
Virginia HIV/AIDS Prevention and Treatment Programs**

Michele L. Chesser, Ph.D.  
Senior Health Policy Analyst

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

**Background**

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

**Study Findings**

Results of the study indicate that VDH's Division of Disease Prevention provides and/or supports a wide range of prevention and treatment programs that have been effective in stabilizing new HIV infection rates over the past two decades; however, increased prevention funding and greater access to testing, post-testing services, and treatment are needed to further reduce HIV transmission in Virginia.

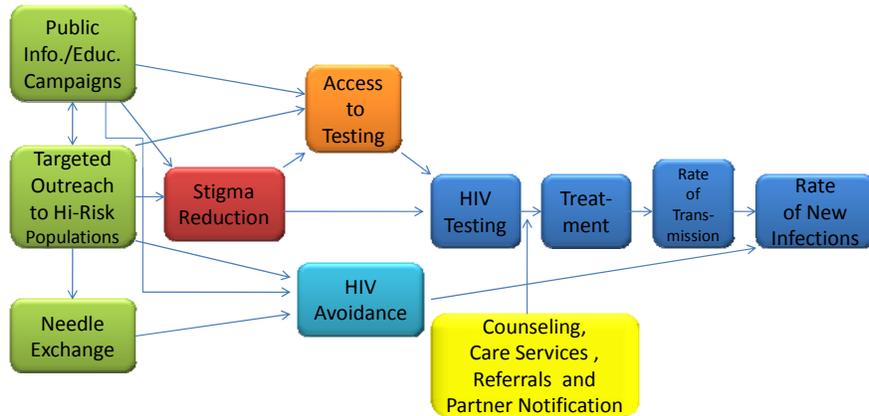
Research has shown that extensive HIV testing combined with early treatment for HIV positive individuals is an effective prevention model. Highly Active Anti-Retroviral Treatment (HAART) results in a significant reduction in transmission rates by decreasing an individual's viral load to very low levels. A 2009 study of 5021 serodiscordant heterosexual couples found a 92% decrease in transmission among groups receiving HAART.

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

Other key factors in decreasing rates of HIV infection include public information/education campaigns; targeted outreach to high-risk populations; needle exchange programs/access to clean needles; reduction in stigma; and increased access to testing, counseling, care services and partner notification services. A multipronged approach that provides consistent support for all of these factors is necessary to effectively address the HIV/AIDS epidemic (please see graph on next page).

## Importance of a Multipronged Approach



2

The AIDS Drug Assistance Program (ADAP) is central to the success of Virginia’s HIV/AIDS prevention and treatment efforts; however, this program is experiencing new funding challenges due to large increases in program enrollment and expenditures over the last several years. For the first time, VDH expects to have a waitlist for ADAP assistance. The following chart shows the estimated program shortfalls for the next three years.

	SFY 2011	SFY 2012	SFY 2013
Annual Medication Costs	\$30 M	\$35 M	\$40.6 M
Budget Shortfall	\$ 2.267 M*	\$14.6 M**	\$20.2 M**
Estimated PPACA Savings		\$ 2 M	\$ 2.5 M
<b>Total Budget Shortfall</b>	<b>\$ 2.267 M*</b>	<b>\$12.6 M**</b>	<b>\$17.7 M**</b>
<i>Projections based on current trends of level funding, increased enrollment, and current eligibility requirements.</i>			
<i>*Actual shortfall = \$6.9 M; Received \$4.68 M in one-time only funding assistance.</i>			
<i>**Estimated shortfall. Shortfalls would be larger, but include \$1-1.4 M in redirected funds from HIV Services budget (This will result in a 15%-20% decrease in HIV services).</i>			

If these changes are made, approximately 408 new clients per year will no longer qualify for ADAP and Virginia’s program will no longer meet established standards of care set by the Centers for Disease Control and Prevention (CDC).

**Policy Options and Public Comments**

Eleven comments were received regarding the policy options.

**In support of Options 2-8 and in opposition to Option 1:**

Robert G. Atkins

Mike King

Sue Rowland, Executive Director, Virginia Organizations Responding to AIDS, on behalf of the VORA Board of Directors

John Ruthinoski

**In support of Options 3-8 and in opposition to Option 1:**

Mike Culver

**In support of Option 3 and in opposition to Option 1:**

James Romano, Director of Government Relations, and Kelly Fitzgerald, Associate Director of Government Relations, Patient Services Inc. (PSI) on behalf of PSI

**In support of Option 3:**

Keith Callahan, Vice-Chair, Northern Virginian HIV Consortium

Gregg Fordham

Wade Menear

Edward C. Oldfield, III, M.D., Director of Infectious Disease Division, Eastern Virginia Medical School

George Zerbe

	Comments in Support	Comments in Opposition
Option 1	0	6
Option 2	4	0
Option 3	11	0
Option 4	5	0
Option 5	5	0
Option 6	5	0
Option 7	5	0
Option 8	5	0

**Option 1:** Take no action.

**Option 2:** Introduce a budget amendment (language and funding) during the 2011 Session to restore \$100,000 GFs to the AIDS Services and Education Grants program.

**Option 3:** Introduce a budget amendment (language and funding) during the 2011 Session to provide ~~\$12.6 million~~ of additional general funds (*in an amount to be determined*) to ADAP to address expected shortfall in FY 2012.

**Option 4:** Introduce legislation to amend §54.1-3466 of the *Code of Virginia* to remove penalties for the possession and distribution of hypodermic syringes/needles without a prescription.

**Option 5:** Introduce a budget amendment (language and funding) during the 2011 Session to provide additional funding for the Department of Health's HIV Prevention Program to be used for anti-stigma campaigns in Virginia's Black and Latino Communities.

- a) \$100,000 GFs; or
- b) other level of funding.

**Option 6:** Request by letter of the JCHC Chairman that the Medical Society of Virginia encourage physicians to routinely offer opt-out HIV testing

- a) for all patients between 13 and 64 years of age regardless of recognized risk factors, as per the Centers for Disease Control and Prevention (CDC) recommendation; or
- b) when testing for other sexually transmitted diseases (STDs).

**Option 7:** Request by letter of the JCHC Chairman that the Virginia Hospital and Healthcare Association encourage hospitals to routinely offer opt-out HIV testing in their emergency departments for all patients between 13 and 64 years of age.

**Option 8:** Request by letter of the JCHC Chairman that the Virginia Association of Health Plans encourage all health plans (including grandfathered/exempt plans) to include HIV testing among the preventive services covered free of cost (as part of the new federal health care reform preventive care provision).

# *Joint Commission Studies*



## Staff Report: State Funding for Cancer Research (SJR 292 – 2009)

Michele L. Chesser, Ph.D.  
Senior Health Policy Analyst

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

### Background

A study work group including the following 16 members was established in 2009 and continued to meet in 2010.

**Donna Berrier**, VCU Massey Cancer Center, (New) Executive Director of Development  
**Vernal Branch**, Virginia Breast Cancer Foundation, Advocacy and Constituency Coordinator  
**Keenan Caldwell**, American Cancer Society, State Director of Government Relations  
**Syd Dorsey**, UVA, Board of Visitors Member, cancer survivor  
**George Emerson**, VCU Massey Cancer Center, Board Member, cancer survivor  
**Gordon Ginder, M.D.**; VCU Massey Cancer Center; Director  
**Dina Halme**; UVA Cancer Center, Associate Director of Research  
**Meredith Strohm Gunter**; UVA Cancer Center, Board Member; Co-Founder of Patients and Friends Research Fund Steering Committee; cancer patient  
**Rosemary LaVista**, VCU Massey Cancer Center, Executive Director of Development  
**John Roberts, M.D.**; VCU Massey Cancer Center; Associate Director of Clinical Research  
**Christina Sheffield**, UVA Cancer Center/Cancer Prevention Action Coalition (CPAC), Manager of UVA Comprehensive Cancer Program and CPAC Member  
**Mark Smith**, VCU, Associate Vice President for Government Relations & Health Policy  
**Judy Turbeville**, VCU Massey Cancer Center, Advisory Board Member, cancer survivor  
**Cynthia Vinson**, National Institutes of Health, National Cancer Institute  
**Michael Weber, Ph.D.**; UVA Cancer Center; Director  
**Geoffrey Weiss, M.D.**; UVA Cancer Center; Medical Director and Chief of Hematology-Oncology

This year in Virginia, 36,410 new cases of cancer will be diagnosed and 14,230 people will die of the disease. Incidence and mortality rates are highest for African American men. African American women have the lowest incidence rate, but have a higher mortality rate than white women due to lack of access to care and/or later stage of diagnosis.

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

In the U.S., it is estimated that \$264 billion will be spent on health care costs for cancer this year; and in 2000, approximately \$2.6 billion in lifetime productivity was lost in Virginia due to cancer. Also in Virginia, there were 25,454 inpatient hospitalizations for cancer in 2008 which resulted in a total cost of over \$1 billion.

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

### **Study Findings**

The study results indicate that increasing State support for Virginia's NCI Cancer Centers could result in the following positive outcomes:

- Longer, better lives for Virginians as a result of advanced cancer care that is closer to home, expanded statewide access to clinical trials, and development of new and effective prevention and control interventions and public education programs.
- Economic improvements due to a reduction in lost productivity resulting from illness and death, job-creation (via grants, contracts, and clinical activity), enhanced investment in the health industry, company spin-offs and licensing revenues from intellectual property, increased early detection and prevention practices that can lower Medicaid expenses, and a reduction in loss of revenue due to Virginians going out of state for cancer treatment.
- Attainment of Comprehensive status for the two NCI Cancer Centers. Being designated as a NCI Comprehensive Cancer Center increases each Center's ability to access additional grant funding mechanisms and receive larger NCI support grants, recruit top physician-scientists and staff, provide more cutting-edge clinical trials for Virginians, and enable more cancer-related discoveries and better treatment options for Virginians. Of the 12 most populous states, only Virginia and Georgia do not have a NCI Comprehensive Cancer Center.

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

## Policy Options and Public Comments

Thirty-seven comments were received regarding the policy options.

	Comments in Support
Option 1	0
Option 2	34
Option 3	12
Option 4	28
Other	2

**Option 1:** Take no action.

**Option 2:** Introduce a budget amendment (language and funding) during the 2011 Session to increase the State funding for Virginia's NCI Cancer Centers from \$1 million GFs for each center to \$5 million GFs for each center.

**30 comments received in support** of this Option:

**Carolyn Achenbach**, University of Virginia Cancer Center Board Member

**Shelly Arthur**, VCU Massey Cancer Center Advisory Board Member and **Douglas Arthur, M.D.**

**Keenan Caldwell**, State Director of Government Relations, American Cancer Society

**Melba M. Campbell**

**Theodore L. Chandler**, Chair, VCU Massey Cancer Center Advisory Board and **George Emerson**,  
Chair of Legislative Committee, VCU Massey Cancer Center Advisory Board

**S. Dwyer**, Virginia Cancer Plan Action Coalition (CPAC) Member

**Jeanette Peters Ern**

**Will Ferrell**, VCU Massey Cancer Center Advisory Board Member

**Paula M. Fracasso, M.D., Ph.D.**, Deputy Director, University of Virginia Cancer Center

**Harry Frazier**

**Becky Gildersleeve**

**Gordon D. Ginder, M.D.**, Director, VCU Massey Cancer Center

**Bradley H. Gunter**

**Dina Gould Halme, PhD**, University of Virginia Cancer Center, Associate Director of Research

**Kathryn Hamilton**, University of Virginia Cancer Center Board Member

**Ted Hanson**, VCU Massey Cancer Center Advisory Board Member

**Gordon Hay**, Director, Life with Cancer, Inova Health System

**David A. Lyons**, Immediate Past Chair, VCU Massey Cancer Center Advisory Board

**Rebecca C. Massey**, Vice Chair, VCU Massey Cancer Center Advisory Board

**Howard and Diane Melton**

**Henry R. Miller IV**, VCU Massey Cancer Center Advisory Board Member

**Lorna D. Miller**

**Karen L. Morris**

**Carol Noggle**

**Rives Richey**, University of Virginia Cancer Center Board Member

**Pamela Kiecker Royall**, VCU Massey Cancer Center Advisory Board Member  
**Joshua Scott**  
**Raymond M. Slabaugh, III**, VCU Massey Cancer Center Advisory Board Member  
**Julie B. Speasmaker, L.C.S.W.**, University of Virginia Cancer Center Board Member  
**Matthew G. Thompson**, VCU Massey Cancer Center Advisory Board Member  
**Linda Tiller**, Executive Director, Susan G. Komen for the Cure, Central Virginia Affiliate  
**Judy Harris Turbeville**, VCU Massey Cancer Center Advisory Board Member  
**Michael J. Weber, Ph.D.**, Director, University of Virginia Cancer Center  
**Dianne Harris Wright**, VCU Massey Cancer Center Advisory Board Member

**Option 3:** Introduce a 1-2 cent “health impact assessment” on tobacco products with revenues to be divided equally between the two Virginia NCI Cancer Centers.

**10 comments received in support** of this Option:

**Carolyn Achenbach**, University of Virginia Cancer Center Board Member  
**S. Dwyer**, Virginia Cancer Plan Action Coalition (CPAC) Member  
**Jeanette Peters Ern**  
**Paula M. Fracasso, M.D., Ph.D.**, Deputy Director, University of Virginia Cancer Center  
**Bradley H. Gunter**  
**Dina Gould Halme, PhD**, University of Virginia Cancer Center, Associate Director of Research  
**Karen L. Morris**  
**Carol Noggle**  
**Rives Richey**, University of Virginia Cancer Center Board Member  
**Julie B. Speasmaker, L.C.S.W.**, University of Virginia Cancer Center Board Member  
**Linda Tiller**, Executive Director, Susan G. Komen for the Cure, Central Virginia Affiliate  
**Michael J. Weber, Ph.D.**, Director, University of Virginia Cancer Center

**Option 4:** Introduce legislation to grant the Tobacco Indemnification and Community Revitalization Commission permissive authority to fund cancer research grants, which may be partially used for supporting research outside of the South Side and Southwest footprint, for the two Virginia NCI Cancer Centers.

**24 comments received in support** of this Option:

**Carolyn Achenbach**, University of Virginia Cancer Center Board Member  
**Shelly Arthur**, VCU Massey Cancer Center Advisory Board Member and **Douglas Arthur, M.D.**  
**Keenan Caldwell**, State Director of Government Relations, American Cancer Society  
**J. Brian Cassel, Ph.D.**  
**Theodore L. Chandler**, Chair, VCU Massey Cancer Center Advisory Board and **George Emerson**,  
Chair of Legislative Committee, VCU Massey Cancer Center Advisory Board  
**Jeanette Peters Ern**  
**Will Ferrell**, VCU Massey Cancer Center Advisory Board Member  
**Paula M. Fracasso, M.D., Ph.D.**, Deputy Director, University of Virginia Cancer Center  
**Gordon D. Ginder, M.D.**, Director, VCU Massey Cancer Center  
**Bradley H. Gunter**

**Dina Gould Halme, PhD**, University of Virginia Cancer Center, Associate Director of Research  
**Ted Hanson**, VCU Massey Cancer Center Advisory Board Member  
**Gordon Hay**, Director, Life with Cancer, Inova Health System  
**David A. Lyons**, Immediate Past Chair, VCU Massey Cancer Center Advisory Board  
**Rebecca C. Massey**, Vice Chair, VCU Massey Cancer Center Advisory Board  
**Henry R. Miller IV**, VCU Massey Cancer Center Advisory Board Member  
**Karen L. Morris**  
**Carol Noggle**  
**Rives Richey**, University of Virginia Cancer Center Board Member  
**Pamela Kiecker Royall**, VCU Massey Cancer Center Advisory Board Member  
**Joshua Scott**  
**Raymond M. Slabaugh, III**, VCU Massey Cancer Center Advisory Board Member  
**Julie B. Speasmaker, L.C.S.W.**, University of Virginia Cancer Center Board Member  
**Matthew G. Thompson**, VCU Massey Cancer Center Advisory Board Member  
**Linda Tiller**, Executive Director, Susan G. Komen for the Cure, Central Virginia Affiliate  
**Judy Harris Turbeville**, VCU Massey Cancer Center Advisory Board Member  
**Michael J. Weber, Ph.D.**, Director, University of Virginia Cancer Center  
**Dianne Harris Wright**, VCU Massey Cancer Center Advisory Board Member

#### **Other Comments Received:**

**Kirsten Edmiston, M.D., FACS**, Medical Director of Inova Cancer Services and **Reuven Pasternak, M.D., MPH, MBA**, Chief Executive Officer of Inova Fairfax Campus on behalf of Inova Health System

“We strongly advocate for expanding the Study on Cancer Research to examine the feasibility of creating and implementing a comprehensive cancer network to enable Virginia to better respond to the needs of current and future cancer patients and accelerate economic growth throughout the state of Virginia.”

**Harry T. Lester**, President of Eastern Virginia Medical School on behalf of EVMS and **David L. Bernd**, Chief Executive Officer, Sentara Healthcare on behalf of Sentara Healthcare

“We are respectfully requesting that other funding options be considered that would allow for inclusion of our own excellent cancer research program...there is significant cancer research being conducted in Hampton Roads and that inclusion of this program in the JCHC proposal will both foster cancer research in our area and bolster the clinical and translational capabilities of the other two research programs. We invite a closer look at Eastern Virginia Medical School and the Sentara Cancer Network.”

**Option 5: Include in the 2011 JCHC work plan, a review of how the various cancer research centers in Virginia could be involved in advancing cancer research and treatment.**

**Staff Report:**  
**Catastrophic Health Insurance (HJR 99 – 2010)**

Stephen W. Bowman  
Senior Staff Attorney/Methodologist

House Joint Resolution 99, introduced by Delegate Christopher P. Stolle in 2010, directed JCHC to:

“(1) determine the availability and usage of catastrophic health insurance policies in the Commonwealth, (2) examine the results of efforts in other states to increase the use of catastrophic health insurance policies, and (3) evaluate the potential benefits and risks of facilitating the offering within the Commonwealth of health insurance policies or plans that provide catastrophic coverage only.”

### **Background**

Catastrophic health insurance policies financially protect individuals from responsibility for high health care expenses while leaving the policy holder fully responsible for a predetermined amount of initial medical expenses. The most common type of catastrophic health insurance is the high-deductible health plan (HDHP). HDHPs are typically less expensive than traditional health insurance. The Internal Revenue Service allows the policy holder of a HDHP that meets certain standards (known as a “qualified-HDHP”) to fund an associated health savings account (HSA). Similarly, an employer may fund a health reimbursement account (HRA) that is associated with an employee’s HDHP. These accounts are used to pay for medical expenses with pre-tax funds the enrollee or the employer contributes. A number of individuals, who choose an HDHP for the lower premiums, do not have an HSA or HRA.

### **Findings**

Research indicates that when insurance plans are structured so that the consumer has more cost-sharing requirements, such as HDHPs, those consumers become more cost-conscious and appropriate and inappropriate medical care is avoided. While providing positive benefits to some individuals, research also indicates that low-income and moderately sick individuals often have poorer health outcomes in high-cost sharing plans like HDHPs when compared to traditional health insurance coverage.

*In 2008, 114,700 individuals were covered by qualified HDHPs in Virginia, an increase from 50,100 individuals in 2006.*

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

Virginia's Efforts	Other States' Efforts Promoting HDHPs
2004	<i>Financial:</i> No state tax on HSA contributions
2005	<i>Insurance Market:</i> Allow HDHPs to be used in conjunction with a HSA and Medical Savings Accounts to convert to a HSA
2005	<i>Availability:</i> Mandate state employee health plan offer HDHP
2008	<i>Transparency:</i> Publicly available aggregate cost information for at least 25 common procedures
	<i>Transparency:</i> Publicly available specific cost and quality information by provider and facility for selected procedures

Maine, Massachusetts, Minnesota, New Hampshire, and New York have enacted legislation to provide greater transparency of cost and quality information. These states have made available specific out-of-pocket cost estimates for procedures by specific provider or facility for uninsured and insured consumers. In addition, these cost-to-consumer estimates may be refined by consumer location, distance willing to travel, insurer, type of insurance product, plan deductible, and level of coinsurance. This information allows consumers to gauge more accurately out-of-pocket costs for procedures.

**Policy Options and Public Comments**

Three comments were received regarding the policy options from:

- **Michael Jurgensen**, Medical Society of Virginia (MSV)
- **Doug Gray**, Virginia Association of Health Plans (VAHP)
- **Christopher S. Bailey**, Virginia Hospital and Healthcare Association (VHHA)

**MSV and VHHA commented in support of Option 2. VAHP suggests modifying Option 2** to “study the creation of an APCD for clinical data to improve quality and health outcomes.”

	Comments in Support	Other Comments
Option 1	0	0
Option 2	2	1

**Option 1:** Take no action.

**Option 2:** Include in the JCHC 2011 work plan, a staff study to review (i) other states’ efforts to publicly disseminate expansive cost and quality information by specific facility and provider for selected medical procedures; and (ii) legal, financial, data and other requirements for Virginia Health Information to provide similar specific cost and quality information through an All-Payer Claims Database *in order to improve quality and health outcomes*.

In addition, by letter of the JCHC Chairman, request that Virginia Health Information, the Virginia Association of Health Plans, the Medical Society of Virginia, and the Virginia Hospital and Healthcare Association provide assistance. A report to JCHC will be due by November 2011.

**Staff Report:**  
**Medical Care for Uninsured Individuals**  
**with Life-Threatening Conditions (SJR 339 – 2009)**

Stephen W. Bowman  
Senior Staff Attorney/Methodologist

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

**Background**

Individuals with life-threatening conditions (ILTCs) typically have a variety of care needs that may include: medical procedures, medications, physician visits and physical therapy. Uninsured ILTCs can have difficulty affording their medical care needs and may have to find charity care or negotiate in order to receive medical treatment and medications.

**Findings**

Uninsured ILTCs will not always be able to receive needed medical treatments and medications. There are avenues for uninsured ILTCs to receive free and discounted care, particularly from providers and pharmaceutical companies that seek to assist low-income individuals. Although many programs are available, program eligibility and benefits vary significantly; as a result specialized assistance is often needed to enable ILTCs to find and access available resources.

Virginia provides some funding for certain uninsured ILTCs to receive care through patient assistance, medical treatment and medication. The following six programs receive State appropriations.

- *Virginia Cares Uninsured Program (VCUP)* is a service offered by the Patient Advocate Foundation (PAF) that provides professional case management assistance to Virginians in navigating the health care system. Eligibility is limited to uninsured individuals with chronic, life-threatening, or debilitating diseases. Virginia has provided funding to PAF for VCUP since 2007 and 3,945 Virginians have been served. Greater efforts could be made through the Department of Social Services to publicize and refer citizens in need to VCUP and other patient assistance programs. However, no State funds are budgeted for VCUP in FY 2012 and PAF indicates that the lack of State funding “would have a significant and profound impact on the number of uninsured patients that VCUP could serve.”
- *Virginia’s Uninsured Medical Catastrophe Fund (UMCF)* is a State program administered through the Department of Medical Assistance Services for low-income individuals who have a life-threatening illness or injury. UMCF has been funded by tax contributions and State funding.

Uninsured Medical Catastrophe Fund

Voluntary Tax Contributions	\$ 25,828	Tax Year 2008
State Appropriations	\$265,000	FY 2011
	\$265,000	FY 2012

In FY 2009, 71 applications for assistance were received and 36 were approved for an average allocation of \$10,093. The program is not well publicized due to limited program funds.

- *Rx Partnership* is a public-private partnership that solicits free medications in bulk from pharmaceutical companies. The medications are directly distributed to 21 nonprofit affiliate pharmacies in Virginia. In FY 2011, the State provided funding of \$105,000 for the program.
- *The Pharmacy Connection (TPC)* is computer software developed by the Virginia Health Care Foundation that helps access more than 250 types of medications for chronically ill uninsured individuals. TPC makes “it easier and faster...to enroll patients in brand name pharmaceutical companies’ patient assistance programs....” Currently, 150 hospitals and health safety organizations use TPC and \$124 million in medication was distributed in 2009. The State provided funding of \$125,000 in FY 2011.
- *RxRelief* funds medication assistance caseworkers who assist uninsured individuals in applying for free chronic care medication through the TPC. Twenty-eight medication assistance programs have been funded and serve 76 localities. In FY 2010, RxRelief helped 14,911 patients to receive 112,173 medications valued at \$48.5 million.

Although State funding of \$1,850,000 was appropriated for FY 2010 to enable the Virginia Health Care Foundation to disburse grant funds to medication assistance programs, some RxRelief grantee requests were not funded. Fulfilling, all grantee requests would require an additional State appropriation of \$344,144 in order to assist an additional 3,343 patients with approximately 26,740 chronic care medications valued at \$11.7 million.

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

As a result of a program funding shortfall, an ADAP wait list is expected for the first time in program history. Another JCHC study, *Virginia HIV/AIDS Prevention and Treatment Programs* (presented to the Healthy Living/Health Services Subcommittee October 6, 2010) examines Virginia’s medication assistance programs and includes a policy option (Option 3) to address the expected funding shortfall.

- *Virginia Bleeding Disorders Program* provides assistance for individuals with Hemophilia A/B or von Willebrand disease. Funding for medical treatment and medications is available for individuals whose income is less than 200% FPL. State funding of \$214,247, appropriated for this program in FY 2011, is expected to be adequate.

## Policy Options and Public Comments

Forty-two comments were received regarding the policy options.

**Nancy Davenport-Ennis, CEO of the Patient Advocate Foundation commented in support of Options 2, 3, and 4** to request DSS to work with PAF to communicate about the VCUP program and emphasize patient assistance services on the 2-1-1 Virginia website, as well as provide funding for PAF’s Virginia Cares Uninsured Program; **25 comments were in support of Option 5** to provide additional funding for the Uninsured Medical Catastrophe Fund; **16 comments were in support of Option 6** to provide additional funding for the RxRelief program.

	Comments in Support
Option 1	0
Option 2	1
Option 3	1
Option 4	1
Option 5	25
Option 6	16

Option 3: By letter of the JCHC Chairman, request that the Department of Social Services emphasize patient assistance organizations and on the 2-1-1 Virginia website.

**Option 1:** Take no action

**Option 2:** By letter of the JCHC Chairman, request that the Department of Social Services:  
i) work with the Patient Advocate Foundation to communicate with agency case workers concerning VCUP through the most appropriate means, including a “broadcast message” *and*  
ii) *communicate with agency case workers concerning the Uninsured Medical Catastrophe Fund through the most appropriate means, including a “broadcast message.”*

**1 comment received in support** of this option:

**Nancy Davenport-Ennis, Patient Advocate Foundation**

**Option 3:** By letter of the JCHC Chairman, request that the Department of Social Services emphasize patient assistance organizations *and the Uninsured Medical Catastrophe Fund* on the 2-1-1 Virginia website.

**1 comment received in support** of this option:

**Nancy Davenport-Ennis, Patient Advocate Foundation**

**Option 4:** Introduce a budget amendment to provide \$95,625 GFs in FY 2012 for the PAF’s Virginia Cares Uninsured Program (administered by the Patient Advocate Foundation).

**1 comment received in support** of this option:

**Nancy Davenport-Ennis, Patient Advocate Foundation**

 **Option 5:** Introduce a budget amendment to provide an additional \$100,000 GFs in FY 2012 to the Uninsured Medical Catastrophe Fund.

**25 comments received in support** of this option:

<b>Dan Albert</b>	<b>Bobby Huskey</b>
<b>Gwen Albert</b>	<b>Penny Huskey</b>
<b>Rob Anderson</b>	<b>Teresa McIntire-Harnett</b>
<b>Rhonda Arnold</b>	<b>Robin McLane</b>
<b>Dorothy Booth</b>	<b>Angela M. Jackson</b>
<b>Michael Cheuk</b>	<b>Kerry Mossler</b>
<b>Ken Copeland</b>	<b>Jason A. Norton</b>
<b>Sarah Detrick</b>	<b>Jennifer M. Pillow</b>
<b>Mrs. E. Dimino</b>	<b>William E. Watson</b>
<b>Michael B. Ferguson</b>	<b>Elizabeth Whiley</b>
<b>Melinda I. Fowlkes</b>	<b>Wanda Whitus</b>
<b>Sheriff Travis D. Harris Jr.</b>	<b>Ken Woodley</b>
<b>Michael D. Harnett</b>	

**Option 6:** Introduce a budget amendment to provide an additional \$344,144 GFs in FY 2012 to the Virginia Health Care Foundation's Rx Relief program.

**16 comments received in support** of this option:

**Dave Baldwin**, Center for High Blood Pressure  
**Rich Bodemann**, Fan Free Clinic  
**Sharon S. Frost**, Northern Virginia Family Service  
**Cecil Hazelwood**, MedAssist of Halifax  
**Barbara A. Jackman**  
**Chris Karnei**, Benevolent Medication Program  
**Eileen G. Lepro**  
**Faye Mathews**  
**Deborah D. Oswald**, Virginia Health Care Foundation  
**Beth O'Connor**, Virginia Rural Health Association  
**Cathy Revell**, Chesapeake Care, Inc.  
**Virginia L. Savage**  
**Helen Scott**, Healing Hands Health Center  
**Debra Shelor**, Tri-Area Community Health  
**Peggy Whitehead**  
**Pamela H. Witt**

## Sunset Date for the Joint Commission on Health Care

Kim Snead  
Executive Director

In 1992, when the Joint Commission on Health Care was established to continue the work of the Commission on Health Care for All Virginians, a sunset date of July 1, 1997 was included. The sunset date has been extended since that time resulting in a current sunset date for the Joint Commission of July 1, 2012. If legislation is not introduced and enacted to extend JCHC's sunset date, the Commission will go out of existence on that date.

It has been the practice to vote on the issue of the sunset date to allow legislation to be considered the year prior to the sunset date's expiration.

### Policy Options

**Option 1:** Take no action.

**Option 2:** Introduce legislation to amend the *Code of Virginia* § 30.170 to extend the sunset provision to July 1, 2016.

**Staff Report:**  
**Indigent and Charity Care Provided by Hospitals (HJR 27)**

Stephen W. Bowman  
 Senior Staff Attorney/Methodologist

HJR 27 introduced by Delegate Harry R. Purkey in 2010 requested that JCHC “(i) determine the volume of indigent health care provided by private, specialty, and not-for-profit hospitals in the Commonwealth; (ii) determine the financial cost of indigent health care to private, specialty, and not-for-profit hospitals in the Commonwealth; and (iii) identify and analyze potential tax and other incentives that may be offered to private and specialty hospitals and other health care providers to encourage the provision of care to indigent individuals.”

**Study Findings**

Study findings include:

- In 2008, Virginia hospitals provided \$400 million in charity care.
- Non-profit hospitals provide more charity care than for-profit hospitals as a percentage of revenues.
- Federal health care reform is expected to decrease the need for charity care in 2014.
- It is too soon to determine how federal changes will impact hospital charity care offerings.
- VDH may need to reevaluate previously approved certificate of public need (COPN) charity care conditions, as less charity care will be needed in 2014.

Federal health reform may impact Virginia’s COPN program. In 2010, 205 charity care conditions were included on approved COPN certificates. Most of the conditions were based on a percentage of gross revenue and based on regional averages at the time of COPN approval. There are no regulations to define how the charity care requirements should be determined. With a decreasing need for charity care, there may be justification for lowering existing COPN charity care conditions after 2014.

**Policy Options**

**Option 1:** Take no action.

**Option 2:** By letter of the Chairman, request that the Virginia Department of Health report to JCHC by August 30, 2012 regarding the impact of federal health reform on existing COPN charity care conditions and recommendations to address any program, regulatory or statutory changes that may be needed.

**Option 3:** *Include in the JCHC 2011 work plan, a staff review of ways to define hospital-offered charity care to include determining the availability of data to support any charity-care definitions being considered. The purpose of the review would be to further future State-level charity care discussions and analyses.*

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