Decision Matrix

Joint Commission on Health Care

November 24, 2008

Joint Commission on Health Care

Decision Matrix

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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 2008.
B. To develop Commission recommendations to advance to the 2009 General Assembly.

Behavioral Health Care Subcommittee

Staff Report:
Overview of Underage Drinking

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

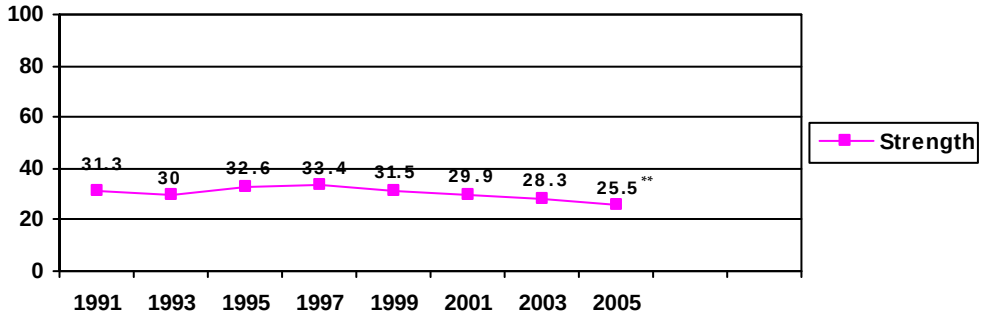
Background

Underage drinking continues to be a problem in the U.S. Alcohol is easy to obtain, drinking tends to begin early (prior to the age of 13 years), and heavy/binge drinking is prevalent among high school (25.5%) and college students (43%). Those who drink regularly before the age of 15 years are four times more likely to develop alcoholism during their lifetime.

Underage drinking is linked to increases in

- Driving accidents
- Developmental problems
- Academic problems
- Suicide
- Other risky behavior
  - Unintended sex, injury to self & others, memory loss

Percentage of High School Students Who Reported Episodic Heavy Drinking,* 1991 - 2005



* Had ³ 5 drinks of alcohol in a row (i.e., within a couple of hours) on ³ 1 of the 30 days preceding the survey.
** Significant linear decrease and quadratic change, $P < .05$ *National Youth Risk Behavior Surveys, 1991 – 2005*

Prevention strategies

Reduce availability by promoting responsible adult behavior and holding adults accountable when they provide alcohol to minors.

- "Parents Who Host Lose the Most" program

- Keg registration laws

Increase enforcement

- School campuses
- Sale of alcohol to minors
- Drinking and driving

Change social norms

- Social norms marketing programs
  - Informing students that most of their peers do not drink should lower drinking rates
- Limit advertising of alcohol to youth
- Educate parents and community
  - Effects of alcohol on development
  - Change "Right of Passage" norms

Options

Option 1: Take no action.

☑ **Option 2:** Introduce legislation to address the hosting of underage drinking parties.

Option 3: Designate a percentage or fixed amount (to be determined) of the additional revenue collected by the Department of Alcoholic Beverage Control for prevention of underage drinking and other substance abuse by youth. Additional revenue is expected to be generated through Sunday sales and additional retail locations.

Funds would be transferred to DMHMRSAS which would be responsible for contracting with local public and private agencies for provision of services.

No public comments were received for this study.

Review of CSB Child & Adolescent Services

James W. Stewart, III, Inspector General
Office of the Inspector General (OIG)
Mental Health, Mental Retardation and Substance Abuse Services

During the BHC Subcommittee's July 29th meeting, Mr. Stewart reported the findings of the OIG survey and report on services provided by community services boards (CSBs) for children and adolescents.

OIG Review Findings

In FY 2007, CSBs served a total of 42,089 children and adolescents or 2.2 percent of Virginia's population aged 0-17; 76.5 percent of the children/adolescents served received mental health services, 12.6 percent received substance abuse services, and 10.9 percent received services related to their intellectual disabilities. Key findings presented by Mr. Stewart include:

There are significant differences in the services available:

- "Whether measured by expenditures, staffing or percentage of child population served the availability of services for children and adolescents offered by CSBs varies widely among communities."
    - Budgeted mental health services varied substantially:
        - High of $258.36 per child/adolescent in Richmond City
        - Low of $0.96 per child/adolescent in Portsmouth
        - Average of $58.01 per child/adolescent
        - Median of $37.26 per child/adolescent
    - Mental health staffing ranged from 1.5 to 223 staff per CSB with staff to community child/adolescent population ratios of:
        - High of 1 to 237 child/adolescent population
        - Low of 1 to 15,380 child/adolescent population
        - Average of 1 to 3,038 child/adolescent population
        - Median of 1 to 1,997 child/adolescent population
    - Number of children/adolescents served by each CSB ranged from 48 to 3,094 with service penetration in the community of:
        - High of 10.21 percent in Planning District 1 (Lee, Scott, and Wise Counties, and the City of Norton)

- Low of 0.38 percent in Prince William
- Average of 2.2 percent
- Median of 1.6 percent

In terms of the sources of funding for CSBs, the review found that "State general funds and local funding make up a relatively small portion of total funds for child and adolescent services statewide. CSA funding to CSBs is also a limited source. CSBs that have developed the most extensive systems of services…have done so primarily through the use of Medicaid." In fact, for almost half of the CSBs, at least 50 percent of their funding came from Medicaid reimbursement. The review found that parents/ caregivers of the children who received CSB services reported "very high levels of satisfaction" although "few CSBs offer nationally recognized 'evidence-based practices' [and] identification and treatment of co-occurring SA & MH issues is less than optimal." The review also reported:

- "No CSB offers a complete array of C/A services with sufficient capacity to meet community needs.
- Many CSBs have very limited service systems and some provide only minimal levels of case management and emergency services.
- C/A services at CSBs are full to capacity, resulting in long waiting lists.
- Access to services for uninsured families is extremely limited."

Report Recommendations

The OIG report recommends that DMHMRSAS "lead an interagency process to develop a comprehensive plan for the provision of publicly supported, community based mental health, intellectual disability and substance abuse services for children, adolescents, and their families….It is further recommended that DMHMRSAS present the plan to the General Assembly clarifying the level of support that can be anticipated from non-state sources and identifying specific needs from state sources to enable responsible expansion of services in the first two years of implementing the plan." In addition, the recommendation went on to suggest continuing reports to the General Assembly in order to report on progress made in expanding services, in "leveraging funds from non-state sources" and to request any additional state funding needed.

Options

Option 1: Take no action.

Option 2: Request by letter from the JCHC Chairman that the Department of Mental Health, Mental Retardation and Substance Abuse Services share with the Joint

Commission the comprehensive plan for the delivery of behavioral health care services for children, adolescents and their families (if a plan is developed by July 2009 as recommended by the Office of the Inspector General).

☑ **Option 3:** Request by letter of the JCHC Chairman that the Secretary of Health and Human Resources ensure the development of a comprehensive plan for the delivery of behavioral health care services for children, adolescents and their families prior to the 2010 General Assembly Session. The letter would include the request for the plan to be submitted to the Joint Commission by October 1, 2009.

Mental Health Reform Initiatives

Authority for Study

Senate Joint Resolution 42 (Senator Lucas) directed JCHC to complete a two-year evaluation of "the impact of certain recommendations and legislation on the mental health system in the Commonwealth." Responsibility for the evaluation was assumed by the BHC Subcommittee which heard from a number of mental health system participants during Subcommittee meetings held in August and October.

Summary of Mental Health Reform Initiatives

Two tables follow. The first table (*Summary of 2008 Mental Health Reform Legislation*) summarizes the mental health reform legislation enacted during the 2008 General Assembly Session including substantive changes in:

- Commitment criteria by removing "imminent" from the dangerousness criteria.
  - Virginia was 1 of only 5 states that still included "imminent" danger in its requirement for commitment.
- Information/evidence considered for ECOs/TDOs (temporary detention orders) including treating physician's recommendation and relevant hearsay evidence.
- Involuntary commitment process such as the information to be considered by the special justice including the pre-admission screening report and independent examiner's report.
- Requirements for independent examiner and treating physician to attend commitment hearing or be available for questioning; in addition CSB representative must attend the hearing or participate via telephone or "two-way electronic video and audio communication system…."
- Mandatory outpatient treatment (MOT) plans which are to include the "specific services to be provided" as well as who will provide each service and the CSB responsible for the plan and for reporting "any material noncompliance to the court."
- Psychiatric inpatient treatment of minors by extending the maximum period of temporary detention from 72 to 96 hours and allowing a parent or legal custodian to authorize inpatient treatment for minors 14 and older who are "incapable of making an informed decision…."

The second table (*Summary of Potential 2009 Mental Health Reform Legislation*) summarizes mental health reform bills which may be considered during the 2009 Session. Three task forces – Future Commitment Reform, Advance Directives, and Access to Services – considered bills which were carried over from 2008. Richard J. Bonnie, L.L.B., Chair of the Commission on Mental Health Law Reform indicated "a Progress Report on Mental Health Law Reform" will be sent for your review in December. The report will summarize "the Commonwealth's early experience in implementing the 2008 reforms" and suggest additional legislation to consider for 2009. (The legislation is likely to be in the areas listed in the table such as transportation, the Health Care Decisions Act, and allowing mandatory outpatient treatment to follow inpatient commitment or to prevent hospitalization.)

SUMMARY OF 2008 MENTAL HEALTH REFORM LEGISLATION

	New Commitment Criteria
HB 499 (Hamilton) **SB 246** (Howell)	Removes "imminent" from dangerousness criteria for commitment.
HB 499 (Hamilton **SB 246** (Howell) **HB 559** (Bell)	Adds more specific criteria to "substantially unable to care for self" criteria.
	Emergency Custody Order (ECO) Changes
HB 499 (Hamilton) **SB 246** (Howell) **HB 583** (Marsden)	Permits magistrate to renew 4-hour ECO for up to 2 additional hours for good cause.
HB 401 (Hamilton) **SB 81** (Cuccinelli)	Permits law enforcement to transfer custody of person to crisis stabilization or other facility under certain circumstances.
	Information/Evidence Considered for ECOs/TDOs (Temporary Detention Orders)
HB 499 (Hamilton) **SB 246** (Howell) **HB 1144** (Fralin)	Adds detailed list of information and evidence, including recommendations of any treating physician and relevant hearsay evidence.
	Involuntary Commitment Changes
HB 499 (Hamilton) **SB 246** (Howell) **HB 1144** (Fralin)	Adds detailed list of information and evidence to be considered by the special justice including the pre-admission screening and independent examiner's report.
HB 499 (Hamilton) **SB 246** (Howell)	Provides sufficient time to allow for completion of examiner's report and preadmission screening report and initiation of treatment to stabilize person's psychiatric condition to avoid involuntary commitment. Defines more specifically the licensed mental health professionals who (if a psychiatrist or licensed psychologist is not available) may complete an independent examination. These professionals include "clinical social worker, licensed professional counselor, psychiatric nurse practitioner, or clinical nurse specialist…." (These newly authorized professionals are required to complete a certification program approved by DMHMRSAS.)
HB 499 (Hamilton) **SB 246** (Howell) **HB 560** (Bell)	Provides comprehensive list of what examination must consist of, including clinical assessment and review of TDO facility records, labs and toxicology reports, admission forms and nurses notes. Requires independent examiner, treating physician, and CSB representative to attend hearing or be available for questioning by telephone or two-way electronic video and audio communication system.
HB 499 (Hamilton) **SB 246** (Howell)	Allows another CSB to attend the hearing if it is outside the "home" CSB's area with detailed procedures regarding delivery of reports and receipt of orders entered. The Court must provide time and location of hearing to CSB at least 12 hours prior to hearing. Reduces duration of initial involuntary inpatient treatment order from 180 days to 30 days; any subsequent order for involuntary inpatient treatment shall not exceed 180 days.

Mandatory Outpatient Treatment (MOT) Changes

HB 499 (Hamilton)
SB 246
(Howell)

Indicates MOT treatment criteria is the same as for inpatient treatment but MOT must be deliverable on out-patient basis by CSB or designated provider, services must actually be available in community, and providers must actually agree to deliver the services.

Limits MOT duration to 90 days initially unless continued for not more than 180 days (per continuance; MOT order to designate that CSB where person resides is to monitor plan and report material noncompliance to Court.

Spells out MOT requirements for CSB including: development of initial treatment plan and filing of compre-hensive plans with Court; detailed requirements for CSB monitoring of compliance and reporting to court; court review hearings; transportation to hearings and exams; and mandatory examination orders and capias.

Requires Court clerk to serve notice of hearings and orders.

Hearing Records and Privacy Disclosures

HB 499
(Hamilton)
SB 246
(Howell)

Requires all court documents to be confidential but permits dispositional order to be provided upon written motion if court finds disclosure in interest of person or public.

Requires records to be available to all treatment providers and CSB (including MOT providers).

Requires providers to disclose to one another all information on a person involved in juvenile or adult com-mitment hearings or jail transfer hearings; ECOs, TDOs, court orders, and health records to be provided to other health care providers and others involved in process. Provides immunity from civil liability for these disclosures unless harm intended or acted in bad faith.

Psychiatric Inpatient Treatment of Minors

SB 247/SB 67
SB 68
(Howell)
HB 400/HB 402
(Hamilton)

Extends maximum period of temporary detention from 72 hours to 96 hours; requires appointment of both counsel and guardian ad litem; allows minor, age 14 or older and incapable of making informed decision to be admitted for inpatient treatment upon parental admission; and removes need for service of petition and notice of hearing when petition withdrawn or dismissed.

SUMMARY OF 2009 MENTAL HEALTH REFORM LEGISLATION

Legislation Carried Over from 2008	Bills Referred to MHLR Commission	Potential MHLR Commission Legislation

Task Force on Future Commitment Reform

HB 735 (Caputo)
Allowing 3rd year law students to represent petitioners in commitment hearings

SB 274 (Cuccinelli)
Transfer to outpatient treatment

SB 177 (Marsh)
Assisted outpatient treatment

HB 267 (Albo)
Appointment of counsel for indigent petitioners in commitment hearings

HB 938 (Gilbert)
Petitioner right of appeal

SB 102 (Cuccinelli)
3-tier transportation system

SB 106 (Cuccinelli)
Substantial deterioration outpatient commitment criteria

SB 143 (Edwards)
Extension of TDO to 96 hours

SB 214 (Edwards)
Mandated special justice training

SB 333 (Cuccinelli)
Independent examiner authorization to release detained persons

SB 335 (Cuccinelli)
Offer of voluntary outpatient treatment to detained person; conditions

Transportation

Allow persons and entities other than law enforcement to transport for ECOs/TDOs

Privacy Proposal
Permit health care providers to notify family members or personal representative of person's location and general condition

Health Care Decisions Act
Would permit health care agent designated by person in advance directive or guardian authorized by circuit court order to admit person who is determined incapacitated to mental health facility for up to 7 days

Independent Examiner Training Proposal
Psychiatrists and psychologists should also be required to complete DMMRSAS certification program

Would provide training on requirements of VA law on commitment and health records privacy

Task Force on Advance Directives

HB 1004 (Bell)
Advance mental health directives

SB 47 (Whipple/Lucas)
Advance mental health directives

Legislation Carried Over from 2008	Bills Referred to MHLR Commission	Potential MHLR Commission Legislation

Task Force on Access to Services

SB 16 (Edwards)
Crisis intervention teams

SB 18 (Edwards)
Pilot mental health courts

SB 65 (Howell)
MH representation on community criminal justice boards

SB 138 (Puller)
DOC to identify medical and psychiatric benefits for prisoners

SB 275 (Cuccinelli)
Emergency psychiatric treatment for inmates

SB 440 (McEachin)
Emergency psychiatric treatment for inmates

SB 64 (Howell)
Mandated CSB core services

Rights of Persons in Commitment Process

Provide person opportunity to have family member, friend or personal representative notified of hospitalization and transfer

Add to events that permit set aside of default judgment for person involuntarily detained or admitted to mental health facility

Additional Legislation

Allow for extension of TDO to 4 or 5 days

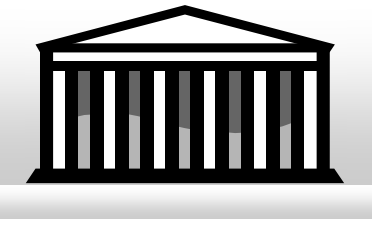
Allow for mandatory outpatient treatment after inpatient commitment

Allow for mandatory outpatient treatment to prevent inpatient hospitalization

Commission for Special Collaborative Study with SCHEV

HB 751 (Peace)
Providing mental health information to colleges and universities

HB 752 (Peace)
Medical record release information



Long-Term Medicaid Reform Subcommittee

Virginia Medicaid Policies: Implications for Health System Performance, Care Integration/Improvement and Communities

Chris Bailey, Senior Vice President , Virginia Hospital & Healthcare Association
Scott Burnette, President/CEO, Community Memorial Healthcenter
Stephen Morrisette, President, Virginia Health Care Association

On August 12th a health care provider and two provider organizations presented to the Long Term Care and Medicaid Reform Subcommittee about Virginia's Medicaid system and the effect of recent budget reductions on long-term care. The following summarizes key points from the presentations.

Virginia's Medicaid System

Virginia's Medicaid system is a lean system with conservative eligibility, aggressive utilization controls, low provider payments, and relatively extensive managed care systems. As compared to other states, Virginia is 48th in Medicaid spending per capita, 48th in eligibility for working parents (< $6,000), and 45th in state-directed health spending as a share of total state budget (17%).

In 2008, Medicaid payment rates to hospitals were cut and these cuts have significant implications, including "greater inflationary pressure on private health care costs, delayed care also means more expensive care later, and foregone matching funds." Every $1 in General Fund savings yields $2 in cuts to providers and the related economic impact (because of the 50 percent federal match for Medicaid).

Medicaid Payments to Nursing Facilities

Most nursing facility residents have their care paid for by Medicaid. Consequently, Medicaid payment rates have a significant effect on the operations of nursing facilities. Seventy-two (29%) of the 250 nursing facilities that reported to Virginia Health Information in 2006 reported operating losses for the year.

> "While Virginia has made some headway in raising reimbursement for Medicaid nursing home care, rates still significantly lag most surrounding states, despite the fact that we have higher average acuity levels." Virginia's daily nursing home rate is $142 as compared with the following rates of three surrounding states:
>
> - Maryland $203
> - North Carolina $150

- West Virginia $174

VHCA and VHHA believe nursing facilities sustained deeper reductions than the General Assembly intended in taking action during the 2008 Session. Results of a VHCA-member survey conducted in July 2008 indicate that operating costs increased the past year by 5.1 percent. This increase was significantly higher than the Medicaid estimate for the cost increases which was 2.8 percent. Further, nursing homes' cost of operation is being impacted by the rising costs of fuel and energy, food, medical supplies, and staffing.

Recommendations

VHHA and VHCA made several general recommendations, to:

- "Pursue administrative efficiencies (e.g. modern enrollment and uniform assessment systems to save state and provider time)
- Continue prudent investment in care management and care coordination systems with emphasis on quality improvement, strong linkages to local systems and transparency of funding/results
- Partner with other employers and payers on system performance improvement (e.g., chronic disease)"

JCHC staff contacted VHCA and VHHA regarding any specific recommendations they might have. For short-term options they urged policymakers to ensure reductions are spread evenly across all areas of the budget and to consider that every Medicaid dollar cut is a $2 dollar cut in services. Regarding a long-term recommendation, VHCA and VHHA posited a counter cyclical nature of Medicaid and a belief that it is the only major state program in which demand grows when state revenues are most tight. To address this challenge, it was suggested that DMAS study converting the Virginia Health Care Fund into a Medicaid Stabilization Fund, including potential funding sources and rules to access the funds.

DMAS Comments on the Virginia Health Care Fund

Cindi Jones, Chief Deputy Director of the Department of Medical Assistance Services (DMAS) discussed the issue of converting the Virginia Health Care Fund into a Medicaid Stabilization Fund with JCHC staff.

The Virginia Health Care Fund (VHCF) is a special non-reverting fund established in 2004 to be used in lieu of general funds for health care services. Moneys deposited into VHCF include:

- Forty percent of Virginia's allocation of Master Settlement Agreement funds
- Tobacco tax revenues
- Tobacco manufacturer escrow funds
- Medicaid recoveries

VHCF funding is being used to reduce Medicaid's demands on the state's general fund. Since FY 2005, all funds in the VHCF have been appropriated for the Virginia Medicaid program. Deposits into VHCF are fully utilized each year to help pay the state share of Medicaid expenditures. VHCF contributed $296 million of the $2.89 billion that made up the state share of DMAS' budget in FY 2008.

The idea of allowing VHCF funding to be placed into a Medicaid-specific "rainy day fund" poses several issues. First, if funds currently allocated to support Medicaid spending will be used instead to create a "reserve" for later years, the state would need to allocate additional general fund dollars to make up for the lost "reserve funding." Second, DMAS believes there is a significant policy question as to whether policymakers want to consider a specific rainy day fund for one agency, when the state already has one that is not agency specific.

DMAS would not object to a study, which could be a joint study with the Department of Planning and Budget or could be studied independently by JLARC. If undertaken, DMAS believes the study should focus on the relationship between two counter-cyclical phenomena - tax revenue and Medicaid enrollment and expenditures. Additional questions that would need to be addressed include how much of a reserve would be needed to maintain adequate Medicaid funding when tax revenue is lower and when Medicaid spending is higher.

Options

☑ **Option 1:** Take no action.

Option 2: Request by letter of the JCHC Chairman that DMAS study the idea of transforming the Virginia Health Care Fund into a Medicaid Stabilization Fund including potential funding sources and rules for accessing the funds.

Joint Commission On Health Care

Staff Report:
Section 125 Plans

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Authority for Study

In 2006, Senate Joint Resolution 4 directed JCHC to study 1) the derivative effects of increases in health care costs on health insurance premiums and 2) ways to reduce health care costs. Stemming from that study, in 2008 JCHC recommended continuing the study to review the advisability of:

i) establishing a Virginia health insurance exchange targeted for small businesses,

ii) increasing employer adoption of Section 125 plans, and

iii) any other health insurance issues as deemed appropriate.

Report Findings

Health insurance costs continue to increase. One way to make health insurance more affordable is for more employers to allow employee payment of premiums with pre-tax dollars, which can result in savings of 25 to 40 percent for the employee. According to the Agency for Healthcare Research and Quality, many of the over 400,000 Virginians offered employer-sponsored health coverage cannot pay health insurance premiums with pre-tax monies. However, if employers adopt a Section 125 Plan, their employees are allowed to pay their health insurance premiums with pre-tax dollars. Section 125 Plans are defined in the U.S. Internal Revenue Code and are commonly known as "cafeteria plans." In addition, Section 125 Plans may reduce the payroll taxes owed by employers that offer employee health insurance. (To qualify for the payroll tax reduction, the employer must pay some but not all of the cost of their employees' health insurance as required by Section 125 of the U.S. Internal Revenue Code.)

Description of Section 125 Plans. Section 125 Plans are detailed documents created by or for employers to enable employees to purchase health insurance policies with pre-tax dollars. (These Plans are designed in conformance with requirements of Section 125 of the U.S. Internal Revenue Code and apply to group insurance plans.) The use of pre-tax dollars reduces FICA (Social Security and Medicare payroll tax) and federal and state income tax liabilities for participating employees, thereby reducing the "experienced" cost of health insurance coverage. An example of the potential savings is shown on the next page.

Individual Earning $50,000 Annually		Single
VA Small Group avg. monthly premium (2006)		$ 246
Payroll deduction amount (through 125 plan)		$ 246
Reduction in FICA tax →	7.65%	$ 19
Reduction in federal tax liability →		$ 44
Reduction in VA state tax liability →	5.2%	$ 13
Net premium cost to employee		$ 170
Total Monthly Tax Savings →	**31%**	**$ 76**

While there are three versions of pre-tax plans defined in the Internal Revenue Code, the policy options below address the simplest version, the Premium-Only Plan (POP). POPs are plans that allow for pre-taxing for only health insurance premiums. The Internal Revenue Code specifies certain limitations for Section 125 Plans including:

- Plans cannot be set up to cover self-employed individuals, partners in a partnership, and directors and limited partners in a limited liability corporation.
- Employers that do not offer health insurance or that pay 100 percent of their employees' health premiums would realize no reduction in their payroll tax liability by establishing a Plan.
- While Section 125 Plans can significantly decrease the cost of health insurance for many employees, it does not make insurance inexpensive so many employed Virginians would still be unable to afford health insurance.

Section 125 Plans in Virginia. As noted, Section 125 Plans can result in significant cost-savings for employees and employers. Despite this fact, many businesses in Virginia, particularly smaller businesses, have not adopted a Plan.

- Sixty-eight percent of small businesses, employing approximately 291,000 individuals that offer health insurance do not offer a Section 125 Plan. (Small business is defined as having fewer than 50 employees.)
- Only eight percent of larger businesses (with 50 or more employees), employing approximately 139,000 individuals that offer health insurance do not offer a Section 125 Plan.

There are a number of reasons that Section 125 Plans have not been adopted more broadly. There is a perception that establishing a Plan would result in significant increased administrative burden, as well as questions regarding the cost and time it would take to understand and develop the Plan. In addition, there are negative tax consequences if a Plan is not set-up correctly. However, the primary reason that more employers have not adopted a Section 125 Plan is that employers lack knowledge about such Plans. When Section 125 Plans are understood, the challenges associated in creating them are generally minor while the benefits are significant.

Additional Health Insurance Issues. There is no consistent resource in Virginia's health insurance market to assist employers in determining all of the health insurance options available in their area. A listing of health insurers and contact information by locality could be developed and added to the health insurance section of the Virginia Health Information (VHI) website.

Options

Option 1: Take no action

Option 2: Amend the *Code of Virginia* to mandate that employers offer a Section 125 Plan if all of the following provisions are met:

- At least 10 full-time employees
- Group health insurance is offered
- Employee pays some part of the health insurance premium

Note: No requirement for employers to provide health insurance or contribute to plan premiums.

Option 3: Request by letter of the JCHC Chairman that the Department of Human Resources Management (DHRM) in consultation with the Department of Business Assistance (VDBA) create a:

- Brief electronic document highlighting Section 125 benefits to post on the VDBA website and on Virginia's business portal website.

Option 4: Request by letter of the JCHC Chairman that the Department of Human Resources Management in consultation with the Department of Business Assistance (VDBA) create a:

- Detailed electronic document highlighting Section 125 benefits; requirements for adoption; and COBRA, ERISA and HIPPA implications to

post on the VDBA website and on Virginia's business portal website.

☑ **Option 5:** Request by letter of the JCHC Chairman that the Department of Human Resources Management in consultation with the Department of Business Assistance (VDBA) create a:

- Detailed electronic document highlighting Section 125 benefits; requirements for adoption; COBRA, ERISA, and HIPPA implications; and a simple Section 125 Plan form to post on the VDBA website and on Virginia's business portal website.

Option 6: Amend the *Code of Virginia* to require employers to affirm on the Virginia Department of Taxation Form VA-6 that:

- Employer has a Section 125 Plan, or
- Employer has read the State-created document regarding Section 125 Plans.

Option 7: Request by letter of the JCHC Chairman that the State Corporation Commission consider and report to JCHC on including Section 125 Plan information on both the Health and the Life & Annuities & Health insurance examinations.

☑ **Option 8:** Request by letter of the JCHC Chairman that the Virginia Chamber of Commerce inform its membership of Section 125 Plans and associated benefits through its newsletter.

☑ **Option 9:** Request by letter of the JCHC Chairman that the National Federation of Independent Businesses/Virginia include information on Section 125 Plans as part of the Federation's Area Action Council meetings with small businesses.

☑ **Option 10:** Include in the 2009 workplan that the Joint Commission convene a workgroup to compile information needed for an informational website on health insurers to be hosted by Virginia Health Information (VHI) with appropriate linkages on other state websites and address other health insurance issues as appropriate. The workgroup to develop the website should include:

- National Federation of Independent Businesses
- Virginia Association of Health Plans
- Virginia Association of Health Underwriters
- Virginia Chamber of Commerce
- Virginia Department of Health

- Virginia Department of Business Assistance
- Virginia Health Information

Public Comments

Keith D. Cheatham, Vice President of Government Affairs, commented on behalf of the **Virginia Chamber of Commerce in support of Options 3 and 8**. Mr. Cheatham's letter indicated the following:

> "Section 125 Plans can make purchasing health care more affordable by providing considerable tax savings to employers and employees. Of the nine policy options you present, we would **support Options 3 and 8**…The Virginia Chamber, a small business itself, has offered a Section 125 Plan for years, so we are well aware of its benefits and costs. It has been a positive experience for us and our employees."

Interim Staff Report:
Analysis of Health Workforce Pipelines

(Physicians, Dentists, Clinical Psychologists and Pharmacists)

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Background

This study was the result of a policy option presented to the Joint Commission last year concerning the shortage of geriatricians in the Commonwealth. The policy option called for a two-year study by JCHC of Virginia's pipeline for the education of certain health care professionals as compared with the projected need for those professionals.

The statewide demand for health care is envisioned to increase, especially as the Commonwealth's population over the age sixty-five increases.

According to the Virginia Department of Health's FY 2007 Workforce Report, Virginia's general population is expected to increase by 17% between 2000 and 2020, whereas the growth among the population over 65 years of age will increase by 65%.

Report Findings

This two-year study will focus on the educational pipelines as well as professional responsibilities for physicians (including some specialists such as psychiatrists), dentists, clinical psychologists and pharmacists. The Interim Report provides general information pertaining to the 2008 educational pipelines (see Table below).

HC Professional	# Licensed	Type of Institution Offering Degree Program	# Degree Programs	2008-09 Enrollment	2008 Graduates	2007-08 General Fund Appropriation *in millions*
Physicians	16,191	Public	3	1745	418	$50.6
		Private	*1*	*680*	*139*	*$0.0*
Dentists	4,995	Public	1	374	92	$6.6
		Private	*0*	*0*	*0*	*$0.0*
Clinical Psy-	2,434	Public	8	317	38	***
		Private	*3*	*536*	*75*	*$0.0*
Pharmacists	9,636	Public	1	512	115	$4.1
		Private	*3*	*745*	*187*	*$0.0*

In the course of conducting this study, it was revealed that the Board of Medicine does not save an annual historical copy of the Doctor's Profile Database, containing information about the physician, their practice and location. Archiving this information on an annual basis would be a simple procedure that is necessary in developing accurate trend models and making projections about physician practices.

Year-Two

Year-two research will address questions in the four health care professional areas, identifying:

- the most critical short-term and long-term shortages
- state investment in health care professional education to marketplace need
- cost-effective ways to increase the supply of high-need health care providers
- professional area trends that will affect meeting Virginia's future health care needs

Policy Option Note: To enhance year-two activities, the Edward Via Virginia College of Osteopathic Medicine's (VCOM) National Center for the Analysis of Healthcare Data has offered to conduct joint research with JCHC staff. VCOM's National Center has personnel who specialize in studying health care workforce issues as well as data resources that JCHC could not procure. Accordingly, a joint-research venture would significantly enhance the comprehensiveness of the study.

Options

Option 1: Take no action.

☑ **Option 2:** Request by letter of the JCHC Chairman that the Virginia Board of Medicine save an electronic archive copy of the Doctor's Profile Database annually.

☑ **Option 3:** Authorize JCHC staff to conduct joint research with VCOM's National Center for the Analysis of Healthcare Data in completing the workforce pipeline study (to be reported to JCHC by November 2009).

No public comments were received.

Staff Report:
Alternatives to Long Term Care
and Support for Family Caregivers

Michele L. Chesser, Ph.D.
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Authority for Studies

Alternatives to Long-Term Care. House Joint Resolution 69 (Patron: Delegate Kenneth Plum) directed the Joint Commission on Health Care to study alternative solutions to long-term care needs including identifying and reviewing alternatives to traditional long-term care facilities such as intentional communities of clustered homes. The resolution was left in the Committee on Rules but the study was completed upon request by Delegate Phillip Hamilton.

Support for Family Caregivers. Senate Joint Resolution 102 (Senator Walter Stosch) and House Joint Resolution 238 (Delegate Stephen Shannon) directed the Joint Commission on Health Care to study support services for family caregivers of the frail elderly and disabled and community-based caregiver support organizations. SJR 102 was agreed to by both houses of the General Assembly.

Alternatives to Long-Term Care

The traditional long-term care model is not designed to help elders age at home. Instead, it is based on the use of large institutional facilities operated according to a medical model that emphasizes efficiency, a hierarchical management structure, rules, routines, and requirements. The great majority of individuals prefer to live at home as long as possible and, when it is time, to live in a facility that offers a more personal, home-like environment. Many state governments are enacting new programs and/or changing the way their aging agencies are structured to help older individuals stay in their homes longer (e.g. increasing the availability of services and adopting consumer directed programs); and the culture change movement has resulted in widespread changes in nursing and assisted living facilities nationally and in Virginia. Initial research has shown that culture change increases the quality of life for residents and the work environment for staff, lowers turnover rates, and that many improvements can be accomplished without substantially increasing operating costs.

The Green House Model. The Green House model represents the most transformational culture change currently used. Six to ten elders live together in a 'house' with a central hearth, kitchen, and dining area where all elders and staff

interact in a more familial manner. The work structure is less hierarchical and staff members are empowered to make decisions as a collective, with elder input. Challenges to The Green House model include high capital costs, low Medicaid rates, and the obstacles involved in moving Green House homes off of campuses and into communities "where people live and homes belong." To address these problems and facilitate the creation of more Green House homes, the project's director recommends the following:

- Create programs to offset development costs for low-income projects
  - Tax credit equity programs, targeted grants, and interest rate reductions
- Work with states to enhance Medicaid reimbursement rates for person-centered models of care
- Support fast-track review process for state plan amendments that relate to payment rate changes for Green House providers

Aging at Home. Aging at home requires the ability to obtain needed services at home such as nursing, companion and chore services, support for caregivers, and technology. Virginia is moving in the right direction with the creation of No Wrong Door, Virginia Easy Access, Program for All Inclusive Care for the Elderly (PACE), and the Money Follows the Person program; however, there are still challenges such as:

- Limited reimbursement for in-home care
- Fragmented services and funding sources
- Personal in-home care under Elderly or Disabled with Consumer Direction (EDCD) Medicaid waiver is restricted to individuals who meet nursing home criteria (assistance with 4 of 5 activities of daily living)

Two innovative approaches to helping elders age at home are the Cash and Counseling Program and Intentional Communities.

- The Cash and Counseling Program is a consumer-directed model that empowers individuals to control their community support services by allowing elderly and disabled Medicaid consumers who receive personal assistance services to direct their own care through a flexible budget they control. Participants can use their allotted budget to hire personal care aides, purchase items or services (including home modifications), and/or pay a family caregiver. The program also includes a counseling component to provide assistance in planning budgets, handling employee wages and tax paperwork, and accounting for expenditures.

- Intentional communities are non-profit organizations founded by residents that provide support to residents who wish to stay in their homes as they grow older. Members email or call a single telephone number to arrange assistance or to participate in a variety of activities. Services that typically are provided include transportation, home maintenance, assistance with paperwork, occasional meal preparation and companionship, and weekly grocery shopping. Intentional communities provide programs and services more cost-effectively than most conventional retirement communities.

Support for Family Caregivers

Family caregivers provide help with household chores, personal care, transportation, medication, companionship, paying bills, and coordinating services outside the home. In the U.S., 44 million Americans (1 in 5 adults) provide unpaid care, valued at a cost of $350 billion a year. In Virginia, 740,402 caregivers provide 793 million hours of unpaid care, valued at a cost of $7.8 million a year.

Many family caregivers have unmet needs and stress factors such as unrelieved caregiver burden, exhaustion, financial pressures, health risks, emotional strain, mental health problems, workplace issues, retirement insecurity, lost opportunities, and legal concerns. Very often, the result of these stressors is early placement of loved ones into nursing homes. In order to reduce the burden experienced in the caregiver role, caregivers need greater emotional support, access to information and resources, guidance in the decision making process, support from employers, and relief from the financial burden of caregiving. Primary funding sources for family caregiver support in Virginia are the National Family Caregiver Support Program, Virginia Caregivers Grant (which was eliminated from 2008-2010 state budget), Virginia Respite Care Initiative Grant, and Home and Community Based Care waivers.

Model Caregiver Support Programs. Currently there are several programs in other states that can be used as a model for Virginia to provide better support to family caregivers. Key elements of these programs that could be replicated in Virginia are:

- Single coordinating organization for all services
- Central point of entry to caregiver resources and information
  - On-line resource center
  - Standardized call center
- Caregiver assessment
- Consumer direction
- Family caregiver education and training programs

Options

Option 1: Take no action.

☑ **Option 2:** Continue study for one additional year to research options for improving "aging at home" services and support for culture change initiatives in Virginia.

Public Comments

The Virginia Association of Nonprofit Homes for the Aging, AARP, and four representatives of the Virginia Mennonite Retirement Community commented in support of this option.

> Julie Grandle, Resident Association Council President of Virginia Mennonite Retirement Community (VMRC), urges the Commission to continue to consider ways to enable more Virginia seniors to stay in their homes as they age and to make this issue a priority.
>
> Sue Ayscue, Director of Nursing of Virginia Mennonite Retirement Community, asks for continued support for culture change initiatives for Virginia's elders in need of long-term care and for solutions that will improve 'aging at home' for this population.
>
> Ron Yoder, President/CEO, and Sheryl Wyse, Chair of the Board of Directors, also commented on behalf of VMRC.

☑ **Option 3:** Restore funding for Virginia Caregivers Grant when budget allows.

Public Comments

The Virginia Association of Nonprofit Homes for the Aging commented in support of this option.

AARP requested that in lieu of Option 3, JCHC include in its legislative package a budget amendment for $500,000 in FY 2009 for the Virginia Caregivers Grant program.

☑ **Option 4:** Assist local Chambers of Commerce in educating Virginia business owners about caregiver workforce issues and encourage owners to provide caregiver support programs.

Public Comment

The Virginia Association of Nonprofit Homes for the Aging and AARP commented in support of this option.

Staff Report:
Various Responses to Medical Errors

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Authority for Study

HJR 101 of the 2008 General Assembly directed the Joint Commission on Health Care to study, in the case of medical errors and adverse medical outcomes, the use of disclosure, apologies, alternative dispute resolution and other measures. JCHC was also directed to study the impact of such measures on the cost and quality of care, patient confidence and the medical malpractice system.

Report Findings

When there is medical error, needs and concerns arise for both the patient and the Health Care Provider (HCP). The injured patient may need but not receive: an explanation of what happened or an apology; adequate compensation; or reassurance that steps have been taken to assure that the error is not repeated. The HCP may feel powerless to talk openly with the injured patient about what happened and to express an apology. It may be difficult for the HCP to determine how to balance ethical and legal responsibilities with personal, professional and financial liability when deciding what and how to disclose.

Several disincentives exist to disclosure of medical errors:

- Government investigations triggered by Federal and state reporting requirements
- Raised premiums and discontinued malpractice coverage
- Possible waiver of peer review privileges
- Possibility that defense costs could actually rise due to an increased number of claims
- Loss of professional reputation
- Fear of a lawsuit

Fear of lawsuits and loss of reputation remain the biggest barriers to disclosure of medical errors.

However, studies suggest that a majority of patients sue, not because of injury but because they believe: they are not treated with respect, not told the truth, or the HCP has not taken responsibility for his/her actions. The silence of the "deny and defend" culture breeds anger, and is a major determining factor in a patient's decision to sue.

Incentives for disclosure of medical error include:

- Rebuilding trust and solidifying the provider/patient relationship, thereby decreasing malpractice litigation and reducing overall costs.
- Creating a culture of transparency and accountability that fosters an environment where medical errors are identified and corrected, thereby buttressing the patient safety movement.
- Acknowledging an error gives an institution the freedom to correct the mistakes and theoretically prevent future harm and improve patient safety.
- Increasing patient confidence in the integrity of the health care system.
- Encouraging care to be patient-centered, not based on the protection of the organization.

A movement promoting disclosure programs in the medical setting is taking root nationwide. Across the country, including in Virginia, hospitals have been voluntarily implementing disclosure/early resolution programs. Each program has a unique approach but some consistent characteristics include:

- Focusing on early resolution (pre-claim) of the issues.
- Having transparency and accountability as the intended purpose for implementation, not a decrease in medial malpractice costs.
- Having procedures in place to determine, before a disclosure conversation is initiated, if and how an adverse event occurred.
- Having clear policies as to who makes the initial disclosure, as well as future disclosure conversations.
- Employing a strong education/training/support element for all involved.

Options

Option 1: Take no action.

☑ **Option 2:** The JCHC should convene a Task Force consisting of representatives of the primary stakeholders in this subject area – to include the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Department of Health, Department of Health Professions, Board of Medicine, the Virginia Trial Lawyers Association, the Virginia Association of Defense Attorneys, the medical malpractice insurance industry and broader physician, health care provider and consumer representation. We recommend that the JCHC charge this task force with:

- building upon the work already done by the 101 Study Committee;
- developing agreed-upon working definitions of key terms such as adverse

outcome, medical error, and disclosures, to facilitate discussions in Virginia of the issues;

- tracking results and developments in disclosure and resolution programs now operational in Virginia and other states, and federal developments in this area;
- crafting a model or models for disclosure and early resolution programs that could be offered to Virginia health care providers, insurers and attorneys for their use;
- should such a model or models be developed, considering ways to incentivize health care providers to try use of such models and to report outcomes of their use with regard to several factors, including cost, claims experience, impact on quality/patient safety efforts and reported patient/provider satisfaction;
- should the Task Force decide not to offer such model(s), explaining the reasons.

Public Comments

The Virginia Hospital & Healthcare Association (VHHA) commented in support of Option 2.

> "The study committee made significant progress identifying issues raised by this complex topic…One important issue identified is the need to protect the information disclosed to patients so that it is used for its intended ethical, patient safety and legal purposes and not used against providers; current Virginia law dos not address this issue clearly. VHHA maintains that the appropriate goal in addressing medical errors and adverse events is accountability when mistakes occur; fair, reasonable compensation for those injured by mistakes; and protection of access to quality health care services by maintaining a stable statewide health care liability environment that provides reasonable risk management for providers. The work of the HJR 101 Study Committee has begun the work of finding appropriate alternatives to litigation that accomplish these goals, and we hope the Joint Commission on Health Care will support continued discussion of these issues by a task force appointed for this purpose."

Sunset Date for the Joint Commission on Health Care

In 1992, when the Joint Commission on Health Care was established to continue the work of the Commission on Health Care for All Virginians, a sunset date of July 1, 1997 was included. The sunset date has been extended three times resulting in a current sunset date for the Joint Commission of July 1, 2010.

Joint Commission members may wish to extend the sunset provision by another five years or remove the sunset provision. Other legislative commissions with similar objectives as JCHC, including the Joint Legislative Audit and Review Commission, the Virginia Commission on Youth, and the Virginia State Crime Commission, have no sunset provision in their statutory language. Examples of other legislative commissions that have specific sunset dates include the Advisory Council on Career and Technical Education, the Commission on Electric Utility Regulation, and the Virginia Commission on Energy and the Environment.

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, 2015.

Option 3: Introduce legislation to amend the *Code of Virginia* § 30.170 to remove the sunset provision.

Correct Mistake in Enacted Statutory Language Introduced in 2008

Two bills (HB 1203 and SB 381), introduced by JCHC during the 2008 General Assembly Session, were amended (mistakenly) in slightly different ways. As introduced, the bills sought to allow an individual with a misdemeanor conviction of assault or assault and battery against a family or household member to be assessed by a community services board (CSB) or a DMHMRSAS-licensed provider for possible employment in an adult mental health program.

- To qualify for the assessment, the misdemeanor offense would have to be substantially related to the individual's mental illness and the individual would have to be successfully rehabilitated.
- This type of assessment has been allowed for individuals seeking to work in adult substance abuse programs since 2001 (*Code of VA* §§ 37.2-416 and 506).

The Health, Welfare and Institutions Committee voted to remove from both bills, the provision that would allow for a conviction of assault and battery against a family member.

- HB 1203 was amended appropriately.
- However, in SB 381 the provision was removed from *Code* § 37.2-416 (addressing employment by DMHMRSAS-licensed providers) but was not removed from *Code* § 37.2-506 (addressing employment by CSBs).

The mistake was not discovered until after both bills were signed by the Governor, and since SB 381 was signed last, its provisions became law on July 1st.

Options

Option 1: Take no action.

☑ **Option 2:** Introduce legislation to amend the *Code of Virginia* § 37.2-416 to remove the provision allowing an individual with a conviction of assault and battery against a family member to be assessed for employment by community services boards.

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