



# **Joint Commission on Health Care**

## **Decision Matrix for 2006 General Assembly**

**November 10, 2005**

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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 2005.
- B. To develop Commission recommendations to advance to the 2006 General Assembly.

## **Sunset Date for Health Partnership Authorities**

HB 2060 (2001 General Assembly Session) amended *Code of VA* Title 32.1 Chapter 4 by adding Article 6.1 (§§ 32.1-122.10:001 through 32.1-122.10:005):

- Authorized single or multi-jurisdictional health care partnership authorities to allow government and private entities to join forces to address the health care needs of an area
  - Pilot project in Planning District 8 established (i.e. PWHPA)
  - Evaluation of the pilot project by JCHC required by November 2002
- Provided basic outline for the local authority with provisions for membership, board of directors, meeting and voting requirements, and outline of powers and duties
- Required approval by each participating locality
- Allowed for disclosure of medical records
- Protected volunteers from civil liability for noninvasive or minimally invasive procedures
- Included sunset provision for July 1, 2003.

### Legislative Actions during the 2003 General Assembly Session

SB 1068, introduced on behalf of JCHC, and a companion bill HB 1695, introduced by Delegate McQuigg amended *Code of Virginia* § 32.1-122.10:001 to delete the reference to the pilot project in Planning District 8 substituting the language “Any authority created pursuant to this article shall report on programmatic initiatives on an annual basis to the Joint Commission on Health Care.” *Code of Virginia* § 32.1-122.10:002 was amended to extend the sunset date for authorizing local health partnership authorities to July 1, 2006.

### Current Operation of the Prince William Health Partnership Authority

PWHPA operations are supported by the two area hospitals and private and federal grant funding. Prince William Partners, a non-stock corporation has been established as a 501(c)3 holding company. Since 2003, PWHPA has served 1,250 children through programs funded by the following grants:

- \$100,000 (2003): 1st year of Federal grant for youth drug prevention programs
- \$100,000 (2004): 2nd year of Federal grant for youth drug prevention programs
- \$31,000 (2004): Private grant from Kaiser Health Foundation for program to combat youth obesity epidemic.

In October, a 3-year, \$300,000 SAMHSA grant was awarded to “support programs that help youth avoid use and/or abuse of alcohol, tobacco and other drugs.”

OPTIONS

Option I: Take no action (which would allow the legislation to sunset effective July 1, 2006).

*No comments were received in support of Option I.*

Option II: Introduce legislation to amend *Code of Virginia* § 32.1-122.10:001 to extend the sunset date to July 1, 2010.

*No comments were received in support of Option II.*

**Option III: Introduce legislation to amend *Code of Virginia* § 32.1-122.10:001 to remove the sunset clause.**

*Twelve individuals or organizations commented in support of Option III.*

## Licensing of Dietitians

### REVIEW OF PRESENTATION FINDINGS

House Bill 455 (HB 455) was introduced by Delegate McQuigg during the 2004 General Assembly Session. The bill was carried over to the 2005 Session. During the 2005 Session, HB 455 passed the House with an amendment but was passed by in the Senate Education and Health Committee with a letter. The letter was sent to the Joint Commission to review the issue. HB 455 would have required dietitians to be licensed by the Board of Medicine.

### Background

A number of previous studies have addressed the issue of licensure for dietitians. **House Joint Resolution 150 of the 1986 Session requested a study on the need to regulate dietitians and nutritionists.** The study was conducted by the Council on Health Regulatory Boards. The Council had the responsibility to consider and evaluate health care professions and occupations to consider whether they should be regulated and the degree of regulation necessary. The Council had six formal criteria for evaluating whether a profession should be regulated. The main criterion was: "The unregulated practice of an occupation will harm or endanger the health, safety, and welfare of the public. The potential for harm is recognizable and not remote or dependent on tenuous argument." **The conclusion of this study was that dietitians and nutritionists did not require regulation at that time. The Council indicated that safeguards were available including enforcement of: laws against the unlicensed practice of medicine, the Virginia Consumer Protection Act, and the statutes and regulations governing the various health occupations and professions.**

**House Bill 312 of the 1994 General Assembly Session would have established licensure for dietitians and nutritionists. The Bill was vetoed by the Governor when his amendment to reenact the bill in the 1995 Session was not accepted. The Governor directed the Department of Health Professions (DHP) to examine the issue.** The Department had seven criteria to evaluate whether a profession should be regulated. These criteria concern risk for harm to the consumer, specialized skills and training, autonomous practice, scope of practice, economic impact, alternatives to regulation, and least restrictive regulation. The first criterion is the most fundamental test according to DHP. This criterion "pertains to the risk of harm to the public's health, safety, or welfare resulting from the unregulated practice of the profession." There must not be other less restrictive means of redress. **The Department found that the first criterion had not been met and that there were "existing mechanisms in place to afford consumer protection and redress without state regulation of dieticians and nutritionists."**

### Current Status in Virginia

HB 2191 of the 1995 Session set out the minimum educational and training

requirements for a person to hold himself out to be a “dietitian” or “nutritionist.”  
Section 54.1-2731 of the *Code of Virginia* implements these provisions.

A. No person shall hold himself out to be or advertise or permit to be advertised that such person is a dietitian or nutritionist unless such person:

1. Has (i) received a baccalaureate or higher degree in nutritional sciences, community nutrition, public health nutrition, food and nutrition, dietetics or human nutrition from a regionally accredited college or university and (ii) satisfactorily completed a program of supervised clinical experience approved by the Commission on Dietetic Registration of the American Dietetic Association;
2. Has active registration through the Commission on Dietetic Registration of the American Dietetic Association;
3. Has an active certificate of the Certification Board for Nutrition Specialists by the Board of Nutrition Specialists;
4. Has an active accreditation by the Diplomats or Fellows of the American Board of Nutrition;
5. Has a current license or certificate as a dietitian or nutritionist issued by another state; or
6. Has the minimum requisite education, training and experience determined by the Board of Health Professions appropriate for such person to hold himself out to be, or advertise or allow himself to be advertised as, a dietitian or nutritionist.

*The restrictions of this section apply to the use of the terms "dietitian" and "nutritionist" as used alone or in any combination with the terms "licensed," "certified," or "registered," as those terms also imply a minimum level of education, training and competence.*

B. Any person who willfully violates the provisions of this section shall be guilty of a Class 3 misdemeanor.

The *Code of Virginia* also states that:

*Nothing in this chapter shall preclude or affect in any fashion the ability of any person to provide any assessment, evaluation, advice, counseling, information or services of any nature that are otherwise allowed by law, whether or not such services are provided in connection with the marketing and sale of products.*

Title 18, 75-30-10 of the *Virginia Administrative Code* also gives the following requirements:

- Requirements for use of title of dietitian or nutritionist.
- In addition to the criteria established in [§54.1-2731](#) of the Code of Virginia, a person may hold himself out to be a dietitian or nutritionist who has met



**The following three definitions explain the different forms of regulation in the various states.**

**Licensing** - statutes include an explicitly defined scope of practice, and performance of the profession is illegal without first obtaining a license from the state.

**Statutory certification** — limits use of particular titles to persons meeting predetermined requirements, while persons not certified can still practice the occupation or profession.

**Registration** — is the least restrictive form of state regulation. As with certification, unregistered persons are permitted to practice the profession. Typically, exams are not given and enforcement of the registration requirement is minimal.

Fifteen states license both dietitians and nutritionists. Nebraska licenses medical nutrition therapists. Colorado has twice reviewed the proposal to regulate dietitians and the Department of Regulatory Agencies (DORA) recommended against licensing or regulating dietitians. DORA's review of other states found very few complaints regarding dietitians and the related field.

#### Provisions of HB 455

HB 455 defined the practice of dietetics as follows:

*The "practice of dietetics" is defined as the integration and application of principles derived from the sciences of nutrition, biochemistry, food, physiology, management and behavioral and social sciences to achieve and maintain health through the provision of nutrition care services...."*

Licensure requirements in HB 455 included giving the Board of Medicine the authority to establish the criteria for licensure. The bill listed the following criteria:

*(a) at least a bachelors degree in human nutrition, nutrition education, foods and nutrition, food systems management, dietetics, or public health nutrition or a related field from an accredited college that meets the requirements of the Commission on Dietetic Registration;*

*(b) at least 900 hours of supervised experience approved by the Commission on Dietetic Registration;*

*(c) passage of the examination for registration administered by the Commission on Dietetic Registration or current registration with the Commission on Dietetic Registration; and*

*(d) documentation that the applicant for licensure has not had his license or certification as a dietitian suspended or revoked and is not the subject of any disciplinary proceedings in another jurisdiction.*

To limit the impact to certain businesses exemptions were included in HB 455.

The list of exemptions includes the following:

- (1) any student performing activities related to an educational program under the supervision of a licensed dietitian or any person completing the supervised practice required for licensure;*
- (2) a registered dietetic technician working under the supervision and direction of a licensed dietitian;*
- (3) a government employee or a person under contract to the government acting within the scope of such employment or contract;*
- (4) any health professional licensed or certified under this title when engaging in the profession for which he is licensed or any person working under the supervision of such a professional;*
- (5) a certified teacher employed by or under contract to any public or private elementary or secondary school or institution of higher education;*
- (6) any person with management responsibility for food service department policies, procedures, or outcomes in any food service department in any program or facility licensed by the Commonwealth;*
- (7) any person who does not hold himself out to be a dietitian who furnishes general nutrition information on food, food products, or dietary supplements or explains to customers about food, food products, or dietary supplements in connection with marketing and distribution of food or food products; or*
- (8) any person who provides weight control, wellness, or exercise services involving nutrition provided the program has been reviewed by a licensed dietitian, no change is initiated without prior approval of the dietitian, and consultation is available from a licensed dietitian.*

#### Arguments Made by Interested Parties

The public discussion concerning HB 455 was one that was debated by a number of parties on both sides of the licensure issue. Some examples of proponents of the legislation included:

- American Dietetic Association
- Virginia Dietetic Association (proposing legislation that only requires licensure of dieticians who provide medical nutrition therapy.)
- Virginia Nutritionists Association (proposing legislation that would also license nutritionists.)
- Other Nutritionist Group-Herondorf (proposing legislation that would also license nutritionists).

Example of arguments for licensure includes concerns such as the unregulated practice of providing nutritional advice is a threat to public safety and anecdotal evidence of harm to consumers.

Some examples of opponents of the legislation includes:

- Health Food Stores
- Weight Loss Clinics
- Other regulated health professionals
- Native American healers
- Certified Natural Health Professionals
- National Association of Nutrition Professionals.

Examples of arguments against licensure include limitations on the freedom of speech and the ability to engage in a profession, the creation of a monopoly, and undue financial burden.

#### OPTIONS AND PUBLIC COMMENTS

**Option I: Take no action.**

Option II: Introduce legislation that would license dietitians.

Option III: Introduce legislation that would license dietitians & nutritionists.

Option IV: Introduce legislation that would require licensure for dietitians who provide medical nutrition therapy.

Option V: Introduce legislation that would require licensure for dietitians and nutritionists who provide medical nutrition therapy.

Option VI: Request that the Department of Health Professions conduct another thorough review of the issue.

The following table summarizes the public comments that were received on each Policy Option. **Option I** (to take no action) **was supported by** the largest number of commenters (**374**). **Option IV** (to require licensure for dietitians who provide medical nutrition therapy) **was supported by 304** commenters. **Option V** (to require licensure for dietitians and nutritionists who provide medical nutrition therapy) **was supported by 225** commenters. (Note that 221 of these commenters actually commented in support of both Options IV and V.) **One commenter proposed an additional policy option that included specific language for a proposed bill.**

Some other issues that may be considered as part of any legislation on the issue:

- How to define dietitian, nutritionist, or any other provider that would be included in the legislation.
- Education and practice requirements.
- Other credentials or registration that may be required.

- Grandfathering.
- Appropriate exemptions.
- Reciprocity with other states.

<b>Policy Option</b>	<b>Number of Comments in Support</b>
<b>I</b>	374*
<b>II</b>	2
<b>III</b>	2
<b>IV</b>	304
<b>V</b>	225
<b>VI</b>	0

\*Comments that stated opposition to HB 455 or the licensing of dietitians were interpreted as Option I (Take No Action). Only one individual explicitly supported Option I.

## Medicaid Asset Transfers

### REVIEW OF STUDY FINDINGS

House Bill 2601 (2005) would have permitted the Department of Medical Assistance Services, when appropriate and practicable, to seek a waiver of the Social Security Act under Section 1115 to create more restrictive asset transfer limits than those currently allowed under federal law or regulations. Ultimately the bill was left in the Senate Finance Committee. Upon the request of members of the Joint Commission on Health Care, the study was conducted to review a variety of the issues raised by HB 2601.

### Medicaid Long-Term Care

Nationally Medicaid is the largest purchaser of nursing facility services with \$51 billion covered by this federal-state program in 2003. According to the Virginia Department of Medical Assistance Services' (DMAS) Statistical Record, annual expenditures for nursing facility services reached \$547,287,699 in 2003. Just over 76% of these expenditures were for individuals classified as aged.

The improper transfer of assets to gain access to Medicaid payment for long-term care services is an issue that has received national attention. Beginning in 1980 with the Boren-Long Amendments, the federal government enacted legislation designed to curb abuse of the Medicaid system. National studies have come to varying conclusions about the prevalence of inappropriate asset transfers.

### Current Issues Involving Sheltering Assets in Virginia

Interviews with State personnel revealed three major methods that Medicaid applicants are using to shelter assets in Virginia including: increased use of annuities, life estates, and savings bonds. Although the exact number of inappropriate asset transfers is not readily available, anecdotal evidence suggests they are becoming a more pervasive issue. DMAS is currently going through the regulatory process to strengthen regulations regarding the use of annuities to shelter assets.

A number of proposals have been discussed at the national and state levels to help curb the abuse of Medicaid asset transfers. One proposal involves placing additional restrictions on Medicaid asset transfers. A second proposal is to expand estate recovery programs.

**Proposals for imposing additional restrictions on Medicaid asset transfers have focused most often on increasing the look-back period, changing the start date of the penalty period, or altering the formula used to determine the length of the penalty period.**

### Look-Back Period

Currently, states have a look-back period of 36 months (60 months for trusts) in which to examine a Medicaid applicant's financial transactions to determine if unallowable asset transfers have occurred. Several organizations, including the Medicaid Commission and the National Governor's Association have proposed increasing the length of the look-back period from three to five years. The CMS Office of the Actuary estimates that this change would save less than \$100 million over five years.

### Penalty Period

If an individual makes an improper transfer during the look-back period they are assessed a penalty period in which they do not qualify for Medicaid payment of long-term care services. The penalty period is calculated by dividing the uncompensated value of assets transferred during the look-back period by the average monthly cost of private pay nursing facility services at the time of application for Medicaid. At the present time, the first day of the month in which the asset transfer occurred (provided that the date does not occur during an existing penalty period) is the start date for the penalty period. Proposals have been made to change that start date from the date of the asset transfer to either the date of application for Medicaid long-term care services or the nursing home admission date. In addition it has been suggested that the formula used to determine the penalty period be altered by using the average monthly cost of Medicaid nursing facility services instead of the average monthly cost of private pay nursing facility services. This change would dramatically increase the length of the penalty period.

### Waivers Submitted by Other States

Three states including, Connecticut, Massachusetts, and Minnesota, have applied for Medicaid Section 1115 Research and Demonstration Waivers from CMS to implement some or all of the above-mentioned asset transfers restrictions. The earliest waiver was submitted in 2002, but has since been withdrawn by the state. Massachusetts and Minnesota have yet to receive approval from CMS for their waiver proposals.

### Estate Recovery Programs

Since the inception of the Medicaid program, states have been allowed to recover assets from the estates of deceased Medicaid recipients who were over the age of 65 when they received benefits and who had no surviving spouse, minor child, or adult disabled child. The passage of OBRA 1993 required states to implement estate recovery programs.

Under Virginia's Medicaid estate recovery program, adjustments or recoveries

for services Medicaid has covered may be recovered from the estate of a permanently institutionalized individual or from a recipient age 55 or older for payments covering nursing facility services, home and community-based services, and related hospital and prescription drug services.

**Methods for reducing the cost of Medicaid long-term care services for the federal and state governments have received attention also. Two methods include encouraging individuals to use reverse mortgages and to purchase long-term care insurance.**

#### Reverse Mortgages

Home Equity Conversion Mortgages (HECM) are the most common type of reverse mortgage. With an HECM, a lender advances money to a homeowner who must be age 62 or older. The money may be provided in a series of fixed monthly payments, a line of credit from which the borrower may draw from, or a combination of these methods. Payments do not need to be made on the loan as long as the individual remains living in the home. The loan balance collected by the lender includes any accrued interest, other charges, and the amounts paid out. Funds from reverse mortgages can be used to pay for long-term care services. However, restrictions regarding eligibility for reverse mortgages including maximum initial loan amounts mean that reverse mortgages are not a viable option for some individuals.

#### Long-Term Care Insurance Tax Incentives

Governments on both the federal and state level recognize the potential for savings if individuals purchase adequate long-term care coverage. As a result, numerous pieces of legislation across the country have been proposed to encourage the purchase of these plans. According to the National Conference of State Legislators, 26 states have long-term care insurance tax incentives in place. Maine offers both a tax credit and a deduction. Sixteen states, including Virginia offer a tax deduction. Another nine states offer a tax credit.

#### Long-Term Care Partnerships

The Long-Term Care Partnership program allows individuals to access state Medicaid long-term care programs and not deplete their assets, if they have purchased certain approved long-term care insurance policies. California, Connecticut, Indiana, and New York are the only states that have LTC Partnerships in operation. Nineteen states, including Virginia, have enacted some form of enabling legislation to create the program in their state, but the *Omnibus Reconciliation Act (OBRA) of 1993* has restricted the ability of states to create LTC Partnerships.

In response to positive outcomes from the four states with Partnership programs

and growing concerns over Medicaid long-term care budgets, a variety of stakeholders have expressed strong support for removing the restrictions imposed by OBRA 1993. The National Governor's Association and the National Conference of State Legislators have called for the repeal of federal restrictions. In addition, the President included language in his 2006 budget that would provide authority for states to implement LTC Partnership programs; and several bills have been introduced in Congress that would lift federal restrictions.

#### OPTIONS AND PUBLIC COMMENTS

Option I: Take no action.

*No comments were received addressing Option I.*

Option II: Introduce legislation to provide a tax credit for employers who offer long-term care insurance to their employees.

*Six comments in support of Option II were received.*

*Multiple Sclerosis Virginia Consumer Action Network.*

*National Academy of Elder Law Attorneys, Virginia Chapter.*

*Virginia Association of Area Agencies on Aging.*

*Virginia Bar Association.*

*Virginia Health Care Association.*

*Virginia Poverty Law Center.*

**ADDRESSED IN LTC SUBCOMMITTEE.**

Option III: Introduce legislation to provide a tax credit rather than a tax for long-term care insurance.

*Option III received six supportive comments.*

*Multiple Sclerosis Virginia Consumer Action Network.*

*National Academy of Elder Law Attorneys, Virginia Chapter.*

*Virginia Association of Area Agencies on Aging.*

*Virginia Bar Association.*

*Virginia Health Care Association.*

*Virginia Poverty Law Center.*

**ADDRESSED IN LTC SUBCOMMITTEE (10% tax credit approved).**

Option IV: Introduce a budget amendment (language and funding) to create a grant program for individuals purchasing long-term care insurance, to be administered through the Virginia Department for the Aging. VDA would work with stakeholders to develop eligibility criteria for participation in the program.

*Concerns over the ability and applicability of VDA administering this potential program were raised by VDA. Another six comments in support of Option IV were received.*

*Multiple Sclerosis Virginia Consumer Action Network.*

*National Academy of Elder Law Attorneys, Virginia Chapter.*

*Virginia Association of Area Agencies on Aging.*

*Virginia Bar Association.*  
*Virginia Health Care Association.*  
*Virginia Poverty Law Center.*

Option V: Introduce legislation authorizing DMAS to apply for a waiver to implement more restrictive asset transfer restrictions.

*Six comments in opposition to Option V were received.*  
*Multiple Sclerosis Virginia Consumer Action Network.*  
*National Academy of Elder Law Attorneys, Virginia Chapter.*  
*Virginia Association of Area Agencies on Aging.*  
*Virginia Bar Association.*  
*Virginia Health Care Association.*  
*Virginia Poverty Law Center.*

Option VI: Introduce a resolution or send a letter from the JCHC encouraging members of Congress to pass legislation authorizing the further implementation of Long-Term Care Partnership programs in other states.

*Option VI solicited seven supportive comments.*  
*Multiple Sclerosis Virginia Consumer Action Network.*  
*National Academy of Elder Law Attorneys, Virginia Chapter.*  
*Virginia Association of Area Agencies on Aging.*  
*Virginia Association of Nonprofit Homes for the Aging.*  
*Virginia Bar Association.*  
*Virginia Health Care Association.*  
*Virginia Poverty Law Center.*

Option VII: Continue to monitor the actions of Congress regarding additional asset transfer restrictions, reverse mortgages, and Long-Term Care Partnership programs in addition to monitoring the activities in Virginia involving annuities, life estates, and bonds by including the issues on the JCHC workplan for 2006.

*Seven comments in support of Option VII were received.*  
*Multiple Sclerosis Virginia Consumer Action Network.*  
*National Academy of Elder Law Attorneys, Virginia Chapter.*  
*Virginia Association of Area Agencies on Aging.*  
*Virginia Bar Association.*  
*Virginia Health Care Association.*  
*Virginia Hospital and Healthcare Association.*  
*Virginia Poverty Law Center.*

**Option VIII: Introduce a resolution requesting JLARC to conduct a study to determine the extent of the use of asset transfers to shelter assets in order to qualify for Medicaid long-term care.**

*Five comments were received in support of Option VIII.*  
*Multiple Sclerosis Virginia Consumer Action Network.*

*National Academy of Elder Law Attorneys, Virginia Chapter.*  
*Virginia Association of Area Agencies on Aging.*  
*Virginia Bar Association.*  
*Virginia Poverty Law Center.*

## **Federal Funding for HIV/AIDS Prevention and Treatment Programs in Virginia**

### REVIEW OF STUDY FINDINGS

Item 11 B of Chapter 951 of the 2005 Virginia Acts of Assembly directs the Joint Commission on Health Care to conduct a study on federal funding to Virginia's HIV/AIDS prevention and treatment programs. Specifically the Commission was charged with analyzing recent federal funding trends regarding the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and additional sources of federal funding provided to the Commonwealth for the prevention and treatment of HIV/AIDS.

### Background on HIV/AIDS

Acquired Immunodeficiency Syndrome (AIDS) was first reported in the U.S. in 1981. The next year, the first case of AIDS in Virginia was reported. AIDS is caused by the Human Immunodeficiency Virus (HIV), which progressively destroys the body's ability to fight infections and certain cancers by effectively killing or damaging cells in the human immune system. Although no cure has been found, treatment is available. Prescription medications play a pivotal role in treating HIV/AIDS. Highly active antiretroviral therapy (HAART) is the common term for the use of three or more FDA approved drugs for treatment.

The Centers for Disease Control (CDC) estimates that at the end of 2003, 1,039,000 to 1,185,000 individuals were infected with HIV in the U.S. Of those individuals it was estimated that 24% to 27% are undiagnosed and unaware of their HIV status. In Virginia, approximately 17,000 people are known to be living with HIV/AIDS. From 1999 to 2003, the number of individuals living in the U.S. with AIDS increased 30%. During this same time period the CDC reported a 3% decrease in AIDS-related deaths, while the number of AIDS diagnoses increased 4%.

### Medicaid Coverage for Individuals Living with HIV/AIDS

The largest portion of federal spending for providing services to individuals with HIV/AIDS goes to Medicaid. An individual living with HIV/AIDS may qualify for Medicaid if he meets the qualifications of a particular group (low-income children, parents meeting specific income thresholds, pregnant women, the elderly, and individuals with disabilities) and his income and resources fall below required limits.

Medicaid state plans must provide certain mandatory services to individuals who qualify as categorically needy. Examples of these services that are important to individuals living with HIV/AIDS include; inpatient hospital services, physician services, and certain forms of long-term care. States may also choose to provide optional services. Examples of services important to this

population that have been implemented in Virginia include prescription drug coverage and rehabilitative services. In addition, Virginia provides home and community-based care to individuals with HIV/AIDS through its AIDS Waiver. In FY 2004, 274 individuals received services through the AIDS Waiver. The cost of services provided outside of the waiver to AIDS Waiver participants totaled \$6,117,320, with over 60% of this amount a result of pharmacy expenditures. The cost of waiver services totaled \$608,497, with the average cost per recipient totaling \$2,221.

#### Centers for Disease Control (CDC) Funding

Part of CDC's mission includes funding activities related to HIV surveillance, research, prevention, and evaluation through local, state, national and international levels. Programs involving epidemiology and surveillance are critical to producing the data necessary to target the delivery of HIV prevention and treatment services.

The Virginia HIV/AIDS surveillance program receives funding from CDC to collect federally-mandated HIV/AIDS infection data. In FY 2005, VDH received \$467,556 in federal funding, which is less than the \$478,460 received by VDH in 1997. As funding is decreasing, data collection demands are increasing. The CDC has developed Incidence and Resistance Projects in which data on new cases of HIV infection and data on HIV drug resistant infections in newly diagnosed HIV cases are to be collected. To expand the Resistance Project with state funds, \$265,110 GFs are needed.

Preventing HIV infection has proven to be more cost-effective than treating an individual with HIV/AIDS. However, federal funding for prevention efforts in Virginia peaked in 2001 at just over \$5.2 million. Since that time funding has decreased by \$152,000 or 3% (to just under \$5.05 million in 2005). In addition, VDH is anticipating another 3% reduction in the coming year. As a result of decreased federal funding, several programs have been altered to ensure that funds are appropriated to where they will provide the greatest impact and where community-based services to high-risk populations will be preserved. State funding in the amount of \$285,000 GFs are needed to offset the loss of federal HIV prevention dollars (\$150,000 of this funding would address rescissions in 2004-2006; \$135,000 of the \$285,000 would restore service funds redirected to rent, salary increases, and other administrative costs).

In 2003, CDC initiated a new program the Advancing HIV Prevention Initiative (AHP). The program is designed to reduce barriers to early diagnosis of HIV infection, access to care and prevention services for individuals living with HIV. VDH must redirect existing funds to meet the objectives of the AHP initiative. New technology has assisted in the attainment of AHP goals. However, the cost

of this new technology prohibits its expansion. For example, oral fluid testing requires no needles and may be conducted directly in the community. Rapid testing allows individuals to receive test results in as little as 20 minutes. VDH has established pilot sites using both testing methods but expansion is difficult due to the cost.

- Traditional HIV antibody blood test through the Division of Consolidated Laboratory Services = \$2.50 each for the first 72,500 tests, then \$3.68 each for each test thereafter.
- Oral fluid test = \$17.36 each.
- Rapid HIV test = \$10.10 each.
- Newly approved rapid oral test = \$13.00 each.

To address the demands created by AHP, \$164,000 GFs are needed.

- Salary and benefits for a Counseling and Testing Coordinator (\$60,000).
- Expansion of rapid and oral testing (\$84,000).
- Distribution of materials targeted to pregnant women (\$20,000).

Health Resources and Services Administration Funding

The Health Resources and Services Administration (HRSA) administers funding provided under the Ryan White Comprehensive AIDS Resources Emergency Act (RWCA). Funding under RWCA was established to provide a safety net for uninsured, low-income individuals who had no other access to care. As a result funds may only be used as the payer of last resort. The program is the largest federal program designed to provide services for individuals living with HIV/AIDS. RWCA was enacted in 1990, amended and reauthorized in 1996 and 2000, and is being considered for reauthorization.

The following chart displays RWCA funding streams in Virginia.

Funding Stream	Description	Recipients in Virginia	2005 Award
Title I	Provides emergency assistance to severely affected urban areas	Norfolk EMA North. & parts of NW region (DC EMA)	\$4,726,063 \$4,164,593
Title II	Funds services to provide medications, health care, etc.	State of Va. VDH admin.	\$22,679,750
Title III	Funds primary care	6 providers statewide	\$2,463,520

Title IV	Enhances client access to care & research for women & children	2 providers statewide	\$858,391
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RWCA Title II

Title II funds are designed to improve the quality, availability, and organization of health care and support services for individuals and families living with HIV. In Virginia, Title II funds support five regional care consortia and the AIDS Drug Assistance Program (ADAP).

The five regional care consortia supported by Title II funding provide client needs assessments, service gap identification, and needed service provision. Federal funds were originally designed to support a system of short-term access to acute care services. For RWCA's FY 2005 (4/1/05 – 3/31/06) Virginia received \$5,543,229 in base funding. This was a 6.5% decrease in base funding from the previous year even though there has been an increasing demand for services. VDH estimates that \$500,000 GFs are needed to stabilize access to primary care in Northern Virginia.

ADAP is designed to provide medications for the treatment of HIV/AIDS to individuals who have limited or no coverage from private insurance or Medicaid. ADAP-earmarked funds have been the fastest growing component of the RWCA appropriation. However, expenditures in Virginia's program have increased 23.8% from FY 2003 to FY 2004. In FY 2005, Virginia was awarded \$16,782,217 for ADAP. In addition, Virginia was determined to be a state with a severe need, and as such qualified for \$1.6 million in ADAP supplemental funds. This federal funding requires a 4:1 federal/state match. Due to increasing program expenditures and longer client enrollment periods, VDH estimates that \$4,300,000 GFs are needed to offset the projected ADAP shortfall.

Implementation of the Medicare Part D prescription drug benefit on January 1, 2006, may affect the Virginia ADAP participants who are Medicare beneficiaries. Ten percent of Virginia ADAP participants receive Medicare and will be required to enroll in Medicare Part D. The cost-sharing requirements of Part D will be a difficult change for some ADAP participants, especially if their income is over 150%FPL.

VDH has investigated several methods to assist Part D beneficiaries including using ADAP funds to cover out-of-pocket costs for Part D beneficiaries and creating a new State Pharmaceutical Assistance Program (SPAP). Creating a new SPAP, would allow state funds to count towards Part D beneficiaries' out-of-pocket costs, without affecting access to catastrophic drug coverage. It is estimated that \$500,000 GFs are needed to create and implement the program.

Approximately \$21 million of the current Title II award requires a federal/state match of 2:1. If this match is not met, federal funding will be decreased. In the past, Department of Corrections (DOC) expenditures have been used to meet the match. Recently, DOC revised HIV services and medication contracts and realized savings resulting in a reduced state match; thus jeopardizing Virginia's access to federal Title II funding.

### RWCA Title III

Title III provides direct grants to community-based primary health care clinics and public health providers. Funds are distributed through a competitive grant process, with six providers receiving grants in Virginia totaling \$2,611,181 for FY 2004 and \$2,463,520 for FY 2005. Title III serves as an important vehicle for targeting HIV-related medical services to underserved communities of color and rural areas. HRSA has begun capping the number of Title III providers in the state. Subsequent funding shifts have caused a reduction in funding for the Roanoke area. The estimated annual cost to maintain HIV-related primary care services in Southwest Virginia is \$577,000 GFs.

### OPTIONS AND PUBLIC COMMENTS

A number of public comments addressed issues other than the proposed options. Six individuals commented regarding the length of the public comment period. The commenters received expressed concern that the eight days given for public comment did not provide an adequate time frame for the issue brief to be circulated and commented on by the general public. One commenter did not address any of the specific options but expressed the importance of community planning and services.

It should be noted that only comments which specifically addressed support for an Option were counted as supporting that Option. Staff did not attempt to make a judgment call with regard to support.

Option I: Take no action.

*Thirteen comments in opposition to Option I were received.*

*Robert Atkins.*

*Fairfax County Department of Health.*

*Northern Virginia AIDS Ministry.*

*Northern Virginia HIV Consortium.*

*Northern Virginia HIV Consortium Persons with AIDS Committee.*

*Jan Gordon Oellerich.*

*Nicolette Solan Pegler.*

*John Ruthinoski.*

*Ronald Scheraga.*

*Blaine Sheffer.*

*Virginia Department of Health.*

*Virginia Organizations Responding to AIDS.*

*Whitman-Walker Clinic.*

**Option II: Introduce a budget amendment (language and funding) to expand the HIV resistance testing program.**

a) **\$265,110 GFs per year of the 2006-2008 biennium;** or

b) other level of funding.

*Option II received twelve supportive comments.*

*Robert Atkins.*

*Fairfax County Department of Health.*

*Northern Virginia AIDS Ministry.*

*Northern Virginia HIV Consortium.*

*Northern Virginia HIV Consortium Persons with AIDS Committee.*

*Nicolette Solan Pegler.*

*John Ruthinoski.*

*Ronald Scheraga.*

*Blaine Sheffer.*

*Edward Strickler, Jr.*

*Virginia Department of Health.*

*Virginia Organizations Responding to AIDS.*

**Option III: Introduce a budget amendment (language and funding) to cover federal rescissions in prevention funding.**

a) **\$285,000 GFs;** or

b) other funding level.

*Fourteen comments supported Option III. Nine of the supportive comments favored (b) with a higher funding amount.*

*Robert Atkins.*

*Fairfax County Department of Health.*

*Bob Kenney.*

*Northern Virginia AIDS Ministry.*

*Northern Virginia HIV Consortium.*

*Northern Virginia HIV Consortium Persons with AIDS Committee.*

*Nicolette Solan Pegler.*

*John Ruthinoski.*

*Ronald Scheraga.*

*Blaine Sheffer.*

*Edward Strickler, Jr.*

*Virginia Department of Health.*

*Virginia Organizations Responding to AIDS.*

*Whitman-Walker Clinic.*

Option IV: Introduce a budget amendment (language and funding) to cover the federal unfunded mandate, Advancing HIV Prevention Initiative.

- a) \$164,000 GFs; or
- b) other amount of funding.

*Twelve comments in support of Option IV were received. Seven of those comments supported (b) with greater funding.*

*Robert Atkins.*

*Fairfax County Department of Health.*

*Northern Virginia AIDS Ministry.*

*Northern Virginia HIV Consortium.*

*Northern Virginia HIV Consortium Persons with AIDS Committee.*

*Nicolette Solan Pegler.*

*John Ruthinoski.*

*Ronald Scheraga.*

*Blaine Sheffer.*

*Edward Strickler, Jr.*

*Virginia Department of Health.*

*Virginia Organizations Responding to AIDS.*

Option V: Introduce a budget amendment (language and funding) to stabilize access to HIV primary care services statewide ~~in Northern and Southwest Virginia.~~

- a) ~~\$1,077,000 GFs (NOVA \$500,000, SWVA \$577,000); or~~
- b) different amount of funding.

*Eighteen comments were received in support of Option V. Of those comments, twelve supported additional funding.*

*Robert Atkins.*

*Debby Dimon.*

*Fairfax County Department of Health.*

*David Hoover*

*Bob Kenney.*

*Northern Virginia AIDS Ministry.*

*Northern Virginia HIV Consortium.*

*Northern Virginia HIV Consortium Persons with AIDS Committee.*

*Jan Gordon Oellerich.*

*Nicolette Solan Pegler.*

*John Ruthinoski.*

*Ronald Scheraga.*

*Blaine Sheffer.*

*Southwest/Piedmont HIV Care Consortium.*

*Edward Strickler, Jr.*

*Virginia Department of Health.*

*Virginia Organizations Responding to AIDS.*

*Whitman-Walker Clinic.*

Option VI: Introduce a budget amendment (language and funding) to provide additional funding to offset projected ADAP shortfall.

- a) \$4,300,000 GFs;
- b) \$3,800,000 GFs (\$4.3 million offset by SPAP of \$500,000); or
- c) other funding level.

*Sixteen comments supporting Option VI were received, with one comment specifically supporting funding level (b).*

*Robert Atkins.*

*Debby Dimon.*

*Fairfax County Department of Health.*

*David Hoover*

*Northern Virginia AIDS Ministry.*

*Northern Virginia HIV Consortium.*

*Northern Virginia HIV Consortium Persons with AIDS Committee.*

*Nicolette Solan Pegler.*

*John Ruthinoski.*

*Ronald Scheraga.*

*Blaine Sheffer.*

*Southwest/Piedmont HIV Care Consortium.*

*Edward Strickler, Jr.*

*Virginia Organizations Responding to AIDS.*

*Whitman-Walker Clinic.*

Option VII: Introduce a budget amendment (funding and language) to create a SPAP to serve former ADAP Medicare Part D eligible clients.

- a) \$500,000 GFs; or
- b) other amount of funding.

*Option VII received fifteen supportive comments. Of those fifteen, one comment supported (b) in an amount higher than \$500,000.*

*Robert Atkins.*

*Debby Dimon.*

*Fairfax County Department of Health.*

*David Hoover*

*Northern Virginia AIDS Ministry.*

*Northern Virginia HIV Consortium.*

*Northern Virginia HIV Consortium Persons with AIDS Committee.*

*Nicolette Solan Pegler.*

*John Ruthinoski.*

*Ronald Scheraga.*

*Blaine Sheffer.*

*Edward Strickler, Jr.*

*Virginia Department of Health.*

*Virginia Organizations Responding to AIDS.*

*Whitman-Walker Clinic.*

**Option VIII: Introduce a resolution, encouraging the Virginia Commonwealth University School of Dentistry to investigate and if appropriate apply for funding under the RWCA Dental Reimbursement Program and the Community Based Dental Partnership Program.**

*Fourteen comments were received supporting Option VIII. Several comments suggested directing VCU to apply for funding.*

*Robert Atkins.*

*Debby Dimon.*

*Fairfax County Department of Health.*

*Bob Kenney.*

*Northern Virginia AIDS Ministry.*

*Northern Virginia HIV Consortium.*

*Northern Virginia HIV Consortium Persons with AIDS Committee.*

*Jan Gordon Oellerich.*

*Nicolette Solan Pegler.*

*John Ruthinoski.*

*Ronald Scheraga.*

*Blaine Sheffer.*

*Edward Strickler, Jr.*

*Virginia Organizations Responding to AIDS.*

**Option IX: Continue to monitor activities involving RWCA and federal funding by including the issues on the JCHC workplan for 2006.**

*Thirteen comments were received in support of Option IX.*

*Arlington Department of Human Services.*

*Robert Atkins.*

*Debby Dimon.*

*Fairfax County Department of Health.*

*Northern Virginia AIDS Ministry.*

*Northern Virginia HIV Consortium.*

*Northern Virginia HIV Consortium Persons with AIDS Committee.*

*Jan Gordon Oellerich.*

*Nicolette Solan Pegler.*

*John Ruthinoski.*

*Blaine Sheffer.*

*Edward Strickler, Jr.*

*Virginia Organizations Responding to AIDS.*

*In addition to supporting Option IX several comments included suggestions on what JCHC should explore for next year. The following was submitted by Susan R. Rowland, Executive Director of Virginia Organizations Responding to AIDS:*

*“In the next year, the JCHC should review information on:*

- *The results of work undertaken within the Northern Virginia region to improve the efficient use of public funds in providing treatment services. A project is currently underway in Northern Virginia, requested by the Northern Virginia AIDS Ministry and funded by the Washington AIDS Foundation. Similar support should be made available to providers in all regions of the state in order to maximize public funding for treatment services.*
- *Virginia's Medicaid Plan and the trends in services provided to persons living with HIV/AIDS under the Plan, compared to services available in other states. As Ryan White CARE Act funds are diminished, the state's Medicaid Plan provides another option for sharing the cost of care with federal sources.*
- *Virginia's HIV/AIDS Health Insurance Premium Assistance Program, operated by the Department of Medical Assistance Services. This program is designed to assist persons who are at risk of losing private health insurance coverage due to loss of income.*
- *The impact upon Virginia of changes to the Ryan White CARE Act as a result of the expected reauthorization of the Act by Congress this year. The RWCA is authorized for just 5 years at a time, and the Act's authorization expired on September 30, 2005. Reauthorization is expected shortly, and a number of significant revisions are proposed. The JCHC should be informed of these changes, along with the expected impacts upon Virginia's system of prevention and treatment services.*

*Furthermore, VDH, DMAS, the teaching hospitals, and other major medical care providers that operate programs targeting treatment to persons living with HIV/AIDS should regularly report to the JCHC on the status of prevention and treatment services. Such regular reporting would allow the Commission's members to react proactively with appropriate policy and budgetary responses, assuring that Virginia stays in front of the HIV-virus, and is not driven to higher rates of infection as already seen in other states."*

## Virginia Health Information (VHI) Reporting

VHI is requesting state funding to help support operational costs related to the reporting of outpatient surgical data and expanding the number of reports available at no cost to consumers.

Virginia's health care reporting system was expanded to include outpatient surgical data as required in JCHC-sponsored legislation (HB 2763 in 2001). VHI has developed the outpatient data system and has started to process the data without the benefit of state funding. (Note that state general funds provided for work that VHI completes on behalf of the Commonwealth was decreased in October 2002 from \$310,000 to \$131,271. VHI subsequently made many changes in its operations including significantly increasing product sales accounting for 50 percent of revenues. However, VHI cannot continue to fund the outpatient data system without receiving a modest increase of \$75,000 in the funding it receives from the State.)

As the cost of health insurance rises more healthcare costs are being shifted to consumers enrolling in high deductible health plans and other products, increasing the importance of available information on the cost and quality of health care services. VHI has developed a suite of consumer guides and reports to help consumers make more informed health care purchasing decisions. In order to expand and update this information to meet changing needs, VHI is seeking funds to maintain the patient level database. The patient level database provides a wealth of data that is used, in partnership with healthcare stakeholders, to develop new consumer health information products. A funding request for \$100,000 is sought for this effort.

### OPTIONS

Option I: Take no action.

**Option II: Introduce a budget amendment for \$175,000 in general funds for the next two fiscal years to support the outpatient surgical data system and to expand the number of reports available at no cost to consumers.**

## **Continue Study of Mental Health Needs and Treatment of Minority Individuals**

Senate Joint Resolution 25 (2004) directed the Joint Commission on Health Care to “study the mental health needs and treatment of young minority adults in the Commonwealth” and to submit findings and recommendations to the Governor and the General Assembly by the first day of the 2006 session. SJR 25 requires to Joint Commission on Health Care in conducting the study to:

- Estimate the “number of mentally disabled young adults by gender, age, and racial and ethnic classification, in the geographic regions of the Commonwealth.”
- Identify the “prevailing mental health and emotional disorders and their etiology among minority young adults [and]...the mental health needs of minority citizens, particularly minority young adults in Virginia.”
- Determine the “number of racial and ethnic minority persons who receive mental health treatment...and the facilities providing such care.”
- Ascertain whether “mental health providers are trained to provide culturally competent mental health treatment” and the level of need for such treatment in Virginia.
- Review “federal and state laws and regulations...and identify the...extent to which medical records information may be disclosed to parents and family members to assist them in obtaining health, social services, and mental health treatment for mentally disabled young adults” and recommend ways to provide information to allow family members to obtain services and treatment without resorting to involuntary commitment.

A study workgroup was established and met during 2004 and 2005

- Representatives from community services boards, free clinics, community health centers, psychiatrists, indigent defense attorneys, hospitals, Hampton University, VCU and such state agencies such as VDH and DMHMRSAS participated in meetings
  - Contacts will continue to be made to involve additional workgroup members.
- A specific study workplan was developed; however, it was the consensus of the workgroup that the study will require one to two more years to address adequately the study issues.

### OPTIONS

Option I: Take no action.

**Option II: Continue the study the mental health needs and access to treatment of minority individuals in Virginia by including the study on the 2006 workplan for the Joint Commission on Health Care.**

### **Request for Study of Follow-Up Services for Preterm Babies**

In October, Susan Brown, M.D. discussed the developmental problems that many preterm babies experience if early intervention is not undertaken. Some of the remarks made by Dr. Brown in support of a JCHC study in 2006 include:

“According to the March of Dimes, since it began its campaign to eradicate prematurity in the 1980’s, the rate of prematurity has actually increased almost 30%. Nationally the rate of prematurity has risen from 9.6% to 12%. According to the latest Virginia Department of Health statistics, the rate of prematurity in Virginia is almost 11% annually. That means almost 11,000 preterm and low birthweight infants are born in Virginia every year....Tinier babies are surviving and survival rates for these infants steadily improved in the 90’s. However, the latest studies in the pediatric and neonatal literature show that as we have made improvements in medical treatment, neurocognitive impairments are increasing.

Rates of cerebral palsy in the premature population vary between 15 and 30% depending on the infant’s gestational age at birth; deafness and blindness between 3-11%. These children obviously require ongoing medical care and require special assistance at a very early age. However, a much greater problem for the State exists in the greater majority of preterm infants. When these children reach school age, up to 80% of ALL preterm infants will require some form of special assistance in school ranging from speech therapy to special education to grade repetition....

Fortunately, there is a window of opportunity to positively affect the outcomes of these children. Before children reach school age, the brain and central nervous system is still developing and “re-wiring” may take place which can allow the amelioration of some of the effects of prematurity. Many studies have shown the value of early intervention in improving the long term outcomes of children. The key is identifying the children as early as possible and connecting them with the appropriate resources.

There are federally mandated and state run programs in place to identify at risk infants and toddlers who show developmental delays. However, under the Part C Early Intervention programs in Virginia, prematurity is not currently listed as an inclusion diagnosis although it is listed as a risk factor. Virginia does not have any way at this time to identify prematurely born infants or to track them to make sure their families and physicians are properly informed about developmental risks and the referral resources available to them....Lastly, there is no system in place to determine the costs to the State to provide the long term therapy and address the educational needs of the premature.”

OPTIONS

Option I: Take no action.

**Option II: Include a study of the availability and potential need for follow-up services for and tracking of preterm newborns on the 2006 JCHC workplan.**

### **Extend or Remove Sunset Date for JCHC**

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 twice since that time resulting in a current sunset date for the Joint Commission of July 1, 2007.

Joint Commission members may wish to extend the sunset provision by another five years or to 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 Crime Commission, have no sunset provision in their statutory language. Legislative commissions, authorized in *Code of Virginia* Title 30, that have sunset dates include the Commission on Electric Utility Restructuring, the Virginia Delegation to Multistate Tax Administration Discussions, the Commission on Unemployment Compensation, and the Virginia Disability Commission.

#### OPTIONS

Option I: Take no action.

Option II: Introduce legislation to amend the *Code of Virginia* § 30.170 to extend the sunset provision to July 1, 2012.

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

### 2005 HHS Poverty Guidelines

Persons in Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$ 9,570	\$11,950	\$11,010
2	12,830	16,030	14,760
3	16,090	20,110	18,510
4	19,350	24,190	22,260
5	22,610	28,270	26,010
6	25,870	32,350	29,760
7	29,130	36,430	33,510
8	32,390	40,510	37,260
For each additional person, add	3,260	4,080	3,750

**SOURCE:** *Federal Register*, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.