Decision Matrix

Policy Options for 2016 General Assembly Session

Version with Actions Taken

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2015

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

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PURPOSE OF DOCUMENT

- To review and discuss findings, policy options, and public comments regarding staff reports and other issues that came before the Commission in 2015.
- To approve various actions including the introduction of legislation and budget amendments for the 2016 General Assembly Session.

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

Stephen Weiss
Senior Health Policy Analyst

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under *Code* § 16.1-339 when the minor desires to continue inpatient treatment and consent for continued admission is withdrawn by the parent who consented to the minor's admission, and 3) reimbursement issues for services provided when a minor receives inpatient mental health treatment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

Background

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

A variety of perspectives were expressed regarding the need to change admission requirements. Community services board (CSB) staff members, participating in a conference call arranged through their state association, indicated that they were never involved in a case or situation where the child wanted to be in an inpatient setting and the parents objected. If there were parental objection, though, there are remedies already in the law to address the situation.

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

Relevant Statutes from Other States

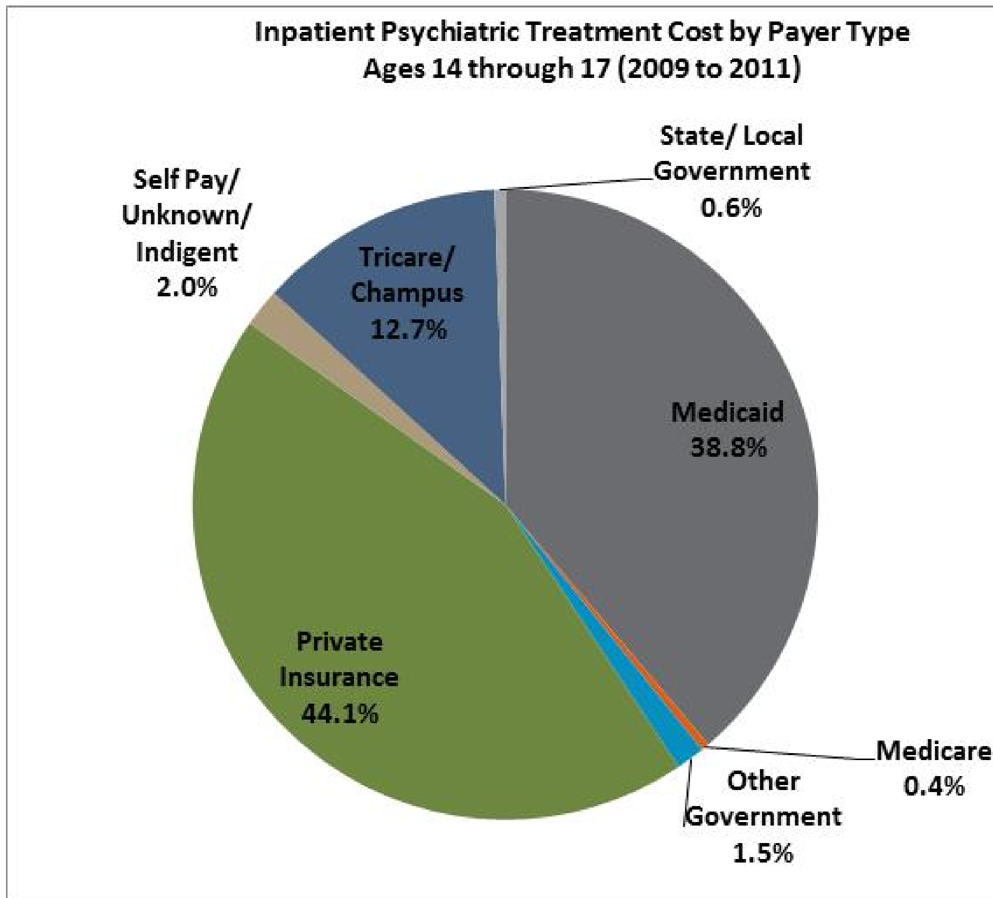
A review of other state statutes found that at least 19 states authorized minors to consent to inpatient mental health care without the consent of a parent. The provisions included in these statutes varied addressing such issues as the application and admission process, relief to the parent for financial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

Potential Financial Implications

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

According to Virginia Health Information (VHI) data, $86.8 million was spent for inpatient treatment for minors aged 14 through 17 in a private psychiatric hospital or on a mental health unit of a general hospital with an average cost-per-discharge of $6,500 to $6,700.

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



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

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

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

Policy Options and Public Comment

Six comments were received regarding the policy options addressing the expansion of the authority for minors to consent to their inpatient mental health treatment.

Comments were submitted by:

- Mr. Richard J. Bonnie, Ph.D., Director
  Institute of Law, Psychiatry and Public Policy at the University of Virginia
- Ms. Jacquelin McKisson
  Parent
- Ms. Claire Guthrie Gastanaga, Executive Director
  American Civil Liberties Union of Virginia (ACLU-VA)
- Ms. Colleen Miller, Executive Director
  disABILITY Law Center of Virginia (dLCV)
- Ms. Mira Signer, Executive Director
  National Alliance for the Mentally Ill of Virginia (NAMI-VA)
- Ms. Jennifer Faison, Executive Director
  Virginia Association of Community Services Boards (VACSB)

Policy Options	Comments
☑ **1**. Take no action. **Vote: 11-3**	NAMI-VA primary option supported. VACSB primary option supported.
2 Introduce legislation to amend *Code of Virginia* Title 16.1 to provide minors with the same rights and responsibilities as an adult in terms of consenting to voluntary inpatient mental health treatment beginning at age: ▪ 14 years ▪ 16 years ▪ 15 years ▪ 17 years	Ms. McKisson at age 16 with provisions similar to Maryland's current law; most importantly that the parent is not responsible for the cost of treatment. ACLU-VA at age 14 dLCV at age of 14
3 Introduce legislation to amend *Code of Virginia* Title 16.1 to establish a process by which a minor, whose parent(s)/guardian(s) will not consent to his/her voluntary inpatient mental health treatment, may request and receive such treatment with the approval of a clinician and/or evaluator who has examined and found the minor to be in need of and likely to benefit from the requested treatment.	Mr. Bonnie reported that his review of civil commitment of juveniles led him to the conclusion that self-admission requests by minors "occur frequently enough (~125/year) to warrant statutory guidance." NAMI-VA is open to option "as long as parents' input is solicited and included in the process." VACSB, if action is to be taken, may support option if an "independent" clinician and/or evaluator must examine the minor and approve of his/her treatment.
4 Introduce legislation to amend *Code of Virginia* Title 16.1 to allow, when consent by his/her parent(s)/guardian(s) is not given, a minor to access the evaluation process of the local community services board in order to receive approval for voluntary inpatient mental health treatment.	NAMI-VA is open to option "as long as parents' input is solicited and included in the process."
5 Introduce legislation to amend *Code of Virginia* Title 16.1 to allow, when consent by his/her parent(s)/guardian(s) is not given, a minor to petition the juvenile court in order to be examined and receive authorization for voluntary inpatient mental health treatment.	

Policy Options	Comments
6 Include the following provisions in introduced legislation to amend *Code of Virginia* Title 16.1 to address: A. Parental Objection – provide opportunity to consider objections, by the parent(s)/ guardian(s), to the minor's voluntary inpatient mental health treatment. B. Admission criteria – establish the clinical criteria, for allowing the minor's admission for voluntary inpatient mental health treatment without the consent by his/her parent(s)/ guardian(s), to be the current inpatient admission standards such as those established by the American Academy of Child and Adolescent Psychiatry. C. Other evaluation criteria – establish criteria to determine that minor has the capacity to consent and is clinically suitable for the voluntary mental health treatment that will be provided. D. Liability Relief – add language that providers are not liable for damages if a minor misrepresents himself except for damages resulting from negligence or willful misconduct. E. Limitations on inpatient stays – establish limitations on the number of days a minor may be treated in the inpatient facility on a voluntary basis and/or the number of times the minor may be admitted without the consent of the parent(s)/guardian(s). F. Financial responsibility – as needed, add language regarding mental health parity provisions, financial liability of parent(s)/ guardian(s), and other payment guidelines. G. Confidentiality – determine and denote requirements in order to comply with Health Insurance Portability and Accountability Act (HIPAA) privacy provisions, such as sharing of treatment or health-insurance payment information with parent(s)/guardian(s).	Mr. Bonnie commented: • 6A – The facility should endeavor to notify the parents within 24 hours after the minor's admission and provide for judicial review if the parent objects to continued hospitalization. • 6C – A qualified evaluator as defined in *Code* § 16.1-336 finds the minor meets admission criteria "under some adaptation of" *Code* § 16.1-338.B. • 6F – "As a matter of policy, I think that parents should remain liable for medically necessary expenses to the same extents as they would be responsible if they had admitted the minor. I fear that any other arrangement would encourage parents to refuse to consent to medically necessary care that they would otherwise seek in the absence of a provision allowing self-admission of the minor." Ms. McKisson recommends that 6F include that the "parent is not liable for any costs of the treatment of the minor….There needs to be some financial provision in the law….Either the local CSB needs to step-in and make payment, the hospital has to voluntarily agree to waive the payment, VA Medicaid rules for long-term care need to be modified to accept children with a 'higher' income or without respect to income, and/or some state budget line needs to be added to provide 'gap'/financial coverage."

Comment Excerpts

Mr. Richard Bonnie discussed his views during the September 9th meeting of JCHC's Behavioral Health Care Subcommittee and subsequently provided written comment. Mr. Bonnie recommended specific statutory provisions for inclusion should JCHC members vote to introduce a bill "to allow minors to admit themselves to inpatient treatment without parental consent" (a bill he would support). The suggested provisions described below address admission criteria and procedures, parental notification and objection to continued hospitalization of child aged 14 or older, and advance directives for minors.

- "A minor 14 or older may be admitted for inpatient treatment if the minor has requested admission and a qualified evaluator [as defined in Section 16.1-336] has found that (i) the minor is capable of making an informed decision regarding admission; (ii) the minor meets the admission criteria specified in [16.1-338 B]; and (iii) parental consent is not available or seeking parental consent would be detrimental to the best interests of the minor."

Code of Virginia § 16.1-336. Definitions.	*Code of Virginia* § 16.1-338.B
"Qualified evaluator" means a psychiatrist or a psychologist licensed in Virginia by either the Board of Medicine or the Board of Psychology, or if such psychiatrist or psychologist is unavailable, (i) any mental health professional licensed in Virginia through the Department of Health Professions as a clinical social worker, professional counselor, marriage and family therapist, psychiatric nurse practitioner, or clinical nurse specialist, or (ii) any mental health professional employed by a community services board. All qualified evaluators shall (a) be skilled in the diagnosis and treatment of mental illness in minors, (b) be familiar with the provisions of this article, and (c) have completed a certification program approved by the Department of Behavioral Health and Developmental Services. The qualified evaluator shall (1) not be related by blood, marriage, or adoption to, or is not the legal guardian of, the minor being evaluated, (2) not be responsible for treating the minor, (3) have no financial interest in the admission or treatment of the minor, (4) have no investment interest in the facility detaining or admitting the minor under this article, and (5) except for employees of state hospitals, the U.S. Department of Veterans Affairs, and community services boards, not be employed by the facility.	…a qualified evaluator who has conducted a personal examination of the minor…has made the following written findings: 1. The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; and 2. The minor has been provided with a clinically appropriate explanation of the nature and purpose of the treatment; and 3. If the minor is 14 years of age or older, that he has been provided with an explanation of his rights under this Act as they would apply if he were to object to admission, and that he has consented to admission; and 4. All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor.

- "The admitting facility shall use its best efforts to notify the minor's parents within 24 hours after admission. If a parent objects to continued hospitalization, the admitting facility shall immediately notify the [juvenile and domestic relations district court] and shall discharge the minor to the custody of a parent within 96 hours unless continued hospitalization is authorized by a judge [under some adaptation of 16.1-345] or [after a medical neglect determination]."

Code of Virginia § 16.1-345. Involuntary commitment; criteria.
…by clear and convincing evidence, that: 1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control; 2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and 3. If the court finds that inpatient treatment is not the least restrictive treatment, the court shall consider entering an order for mandatory outpatient treatment pursuant to § 16.1-345.2.

- "…a minor 14 or older who is capable of making an informed decision may make a written advance directive authorizing his or her admission to a mental health facility and any treatment while hospitalized in a mental health facility for which the assent or consent of the minor is necessary."

Ms. Jacquelin McKisson, in support of Policy Option 2, wrote in part:

"I believe the code that most correctly captures how this process should be administered in the Commonwealth of Virginia is that which currently exists in Maryland: 16 Md. Code Ann., Health-Gen. §10-609 Mental health.Md. Code Ann., Health-Gen. §20-104.

- Capacity as an adult to consent.
- Application for voluntary admission of an individual to a facility may be made if the individual is 16 years old or older. (***Strongly object to anything less than 16 y.o. Simply too young for a child to make a decision of this magnitude on his/her own).
- The individual must understand the nature of the request; is able to give continuous assent to retention by the facility; and is able to ask for release.
- A minor has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic.
- The capacity of a minor to consent to treatment does not include the capacity to refuse treatment for which a parent has given consent. (***This is key).
- The physician heading the treatment team decides whether a parent of the minor should receive information about treatment. (***Only in cases where the child self-admits without parental consent. In cases of parental consent, and when parents are assuming financial responsibility, parent must be given information about their child.)
- The parent is not liable for any costs of the treatment of the minor. (***This is critical.)

My biggest comment is that parent should not be FORCED to assume payment for the costs of treatment if/when they do not give consent. The cost of MH treatment can be financially catastrophic, and long-term inpatient/residential treatment can bankrupt a family."

Ms. Claire Guthrie Gastanaga commenting on the behalf of ACLU-VA wrote in part:

"I write on behalf of the American Civil Liberties Union of Virginia and our more than 10,000 members and supporters to express our support for policy changes that will result in changing the Code of Virginia to allow minors 14 or older (mature minors) to consent to voluntary inpatient psychiatric treatment without requiring the consent of the minor's parent. The existing statute concerning the authority of minors to consent to surgical and medical treatment already allows all minors to independently consent to outpatient psychiatric treatment. As stated in section 54.1-2969E.4 of the Code of Virginia, a minor shall be deemed an adult for the purpose of consenting to medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance. Amending the code to further allow mature minors to make their own decisions about inpatient psychiatric treatment will give them an opportunity to play a meaningful role in choosing the right treatment for them, a role that experts have shown they are able to play and which can be critical to their recovery….

The ability of mature minors to make their own decisions about medical treatment and the importance of allowing them to play a key role in that treatment has been well documented by numerous medical and legal experts. Virginia should follow the advice of experts and its own policies related to outpatient psychiatric treatment and amend the code to reflect the capacity of mature minors to make these important decisions and make provisions for allowing these minors to also consent to inpatient psychiatric treatment without necessitating parental consent."

Ms. Colleen Miller on the behalf of the disABILITY Law Center of Virginia wrote in part:

"The disability Law Center of Virginia (dLCV) recommends that the Commission support legislation to amend Code § 16.1-338, to allow for a minor 14 years of age or older to consent for voluntary inpatient mental health treatment without the consent of the minor's parent, or to continue treatment, if they so choose, if a parent revokes consent during the course of hospitalization. (Option 2)

The Commission's study demonstrates the need for this amendment. Currently, youth are unable to receive treatment if their parent or guardian objects, regardless of the reason for the objection. In our experience, parents may object to treatment for a variety of reasons, including denial or disbelief, cost, or stigma associated with acute inpatient care and mental illness. In addition to these potential barriers to services for youth, dLCV often encounters situations in which children or youth do not receive the services they need as a result of parental disengagement or the parent's own mental health needs overcoming their ability to successfully advocate for their children.

Current law does not allow for youth in Virginia to access inpatient mental health treatment over parental objection without the involvement of the judicial system or Child Protective Services. The proposed amendment will reinforce best practices of client-centered involvement and choice in treatment, and of empowering individuals. It will most certainly result in better outcomes from mental health services. Additionally, this amendment will allow for increased access to services and supports for youth with serious mental illness."

Ms. Jennifer Faison commenting on behalf of VACSB indicated Option 1 is the primary option supported "largely based on…reluctance to recommend changing Virginia's code based on an exceedingly rare occurrence. We feel that there are options within the current code that allow for a minor to access residential treatment, regardless of whether or not a parent consents, and therefore support taking no action with regards to proposing legislation.

However, if the JCHC feels it must move forward with legislation, VACSB recommends…[an] amended version of Policy Option 3 [that would provide for an independent evaluation]….Providing an independent evaluation ensures a conflict-free treatment process for any minor who may request further assessment."

Graduate Medical Education in the Commonwealth

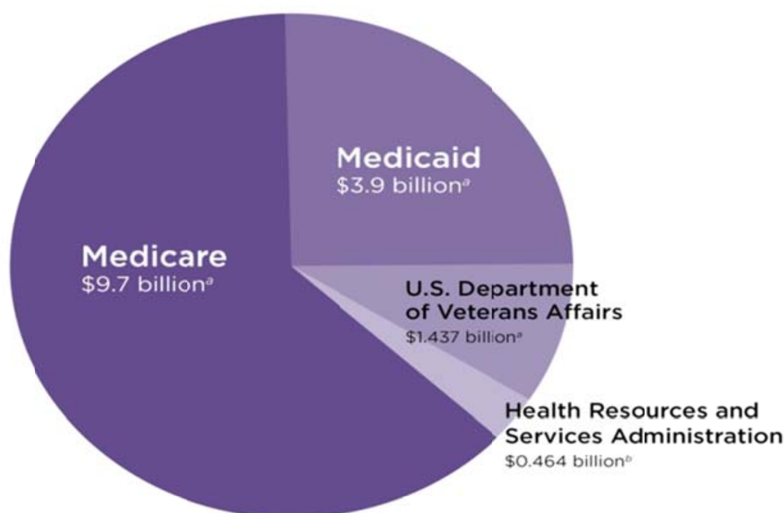
Michele L. Chesser, Ph.D.
Senior Health Policy Analyst

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

Background

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

Primary Sources of GME Funding in the U.S.



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

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

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

residency training programs and perpetuates significant inequities in GME payments among hospitals, localities and geographic regions.

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

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

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

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

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

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

Characteristics of GME in Virginia

Virginia Medical Schools and Residency Programs. Currently, there are 2,745 residents and fellows training in Virginia; 1,950 are reported as positions funded by Medicare and Medicaid. The remainder includes privately-funded positions and those funded by the military and the Department of Veterans Affairs. While approximately 860 Virginia medical school

undergraduates will be applying for residencies each year, Virginia offers about 757 ACGME/AOA approved first-year residency positions of which approximately 50 percent (382) are in primary care (family medicine, internal medicine and pediatrics).

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

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

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

Total Medicare and Medicaid GME Reimbursements, Virginia 2012

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

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

Virginia Physician Retention, 2012*

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

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

Physicians in Rural and/or Underserved Areas of Virginia. Overall, eight percent of Virginia's physicians work in non-metropolitan areas of the State. Only two percent of physicians work in southside Virginia even though the area makes up 6.3 percent of the population. In southwest Virginia, the percentages are three percent and 7.2 percent, respectively; and in the Valley region, five percent and 9.8 percent. According to the Association of American Medical Colleges, 18.2 percent of Virginia's physicians practice in a geographical medical underserved area compared to 32.4 percent in Maryland, 33.6 percent in Kentucky, 35.3 percent in North Carolina, 40.7 percent in West Virginia and 26.7 percent in Tennessee. Finally, only 13 percent of physicians in Virginia are practicing in primary care in rural areas, compared to a total of 35 percent in the State. Generally, it is recommended that at least 50 percent of physicians in a state practice in primary care.

Considerations for Improving GME in Virginia

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

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

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

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

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

Updating Virginia's Medicaid GME Payment System. The per resident amount (PRA) payment used to determine reimbursements to teaching hospitals is based on 1998 fee-for-service costs. While the PRA has been increased for inflation, payments have not kept up with actual per resident costs for many hospitals. On average, Medicaid GME payments cover 40 percent of Medicaid's share of GME costs (based on the Medicaid utilization rate for each hospital), but since payments have not been rebased since 1998, the percent of cost covered varies from 10 percent to over 100 percent of a hospital's cost.

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

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

Policy Options and Public Comment

Six comments were received regarding the policy options addressing graduate medical education in Virginia. Comments were submitted by:

- Ms. Karen Purcell
- Roger Hofford, M.D., FAAFP, CPE
- Ms. Melina Davis-Martin
  Executive Vice-President
  Medical Society of Virginia (**MSV**)
- Susan E. Kirk, M.D.
  Associate Dean for Graduate Medical Education and Designated Institutional Official
  University of Virginia Health System (**UVa**)
- Jerome F. Strauss, III, M.D., Ph.D.
  Executive Vice President for Medical Affairs, VCU Health
  Dean, School of Medicine (**VCU**)
- Christopher S. Bailey
  Executive Vice President
  Virginia Hospital and Healthcare Association (**VHHA**)

Karen Purcell, of Henrico Virginia, **did not address any particular policy option, but commented in part that the Commonwealth needs to do a better job of recruiting residents for practice in rural and underserved areas. She also indicated that the JCHC report does not see "GME as a pipeline issue that begins in middle school or earlier and ends in practice in the community…Our neighboring states, Maryland, NC, and West Virginia do much better jobs of doctor pipeline evidence-based practices alignment from middle school recruitment programs to academic medical center practice support once the doc is in the community**. Virginia has good examples of such programs such as the VCU Family Medicine which provides excellent community practice support to its preceptors. Unfortunately, there is no systematic effort throughout the Commonwealth…"

Roger Hofford, M.D., FAAFP, CPE, who served as a member of the 2010 Department of Health Professions' Physician Workforce Study Group and as program chair of the "Choose Virginia" conference for the Virginia Health Workforce Development Authority's 2010-2013 federal grant, **commented in support of Policy Options 3 through 8**.

Melina Davis-Martin, Executive Vice-President of the **Medical Society of Virginia commented in support of Options 2 through 5 and Option 7; and to suggest further consideration of Options 6 and 8**.

Susan E. Kirk, M.D., Associate Dean for Graduate Medical Education and Designated Institutional Official, **University of Virginia Health System commented** in part:
"We wish to commend the excellent study performed by Dr. Chesser which was thorough and fair, and we appreciate the amount of work that went into pulling this information together. UVa Medical Center supports the General Assembly's goals of expanding clinical training opportunities and retaining graduates who train in Virginia. Our overarching concern is for the state to achieve its goals in the most efficient way possible…**We strongly support Option 7**; **[and]…no matter which options the JCHC chooses, we urge you to consider the efficiency**

of supporting academic medical centers within the state that already have the teaching infrastructure and faculty in place to train new physicians…using inexperienced faculty to oversee residents may not be in the best interests of patients or trainees. We also note that **while it is important for the state to provide funding to support new resident training slots, we hope the state will not overlook the existing family practice residencies it currently funds at UVa, VCU and EVMS**. These highly respected seasoned programs produce numerous family medicine physicians, some of whom have chosen to stay in Virginia to practice. The General Assembly initiated its funding of these programs in the 1970's and while it has continued to fund the programs, the cuts to the higher education budget--where the funding is placed—have steadily eroded the state's support."

Jerome F. Strauss, III, M.D., Ph.D., Executive Vice President for Medical Affairs of VCU Health and Dean, **VCU** School of Medicine **commented in part**:

"**While we appreciate the Joint Commission's suggested policy options regarding the expansion of primary care residencies, we are concerned that the options as presented do not address a matter of crucial importance: the continued, sustainable funding for existing primary care residency slots**….VCU Health encourages that the Joint Commission on Health Care consider the following changes to the study's policy options:

1. **Add a 9th policy option to increase the funding levels for existing primary care residencies supported in the Higher Education budget;** ***or***
2. At a minimum, **revise Option 3 to make new supplemental payments available to support** ***existing*** **(i.e., already accredited) primary care residencies**.
   - **Option 3**: Introduce a budget amendment (language and funding) for DMAS to amend the State plan to establish an additional Medicaid health professional training supplemental payment. Funds would be based on an average per resident amount of $140,000.
     - Criteria developed by DMAS would set aside half of the available funds to support primary care training programs, **including existing programs**, and the remainder for other needed specialties (e.g. psychiatry).
     - Preference for primary care programs would be given to programs that extend their training to community settings, especially in rural or underserved areas."

Christopher S. Bailey, Executive Vice President, **Virginia Hospital and Healthcare Association commented in part** that "the study does a very thorough job of analyzing the issues and offers many well-founded recommendations. **VHHA believes that expansion of graduate medical education and advanced practice professional training opportunities is the single most impactful policy action the Commonwealth can take to ensure an adequate healthcare workforce for the future…The proposed policy options are largely consistent with the findings and recommendations of VHHA's Health Care Workforce Task Force Committee, a group which included representatives from higher education, health systems, physician and nurse professional societies and the Commonwealth." VHHA supports Options 2, 3, 5, 7 and 8**.

Policy Options	Comments
1. Take no action.	Mr. Bailey (**VHHA**), Ms. Davis-Martin (**MSV**) and Dr. Hofford commented in opposition to taking no action.
☑ **2**. Request by letter of the JCHC Chair that DMAS determine a plan, including budget estimates, to rebase the costs used to establish the per resident amount for DME payments and report to JCHC by September 2016. Include estimates for rebasing up to 100 percent of Medicaid's portion of a hospital's GME cost. **Vote 11-0**	Mr. Bailey (**VHHA**) commented that "Option 2 must be done with rebasing up to 100% of the Medicare GME cost for Virginia hospitals. This has not been done since 1998. The DMAS plan should include redirecting funds from out-of-state hospitals to in-state hospitals…" Ms. Davis-Martin (**MSV**) supports this option with the following amendments: 1) "rather than merely identifying a plan, also introduce a budget amendment to fund the implementation of the plan"; and 2) have DMAS study the allocation of payment to out-of-state hospitals and consider reallocating the funds to existing Virginia residency slots in most-needed specialties that are unfilled due to the lack of state and/or federal support. "The MSV requests the opportunity to participate in the development of the plan." Dr. Hofford commented: "Hard to support or oppose without knowing who the winners and losers will be."
☑ **3**. Introduce budget amendment (language and funding) for DMAS to amend the State plan to establish an additional Medicaid health professional training supplemental payment. Funds would be based on an average per resident amount of $140,000 • Criteria developed by DMAS would set aside half of the available funds to support expansion of primary care training programs and the remainder for other needed specialties (e.g. psychiatry). • Preference for primary care programs would be given to programs that extend their training to community settings, especially in rural or underserved areas. **Vote: 11-0**	Mr. Bailey commented that **VHHA** supports this option, "with the modification that funds should also be set aside for expansion of other needed specialties such as radiology, neurology and orthopedics." Ms. Davis-Martin (**MSV**) supports this option with the following additional consideration: The State should "consider opportunities to fund training opportunities that exist currently but lack operational funding…Furthermore, there may be opportunity to partner with the Veteran's Administration to operationalize currently unfunded training programs using a public-private funding model. The MSV requests the opportunity to participate in the development of the criteria." Dr. Hofford commented in support adding: "We need to be careful how we define primary care…to be sure we use objective data in making the case for need and avoid the political process by various graduate medical education specialties lobbying for the GME funding pie." Dr. Strauss (**VCU**) recommended revising the option to have DMAS allow existing primacy care training programs to qualify for Medicaid health professional training supplemental payments.

Policy Options	Comments
☑ **4**. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, contact hospitals that have never had residency programs to determine which ones may be interested in developing such programs and what support, including seed money, might be needed to develop successful programs, *with a report to JCHC by September 2016.* **Vote: 9-1**	Mr. Bailey (**VHHA**) commented the state should ensure "current programs are adequately funded first...consider expanding existing programs before supporting new programs….[and] ensure that graduates would want to do their residencies at these new locations before instituting new programs at these locations." Ms. Davis-Martin (**MSV**) commented in support with revision that "VHWDA collaborate with the medical schools in collecting this information…." Dr. Hofford commented in support recommending the use of "objective, experienced consultants to determine the final setup costs and costs to maintain a residency including payer mix served and whether Virginia expands or does not expand Medicaid coverage."
☑ **5**. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the Virginia Community Healthcare Association and the stakeholder Graduate Medical Education Advisory Group, assess whether it is prudent to develop residency programs based on the Teaching Health Center GME Program Model in Virginia and, if so, what would be needed to develop successful programs, with a report to JCHC by September 2016. **Vote: 9-1**	Mr. Bailey commented that **VHHA** supports this option and recommends that this teaching health center model be part of the work plan undertaken by the GME governing body recommended in Option 8. Ms. Davis-Martin (**MSV**) commented in support of this option and encourages the group to rely on the work of VCU which studied best practices in this are as a grantee of VHWDA. Dr. Hofford commented in support of this option.
☑ **6**. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, assess whether it is prudent to develop a Virginia Sole Community Hospital Residency Fund and, if so, what would be needed to develop successful programs, with a report to JCHC by September 2016. **Vote: 9-1**	Mr. Bailey (**VHHA**) commented that "establishing a Sole Community hospital residency program may not be the best use of resources due to the cost and time associated with implementation. Additionally, thought should be given to whether these programs will be in places where residents want to be trained and live." Ms. Davis-Martin (**MSV**) advised further consideration: since federal funds provide the largest share of program-funding, "it is likely that implementing these programs absent those indirect medical education dollars will jeopardize long-term sustainability. Instead, it may be most appropriate for the Commonwealth to explore ways to draw down additional CMS dollars, perhaps through advocating for a change in CMS policy that currently limits the ability of these hospitals to access these funds."

Policy Options	Comments
	Dr. Hofford commented in support of this option.
☑ **7**. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, assess the effectiveness of the State Loan Repayment Program and the potential benefits of expansion of the program, with a report to JCHC by September 2016. **Vote: 9-1**	Dr. Kirk commented that **UVa** strongly supports this option, stating "we feel that a loan repayment program is integral to the retention of residents in the state. Regardless of where a resident performs his or her residency in the state, the forgiveness of their extraordinary medical school debt in return for practicing in a rural or underserved community is the anchor that will keep them in these communities…If the JCHC chooses this option, we suggest it recommend that the Virginia Health Workforce Development Authority explore other loan repayment programs that work well such as the NIH's Clinical Research Loan Repayment Program." Mr. Bailey (**VHHA**) commented that "a loan repayment program may be an excellent option to retain graduates and encourage others to do their residencies in Virginia and remain here after graduation." Ms. Davis-Martin (**MSV**) commented in support of this option but stated, "we are most in favor of immediate and full funding of this program. Should funding be available for this purpose, the MSV requests that the VDH partner with key stakeholders to promote these opportunities." Dr. Hofford commented in support of this option.
☑ **8**. Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, develop a plan for a GME governing body in Virginia, whose responsibilities would include: • Guide workforce and GME data collection • Provide policy recommendations and oversee policy implementation • Assure that the GME system is meeting the needs of the State and each of its regions. *A report on the proposed plan will be presented to JCHC by September 2016.* **Vote: 9-1**	Mr. Bailey commented that **VHHA** supports this option, "perhaps as an adjunct to the State Council of Higher Education in Virginia's activities." Ms. Davis-Martin commented that "the **MSV** supports the exploration and assessment of the value of establishing a GME governing body. Considering that the Commonwealth is making a substantial investment in GME, it is appropriate for this type of body to be considered. The stakeholder group, of which MSV is a member, should consider how such a group should be formed that has the expertise to conduct this work but may maintain an impartial objectivity to the proposed activities." Dr. Hofford commented to strongly support "if all the right constituencies are present on the Graduate Medical Education Advisory Group and Virginia Health Workforce Development Authority with adequate support of funding and staffing to carry out the charge. One of the study pieces in the GME funding should be how that money that is controlled by the state is spent."

The Advisability of Establishing a Midlevel Provider License
Virginia Department of Health Professions

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

DHP Review of Midlevel Providers

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

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

DHP-Convened Workgroup Recommendations

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

1. Increasing the number of Graduate Medical Education (GME) residency slots.
2. Ensuring state methods and organizational structures target GME positions toward state health workforce needs.
3. Levering emerging technology and telemedicine to reach the underserved and address geographical mal-distribution of physicians.
4. Utilizing a team-based approach to health care delivery with integration of nurse practitioners and physician assistants.
5. Ensuring Virginia effectively utilizes currently regulated professions, such as nurse practitioners and physician assistants, to address access to care issues before establishing a new level of provider.

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

6. Considering an increase in the licensure fee to fund rural physicians.
7. Ensuring the sustainability of any solution to address physician shortages.
8. Ensuring any solution to address workforce issues does not compromise patient care and safety."[4]

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

JCHC-Member Discussion During Decision Matrix Meeting

Delegate Stolle indicated the DHP report provided strong evidence in support of establishing a midlevel provider license for medical school graduates and, that as the GME study reported, a number of Virginia's medical school graduates will be unable to obtain a residency rendering them unable to function as a health care provider even though they have far more education and experience than nurse practitioners (for whom Virginia has a midlevel provider license).

Delegate Stolle then asked that JCHC consider introducing legislation establishing a midlevel provider license for medical school graduates who have not completed a residency as well as for veterans as they leave the military consistent with their care-related experience. Following discussion, a motion to introduce the proposed legislation was made by Senator Puller and seconded by Delegate Stolle and Senator Barker. The motion was approved by a vote of 10 yes and 1 no.

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

[4] Ibid, p.1

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