REPORT ON THE

NEEDS OF MEDICALLY INDIGENT CHILDREN

IN VIRGINIA

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 27

COMMONWEALTH OF VIRGINIA
Richmond, Virginia
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INTRODUCTION

The Secretaries of Human Resources and Public Safety were requested to conduct a study of the needs of medically indigent children by House Joint Resolution No. 55, agreed to by the House of Delegates and the Senate of Virginia during the 1980 Session. That resolution is as follows:

HOUSE JOINT RESOLUTION NO. 55

Requesting that the Secretaries of Human Resources and Public Safety study the needs of medically indigent children.

Agreed to by the House of Delegates, March 6, 1980
Agreed to by the Senate, March 3, 1980

WHEREAS, statistics compiled by the Department of Health in nineteen hundred seventy-eight estimate that there are approximately three hundred sixty thousand medically indigent children under the age of twenty-one living in the Commonwealth; and

WHEREAS, these three hundred sixty thousand medically indigent children do not include children who currently qualify for medical assistance through the Virginia Medical Assistance Plan (Medicaid) as a result of their family's participation in the Aid to Families with Dependent Children program; and

WHEREAS, in its study from nineteen hundred seventy-eight through nineteen hundred seventy-nine, the Commission on Family Life learned about these medically indigent children who, according to the statistics, appear to be receiving no medical services but who, in fact, may be receiving medical services from other public or private sources; and

WHEREAS, the federal government has provided an option by which individual states may separate Medicaid eligibility from the Aid to Families with Dependent Children program for the purpose of providing medical assistance to all medically indigent children in the State; and

WHEREAS, the healthy development of children and the well-being of their families is a primary concern of the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Human Resources and the Secretary of Public Safety are requested to study the needs of medically indigent children in Virginia. They shall consider the programmatic and fiscal feasibility of providing Medicaid benefits for all medically indigent children as well as other options for serving the health care needs of this group of children.

They shall report their findings and recommendations to the Governor and the General Assembly prior to the nineteen hundred eighty-one Session of the General Assembly.

In response to the direction of the General Assembly to conduct a study on the needs of medically indigent children, the Secretaries of Human Resources and Public Safety requested that the Division for Children carry out the study on their behalf.

BACKGROUND

In 1976 and 1977 a subcommittee of the House Committee on Health, Welfare and Institutions conducted a study on the placement of children (see House Document No. 16-1977 and House Document No. 22-1978). During the course of its study, the Subcommittee on the Placement of Children determined that gaps existed in medical coverage for children in the juvenile justice and welfare systems. As a result of their research, the Subcommittee proposed legislation which would establish a study to specifically address the issue of medical care for this group of children. With the passage of that legislation in 1978, a joint subcommittee was established to conduct the study.

The Joint Subcommittee on the Medical Needs of Children in its report to the General Assembly (see House Document No. 28-1979) indicated that significant barriers to the financing of appropriate medical care and treatment for many children in State and local care and custody had been removed. The subcommittee also recognized the importance of a "continuing review of Virginia's resources in the human services delivery system in order to meet the health needs of the children of the Commonwealth."[1]

In 1978 the General Assembly created the Commission on Family Life to study the alternatives available for providing a coordinated approach toward meeting the needs of Virginia's families. In the course of their work, the Commission developed a family impact analysis procedure as a mechanism to be utilized in assessing the impact of governmental actions upon families. As a test of that procedure, the Commission chose to examine the Aid to Families with Dependent Children (AFDC) program, which is administered at the State level by the Department of Welfare. The Commission studied the relationship between the AFDC and Medicaid programs and reported that there are 360,000 children in Virginia under the age of 21 who are medically indigent. The Commission was concerned that this large population of children who are potentially eligible for Medicaid assistance might not be receiving needed health care services. This study is the result of their interest in health services to Virginia's low income children.

Study Design

After being designated as the lead agency with regard to H.J.R. 55, the Division for Children submitted a proposed design for the conduct of the study to the Secretary of Human Resources. That suggested design was approved with few changes. The Division's staff has contacted a wide variety of individuals and organizations regarding health care services to medically indigent children. Telephone and personal interviews were conducted with State officials, private physicians, representatives of professional associations and organizations, community action agencies, local health departments, local departments of social services, legal aid attorneys, hospital administrators, health planners, medical social workers, nursing personnel, child advocates, Federal officials, State legislative staff, physicians in teaching hospitals, and health administrators. Particular attention was given to those cities and counties which were identified as "designated poverty areas" in the 1980 State Plan for Developmentally Disabled Assistance. Other input came as the result of an article in the Division's newsletter, Aware, alerting the readers about the study. Library research also proved to be quite useful in that several recent studies have focused, at least in part, upon the issue of health care for the medically indigent.

The "Findings" section of this report attempts to examine some of the resources available to meet the needs of medically indigent children. Several problems are identified which require resolution. And finally, recommendations are made which, if followed, should result in improved health services to low income children in Virginia.

FINDINGS

In its report to the President in March 1980, the United States National Commission on the International Year of the Child identified the United States as "the only industrialized nation that has not adopted in principle and in practice the right to health care for all children."[2] Good health care is not distributed equally among the nation's children. Children from poor families, and especially children from poor single parent families, tend to be less healthy than children in higher income families. Most of these children live in substandard housing or in crowded conditions. In some parts of the United States, children from low income families have five times more emotional problems, six times more hearing defects and seven times more visual problems than children from more affluent homes.[3]

Because poor children have more health problems than their more affluent counterparts, several governmental programs have been established at the national level to provide poor children with good health care. Unfortunately, these programs are characterized by varying eligibility criteria, overlapping service categories, and gaps in coverage.

Some programs were designed to serve certain categories of low income children, other programs were designed to make medical care available in certain "high risk" or "medically underserved" geographic areas, and still others were established to provide services to children suffering from a specific disease or condition. This hodgepodge of health resources is confusing to physicians, service providers and clients alike and makes it nearly impossible to determine whether these programs actually make resources available to the children who need them.

A similar situation exists at the State level. In addition to many of the services funded by the Federal government, Virginia uses resources of its own to provide health services to the medically indigent. Despite the wide variety of resources theoretically available to assist in meeting the health needs of low income children, some programs are underutilized, other programs cannot meet the demand for services, and many children go without needed health care. Failure to meet these needs robs them of years of their lives, reduces their productivity, and costs us millions of dollars in remedial care.

Health Care Resources

In June 1978, the Joint Legislative Audit and Review Commission published Medical Assistance Programs in Virginia: An Overview which contained an excellent inventory of State and Federal programs providing medical assistance to the poor. Rather than duplicate their efforts, this study has concentrated on a few of the important resources which provide medical assistance to low income children in the State. Other resources will be mentioned but not discussed in any great detail. We encourage any readers interested in a more comprehensive approach to refer to the inventory mentioned above and the State Health Plan.

Medicaid

The largest resource for meeting the health needs of low income children is a jointly funded and administered Federal-State program of medical assistance known as Medicaid. The Medicaid Program was designed to reduce financial barriers to access to health care for low income and medically needy persons by subsidizing their use of services with direct payments to private and public providers of health care. Although not all poor children are eligible for Medicaid, those who are eligible benefit from a broad range of services.

Eligibility for Medicaid is closely linked with eligibility for welfare. Generally, anyone eligible for the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program is automatically eligible for Medicaid. In addition,

Virginia has elected to offer services to the "medically needy," a category of individuals with incomes slightly above the AFDC eligibility level and who might otherwise be eligible for AFDC or SSI benefits. Individuals with incomes above the level set for the "medically needy" may also qualify if their incomes fall below a certain level after deducting medical expenses and if they might otherwise be eligible for AFDC or SSI benefits. Most children in foster care (94.6%) are also eligible for Medicaid.

As a result of policy decisions made at the State level, a significant number of low income children are not eligible for Medicaid benefits. With a few exceptions, Virginia has elected to cover only single parent families under AFDC, thereby denying Medicaid benefits to low income children in intact families. This policy especially discriminates against children in low income, rural families, since it has been found that they are more likely than low income, urban children to have two parents in the home. The problem is compounded by the fact that child health services generally are less accessible in rural areas. Virginia could elect to serve all needy children under the age of 21 even if they all were not included under the State's AFDC program. The projected impact of exercising such an option will be discussed later in this report. Indigent single women, who are pregnant with their first child, also are ineligible for Medicaid benefits until the first day of the month in which the child is born. Although prenatal care is available to low income women at most local health departments, the costs of delivery may not be covered.

As of August 1, 1980, 281,251 individuals were enrolled in the Medicaid program, and slightly more than 46 percent of those recipients were children. In Federal FY 1979 an average of $357.00 per child was spent. Comprising approximately 46 percent of the total Medicaid recipient population, children accounted for 17 percent of the total expenditures for recipient claims during that time period.

During our examination of the Medicaid program, we discovered that except for a few children cared for in St. Mary's Infant Home in Norfolk and the Crippled Children's Hospital in Richmond, there are no pediatric long term care beds outside of the State training centers for the mentally retarded. Because of this shortage, at least 20 children are currently being cared for in geriatric nursing facilities. We recommend that the State Department of Health and other appropriate agencies address this need for additional public or private facilities which can provide long term nursing care for children.

Indigent Care at State Teaching Hospitals

While the primary mission of the State's teaching hospitals is to serve the instructional and research needs of the medical schools, the Medical College of Virginia in Richmond, the University of Virginia in Charlottesville, and the Eastern Virginia Medical Authority in Norfolk all serve as resources for providing services to indigent persons.

Data does not exist which would permit us to assess the effect of the indigent care resource on the medical needs of low income children. Hospital administrators state that they simply do not collect comprehensive data on services to children which are funded through indigent care monies. In fact, the language of the Appropriations Act directs the Medical College of Virginia and the University of Virginia to report only expenditures under the fund and not numbers or characteristics of patients being served.

More information about this State appropriation may be obtained from Inpatient Care In Virginia, a report of the Joint Legislative Audit and Review Commission. It is interesting to note that the amount of State money spent for indigent care at the Medical College of Virginia and the University of Virginia in FY 1976 was nearly equal to State general fund expenditures for Medicaid.

On the basis of our discussions with administrators at the teaching hospitals, we conclude that while State indigent care funds are likely a considerable resource for indigent children, the funds remain a resource that is difficult to measure.

Hill-Burton Charity Care

Hill-Burton Charity Care is provided in hospitals and other medical facilities which received Federal Hill-Burton grants to finance their construction. Receipt of Hill-Burton construction aid obligates a hospital or medical facility to provide a certain amount of free care to the medically indigent. Although an exact figure is not available, Hill-Burton facilities are obligated to provide an estimated $8 million annually in uncompensated care to persons at or below Federal Community Services Administration poverty guidelines.

New regulations have made substantial changes in the requirements for provision of uncompensated care through Hill-Burton. Prior to these regulations, Hill-Burton facilities could elect an "open door" option which did not affix a specific dollar amount to their Hill-Burton responsibility. In the absence of a specified obligation, it was difficult for the program to be effectively monitored and enforced.

The new regulations stipulate that, beginning with the facility's next fiscal year following September 1, 1979, their Hill-Burton responsibility shall be not less than:

a. three percent (3%) of the facility's total operating costs or
b. ten percent (10%) of the original Hill-Burton construction grant received.

In addition to the requirement that uncompensated care would be provided to indigent persons for a period of twenty years following completion of construction, obligated facilities also supplied assurances that medical services would be provided to community residents on a non-discriminatory basis. A Hill-Burton facility must refrain from admissions policies which make medical services unavailable to indigent persons who are eligible to receive free care. This "community service" assurance specifically provides that a Hill-Burton facility shall not:

a. deny emergency service on the grounds that the person is unable to pay;
b. fail to provide service to patients receiving Medicare and Medicaid; and
c. have exclusionary admissions policies (for example, in the case where a hospital admits patients only as patients of physicians with admitting privileges, the hospital must provide a means by which an indigent person (who is not the patient of such a physician) may be admitted.

Individuals contacted through our survey were hesitant to describe Hill-Burton uncompensated care as an important resource for medically indigent children and families. The most frequently described problem was that medically indigent persons who might be eligible for assistance are not informed about the availability of Hill-Burton funds. Required posted notices are often small and easily overlooked. According to our sources, the single most significant barrier to Hill-Burton being an effective resource is that facilities simply do not publicize its availability.

Additionally, the Hill-Burton program has a troubled history of ineffective monitoring and lax enforcement of facility compliance. With changes implemented by the new regulations, responsibility for monitoring Virginia's 113 Hill-Burton facilities has shifted from the State Department of Health to a two-person staff at the Region III Department of Health and Human Services office in Philadelphia. This same staff has responsibility for monitoring all Hill-Burton facilities (over 1200) in the entire region.

Regulations require that Hill-Burton facilities submit reports to the Regional Department of Health and Human Services every three years. The reports do not require information about the number

of patients receiving care under Hill-Burton auspices, but rather the hospital's unaudited report of total dollars expended under Hill-Burton. Thus, data are not available which would identify the numbers of medically indigent children using Hill-Burton as a resource for meeting medical care expenses.

It is recommended that the State Health Department pursue the option of contracting for a role in monitoring, investigating complaints, and/or reviewing reports regarding the Hill-Burton program. The State may utilize funds received under Section 1529 of the 1974 Health Planning and Resource Development Act to pay for expenses incurred in the course of carrying out such a role.

Health Insurance

Although the proportion of the population with health insurance coverage has increased over time, lower income families are less likely to be covered by hospital and/or surgical insurance. In one national survey only 39 percent of the people in families with incomes less than $3,000 had hospital insurance coverage, compared with 90% of persons in families with incomes of $10,000 or more. In 1973 approximately 22 percent of the civilian population under the age of 36 was unprotected by private health insurance. A disproportionate number of this category were children and the poor, although one would expect that part of that population had its medical care covered under Medicaid.[4]

According to the 1978 Virginia Health Survey, only 76 percent of persons in households with incomes less than $7,000 had some health insurance, as compared to 90% for all incomes averaged.[5] In addition, our sources stated that many rural poor families, by nature of their agricultural and seasonal work, were uncovered by health insurance plans. Families with an unemployed head of the household also are likely to be without health insurance.

Special Problems

In the course of this study several areas were identified which are not specific to any one program but which impact in a general way upon the delivery of medical services to low income children. The first and most important of these problems is the lack of access to health care.

Access to Health Care

Access or entry into the system is the initial step toward getting medical assistance. Yet, every day, children in Virginia do not receive the health care that they need. Research has indicated that many low income families remain entirely outside the health care system. One study reported that poor families in a central city area used medical services only 15 percent of the time their symptoms indicated they needed care.[6] Some children only visit a health professional when there is a serious problem; many children never visit a dentist; and a number of children needing mental health services are not receiving them.

Children are unable to get the care they need for a variety of reasons. As mentioned above, our health care system is often fragmented with a confusing variety of overlapping services, eligibility criteria, and public and private access points.[7] After holding a series of public hearings on the unmet health needs of children, the American Nurses Association reported that "the overriding concern in each of the hearings, repeated over and over again, is that the delivery of care to children in this country is in wide disarray, ineffective, fragmented, uneven, and in many instances non-existent."[8]

Families in rural areas have special problems which affect their ability to provided health services for their children. In rural areas there is very little public transportation, some families do not own cars, weather conditions often make roads impassable, and many families have to travel a great distance to visit a health service provider. In addition, "only one-third of the rural poor meet Medicaid requirements and the SLH program is only nominally used in rural areas."[9]

Generally, public health care for indigent children is available on a Monday through Friday basis between 8:00 a.m. and 4:30 p.m. However, children do not always get sick between those hours. Many working parents, especially those in the typically rigid low paying jobs, do not have the flexibility to take their children in for care during the day. Limited hours may discourage some parents who need to bring a child in for care but who have other children at home. Babysitters may be unavailable or expensive, and public health facilities are usually not open in the evenings, when another family member might be able to care for the other children. The General Accounting Office reported that many health officials believe that more women would seek maternity and well baby care if it were offered at more convenient times.[10] Long hours spent in crowded waiting rooms also discourage low income parents from getting needed care for their children.

An understanding of the nature of low income families gives one insight into the reasons why many indigent children do not receive medical assistance. Lacking the resources of more affluent families and living in a constant state of insecurity, poor families tend to be "present" oriented with attention placed upon solving immediate problems and meeting immediate needs. The idea of preventive health care is inconsistent with this orientation, and for many low income families, preventive health care is viewed as an unaffordable luxury. Coupled with such factors as long distances to clinics, inconvenient hours of operation, long waiting times, and/or inadequate physical conditions in public clinics, the child in the "crisis" oriented family receives only episodic care. A family that receives Medicaid benefits has a distinct advantage over a low income family that does not. Yet because of the nature of poverty, Medicaid eligibility, and therefore more continuous care, fluctuates greatly over time. Contrary to the stereotype that welfare recipients have simply resigned themselves to dependency, for many, poverty is not a static condition. A typical AFDC family may receive assistance (and Medicaid benefits) for 2½ years, leave welfare, and eventually receive it for 2 years more. The children in those families may be eligible for Medicaid benefits and the resulting more comprehensive health care for only a relatively short portion of their lives. Health care professionals do not always understand the language or culture of low income clients. While all programs cannot be staffed with individuals who share the clients' ethnic or cultural backgrounds, an applied understanding of and sensitivity to the clients' lifestyles will increase the likelihood that parents will understand their children's problems and follow the suggested treatment instructions.

While there has been increasing publicity about health services available to children and pregnant women, some parents are still not aware of the various sources of medical assistance, and not all service providers have been aggressive in marketing their programs. Sometimes health care providers must take the initiative to find, educate and help bring in parents and their children for services. The General Accounting Office found that "many health care providers offer little or no outreach to attract patients, nor do they follow up on patients who miss appointments."[11] Our own survey found a low level of awareness regarding Hill-Burton benefits and in some cases clients were actively discouraged from applying.

Physicians are not distributed equally around the State, and there are some areas where there is no doctor. A recent study reported that 39 percent of Virginia's 136 counties and cities had no obstetrician or pediatrician and 25 percent lacked both.[12]

Accompanying this maldistribution of physicians is the inability of all local health departments to provide needed services. The health department of one Virginia city, visited during the General Accounting Office study, provided no maternity care, even though the high infant mortality rate in the core city area had been identified as a major health problem.[13] Some Virginia health departments do not offer sick baby/child care. Although all Virginia localities have at least one private physician enrolled as a Medicaid provider, over one-quarter of the licensed physicians in the State are not participating. With regard to hospital care, "striking differences occur among regions in the amount expended for indigent care, and funds are primarily received by a relatively small number of high cost hospitals."[14]

The lack of access to health care programs is a serious problem for many indigent children in Virginia. The discussion above points to some of the reasons why many children are unable to get the care that they need. Despite some obvious problems with the program, in general Medicaid and its Early and Periodic Screening, Diagnosis and Treatment (EPSDT) component have a positive impact upon the health of eligible low income children. A more serious problem, however, is the plight of children in low income families who are not eligible for Medicaid benefits.

Children of the Working Poor and Intact Families

Although Medicaid covers many low income families in Virginia, a substantial number of low income children are not currently eligible for assistance. Because of current restrictive eligibility guidelines and persistent inflation, the number of medically indigent children in Virginia has probably risen over the past few years. Clearly, fewer medical benefits are available to poor families who do not qualify for Medicaid.

Children in two parent families normally are not eligible for benefits under the Virginia's Medicaid program. In many cases these families have a greater need for health care and fewer resources to meet that need than families eligible for Medicaid.[15] The Federal Government provides the State with an option to offer Medicaid services to all medically indigent children under the age of 21. The State Department of Health recently estimated that an additional 360,000 children would be eligible for Medicaid if all low income children under age 21 were covered as a category. This is the same figure submitted in 1978 to the Joint Subcommittee on the Medical Needs of Children. The Health Department also estimated that it would cost an additional $117 million (43.6 percent of which, or $51,012,000, would be State funds) to cover this group of medically indigent children for the current biennium.

Should such an option be instituted in Virginia, increased administrative expenses are expected. The volume of Medicaid applications would increase dramatically with a potential doubling of the number of recipients. Additional welfare staff would be necessary to provide eligibility determination and social services. The cost to the Virginia Medical Assistance Program would increase for all the required administrative procedures related to claims processing, appeals, quality control and utilization control.

Savings in other public health programs serving children (e.g., State Local Hospitalization, Indigent Care Funds) probably would result from such a policy change, but at this time we are unable to accurately predict the extent of such savings. In the long run significant cost savings are likely as a greater number of children would receive preventive health care early in their lives. Early preventive measures can reduce the number of children who are in expensive institutions, shorten hospital stays, prevent handicapping conditions, reduce dental disease, and increase the likelihood that the children served will become productive adult members of our society.

Similar to the children in poor intact families, many pregnant low income women face difficulty in securing necessary health care.

Pregnant Women

Without proper care during her pregnancy, a woman is likely to experience complications and give birth to a baby who may be handicapped in some way. A low income woman is more likely to experience problems with her pregnancy than is a more affluent woman, and low income, non-white women are even more at risk. In 1977, Virginia's infant mortality rate of 15.7 per 1,000 births was approximately 12 percent higher than the national rate.[16] Many women do not make the recommended number of prenatal visits. In 1976, the low birth weight rate for blacks in Virginia was more than twice as high as the rate for whites.[17] In 1978, 12,228 teenagers gave birth. Two hundred seventy-five of those mothers were under 15.[18]

Virginia's Medicaid plan does not cover low income women for their first pregnancy, even if both mother and child would qualify for assistance after birth. The Department of Health estimated that the impact upon Medicaid would be $1 million annually (43.6 percent of which, or $430,000 would be State funds) to cover approximately 5,000 women per year. Most of these expectant mothers are likely to be teenagers who are medically at risk. Although prenatal care is available to many low income women through local health departments, the costs of delivery may not be covered. Many hospitals require a deposit prior to inpatient admission for delivery, and in one case reported to us a patient in labor was denied services for lack of a deposit.

Without some form of financial or medical assistance, many mothers are unable to provide the prenatal and infant care necessary to start their children on the path to good health. Our next topic of discussion examines the needs of medically indigent children in State and local care and custody.

Medical Assistance for Certain Children in the Juvenile Justice and Welfare Systems

As mentioned earlier in this report, the Joint Subcommittee on the Medical Needs of Children studied the barriers to financing appropriate medical care for children in State and local care and custody and identified steps that State agencies could take to ameliorate the problem. Our research indicates that except for a few isolated cases, the implementation of those corrective actions has resulted in more appropriate Medicaid coverage for the children.

Medicaid coverage for children in the programs of the Department of Corrections and local court service units began March 1, 1979. Children who are not excluded, because of inmate status or placement in public institutions having more than 16 residents, are eligible for Medicaid if they meet the financial eligibility critieria. The Department of Health reported that in the year from July 1, 1979 through June 30, 1980, the program served a total of 625 children. Experience has shown that these children remain in the program a short time, and the annual turnover rate is 120 percent. During fiscal year 1979, the Medicaid program expended $112,255 for health care for these children at an average cost of $180 per child.

The Department of Welfare does not have the capability to monitor this policy change through regular reporting, as all Medicaid eligible children in foster care are counted together regardless of their placements. However, they were able to estimate that, on any day, there are 57 children in foster care eligible for Medicaid who would not have been eligible prior to the policy changes. These changes in Medicaid policy have permitted the placement of children in custody of local welfare agencies in community-based group homes without loss of Medicaid coverage. In addition, these policy changes have permitted corrections - related children to be placed in community group homes without automatically being rendered ineligible for Medicaid.

CONCLUSIONS

Since 1965, we have seen an expansion in the role that the Federal government has played in improving health care for the disadvantaged. Significant State expenditures have also contributed to meeting the health needs of many low income children and their families. Although steady progress has been made, as reflected by the recent expansion of the EPSDT and W.I.C. programs, much remains to be done.

Despite the availability of a broad variety of Federal and State resources to provide medical assistance to children, that system is confusing, fragmented, and permits many children to go without needed health services. Because of the major role which the Federal government plays in financing this system, attempts by the State to effectively coordinate this patchwork of services will be difficult indeed.

Medicaid is the major program financing health care for the poor. Clearly, Medicaid has improved the health of many of the disadvantaged, and our sources felt that it was a valuable resource in meeting the health needs of many of the Commonwealth's children. Yet because it is tied to the welfare system, many children are ineligible for its services. Poor children in two parent families, typically with a father who is unemployed or underemployed, could benefit from Medicaid services. The State may wish to consider redirecting general funds for indigent care which currently may be unmatched with federal dollars (i.e., State Local Hospitalization, Indigent Care Funds) and changing Medicaid to cover all indigent children under 21. Such a decision would also remove certain rural-urban inequities.

While children represent approximately 46 percent of the Medicaid recipients in Virginia, only 17 percent of the total expenditures for recipient claims were on claims for children. SSI recipients are the most expensive category of Medicaid recipients to serve. This group contains a large number of elderly recipients, many of whom are in nursing homes. Although a part of this age differential in Medicaid expenditures reflects a lesser cost for medical assistance to children, an argument can be made that poor children should receive greater benefits under Medicaid. Because of the tremendous benefits possible from identifying and treating health problems in their early stages, efforts to expand Medicaid coverage to include more children in need should be seriously considered. In addition, the State should take steps to reduce expenditures for long term care by increasing appropriate services which would enable many of its citizens to remain in their homes.

As mentioned previously in this report, the State should take action to identify additional public or private facilities that can provide long term nursing care to children. It is inappropriate for children to be placed in nursing homes designed for geriatric patients.

We found that many people in the field were unaware of the Hill-Burton program. In addition, we received complaints that some of the Hill-Burton medical facilities are acting contrary to their "community services" assurances and a few may be actively discouraging clients from applying for assistance. The State should take an active interest in this program to insure that Hill-Burton facilities meet their obligations to the poor.

As emphasized by the Children's Defense Fund in their study of health services to children and their families, "doctors and dollars are not enough." Unless the health delivery system is knowledgeable about and responsive to low income families, many children will not gain access to the services which they need. The following suggestions address questions of accessibility.

First, the Department of Health should consider amending its rules to permit local agency-wide mailings of food vouchers in the W.I.C. program. Clients should not be expected to travel monthly to pick up food vouchers in person, especially where long traveling times and distances are involved.

Second, local health providers should consider offering services in the evenings and on weekends. Flexible hours of service, some of which do not conflict with work or school, would prove useful to many disadvantaged families. Flexible hours of operation can be achieved at little cost by a simple rescheduling of staff work hours.

Third, some disadvantaged parents do not know or understand what health benefits are available to their children. Unless health care programs take the initiative to find, educate and help bring in parents and their children for care, needs will go unmet. Trained outreach workers can help solve many problems of access to health care. Outreach must be accompanied by follow-up services to be successful. Effective follow-up insures that the maximum number of children receive screening and treatment services under the EPSDT program.

Finally, local health departments should be more consistent in the types of services which they offer. For example, in our sample survey we found one local health department which was unable to provide maternity care. In addition, some health departments do not coordinate the services they themselves provide. In some cases clients must make two separate visits to the health department to receive prenatal care and W.I.C. benefits.

Nothing is of greater concern to parents than the health of their children. Yet many parents in Virginia are unable to provide for their children's basic health needs. In these times of high inflation, limited resources, and general disillusionment with government, it is Virginia's responsibility and challenge to creatively solve many of the problems that prevent families with children from having their health needs met.

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[17] Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome, op. cit.

[18] Citizen's Packet for School Age Parents, Virginia Division for Children, 1980.