REPORT OF

The Governor's Task Force on Indigent Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

Senate Document No. 11

COMMONWEALTH OF VIRGINIA
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GOVERNOR'S TASK FORCE ON INDIGENT HEALTH CARE

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Virginia House of Delegates

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COMMONWEALTH of VIRGINIA

Office of the Governor

Richmond 23219

Eva S. Teig
Secretary of Human Resources

December 1, 1987

Honorable Members of the Virginia
General Assembly

The Honorable Gerald L. Baliles
Governor
State Capitol
Richmond, Virginia 23219

Dear Governor Baliles and Members of the General Assembly:

We herewith transmit to you the reports of the Governor's Task Force on Indigent Health Care and the Governor's Commission on Medical Care Facilities Certificate of Public Need.

Indigent Health Care, and the continuing increase in health care costs, are among the most critical issues facing the Commonwealth now and for the duration of this decade. In 1986, the General Assembly adopted SJR 32 which requested that you establish a Governor's Task Force on Indigent Health Care. The Task Force was directed to "study all aspects of the indigent health care issue, including the feasibility of establishing a special indigent health care program to fund necessary medical care of indigent mothers and children, identifying problems specific to the Commonwealth, and recommend appropriate actions to resolve these problems." The Task Force was continued through SJR 151 during the 1987 session, and was directed to include in its deliberations "a concentration on efforts to maximize the utilization of available resources in the provision of current health care services to the indigent."

In 1986 you established, by Executive Order Number Thirty-One (86), a Governor's Commission on the Medical Care Facilities Certificate of Public Need Law. The Commission was directed to "examine the effectiveness of the Certificate of Public Need Program in controlling medical care costs while making good quality, accessible health care available to all Virginians." If the study determined that the existing program no longer effectively meets these objectives, the Commission was directed to

"assess alternatives and recommend revisions" to the existing process.

Since their establishment, the members of the Governor's Task Force on Indigent Health Care and the Governor's Commission on the Medical Care Facilities Certificate of Public Need Law, have worked diligently to analyze and review the highly technical and complex issues assigned to them. The Indigent Health Care Task Force has been hampered by a lack of comprehensive data with which to carefully define the scope of the problem within Virginia. The Certificate of Public Need Commission has been hampered by the strong division of opinion between health care providers regarding the effectiveness of the COPN law.

In spite of the above-noted difficulties, the Task Force and the Commission have reached conclusions on the extent of the indigent health care problem in Virginia and the effectiveness of the Certificate of Public Need program. A crucial, and early, conclusion, was the realization by the Task Force that the definition of "indigent persons" includes Virginia's working citizens, who, for a variety of reasons, are not able to participate in a health insurance program. Today, "medical indigence" includes hard-working men and women who are not eligible for existing social programs, but who because of the nature of their employment or catastrophic illness, are unable to afford the health care they so desperately need.

While these reports address different facets of the health care delivery system, a common thread emerged between them early in the deliberations of each group. Both the Task Force and the Commission felt that the provision of health care to persons unable to afford adequate care is a concern of growing magnitude to the Commonwealth, its health care providers, and the general public. The public and private costs of health care are soaring, and the ability of government and the private sector to shoulder the burden of indigent health care and uncompensated care is decreasing. This problem will increase enormously with the aging of our population, and the uncertain future of long-range health care benefits for the elderly. The issue has a significant impact on the future economic and social viability of the Commonwealth. In recent years, the federal government has clearly abdicated its responsibility for identifying long-term solutions to the indigent health care problem. States are being required to develop innovative mechanisms to fund health care for the indigent and elderly. Virginia must also address this coming crisis; it cannot be avoided.

The relationship of the indigent health care problem to the Certificate of Public Need law became apparent to the Commission when, early in its deliberations, it asked representatives of industry groups what effect the positions they were advocating on the Certificate of Public Need law would have on indigent health

care. The Commission perceived, throughout its deliberations, that issues regarding the Certificate of Public Need law and indigent health care, are inextricably linked. References to that linkage are found throughout its Report.

The Indigent Health Care Task Force determined that only a significant restructuring of our health care delivery system would provide viable long-term mechanisms for addressing the problem of access to health care by the indigent. The linkage between Certificate of Public Need and indigent health care was identified while the Task Force was reviewing issues regarding the inequality of the burden borne by health care providers, particularly hospitals, to provide uncompensated care to the indigent. The Task Force sought to ensure that decisions made by the Commission regarding the Certificate of Public Need law be linked to their effect on indigent health care, and that any changes to the present regulatory program not impede, and, if possible, improve the availability of health care to the indigent.

INDIGENT HEALTH CARE

The Governor's Task Force on Indigent Health Care has reached certain conclusions regarding the fundamental issues the Commonwealth faces in ensuring accessibility to health care for indigent persons.

1. Those without the means to obtain adequate health care include many more citizens than those living below the federal poverty level. In fact, there are thousands or more employed persons and their families who are without adequate medical assistance because their household income restricts their ability to pay for services or to purchase health insurance. Ten percent of all Virginians do not have any health insurance, while an additional eight percent have inadequate coverage.

2. Service industries and other small companies, representing a significant number of employers in the Commonwealth, do not offer health insurance benefits. A sampling shows that 35% of businesses with fewer than 51 workers fail to offer health insurance protection for their employees.

3. Health care problems of elderly Virginians, and the ever-growing need for long-term care, are already placing a heavy burden on the Commonwealth's General Fund through the Medicaid Program. In 1987-88, funds for nursing home care are expected to total $221,150,000 in the state budget. This will amount to 27.8% of total Medicaid expenditures, although only 18% of Medicaid recipients are aged. Predictions are that the number of persons 80 years of age and over will nearly double by the year 2000. Technological advances will continue to contribute to longer life spans, but costs of that technology will continue to

soar, and individual expectations for the best possible quality of care will concurrently contribute to increasing costs.

4. The dollar value of uncompensated care borne by the Commonwealth, medical providers, businesses, and paying patients will continue to increase. Across the Commonwealth, the burden of uncompensated care is not equitably shared. Trends indicate greater reliance will be placed on the state for care of the poor in the future. In 1986, 76% of Virginia's hospitals were profitable. Profits ranged as high as 16.12% of gross revenues. Generally, the hospitals which were not profitable are those which provide the greatest amount of uncompensated care. The health care industry should assist government in equalizing the uncompensated care burden.

5. Programs serving the poor and the medically indigent in Virginia represent a patchwork of services, eligibility requirements, and designated providers. Accessibility and quality can therefore be compromised as a result of a fragmented approach which does not always maximize the use of public and private dollars.

6. The importance of health education and prevention programs, both public and private, are viewed as critical to holding down health care cost increases in the future.

7. The costs of initiating community alternatives to institutionalization can be viewed as sound investments to minimize rising costs of continued institutionalization, especially with the demographics of a rapidly aging population.

Among the Task Force recommendations deserving of special attention are:

- Designate one state agency to establish and coordinate health care policy and coordinate management of all state funds used for indigent health care.

- The Secretary of Human Resources should review carefully the report of the Governor's Commission on the Medical Care Facilities Certificate of Public Need law. The Secretary should ensure that none of the Commission's recommendations hamper the ability of indigent persons to obtain health care, or foster greater inequality among health care providers regarding uncompensated care. The Secretary should develop proposals for increasing accessibility to health care for indigent persons for review by the Governor and General Assembly concurrently with their review of the recommendations of the COPN Commission.

- The Secretary of Human Resources should develop a plan of action needed to provide more balance among all hospitals in shouldering responsibility for the burden of uncompensated care.

- The Secretary of Human Resources and the Bureau of Insurance should jointly study and prepare a plan for the Governor and the General Assembly on the feasibility of a) tax incentives for employers to offer health insurance benefits to all employees; and b) a state operated pool of funds for health insurance and long-term care.

- The Medicaid program should be expanded to provide coverage for adult day care and other community-based services which can serve as alternatives to institutionalization. Before allowing admittance of Medicaid-eligible persons into nursing homes, a screening is conducted to determine if less-costly services are suitable and available. In some cases, families can and will keep elderly parents in their homes overnight and on weekends if substitute adequate care is available during daylight work hours. Community-based services such as adult day care, respite care and home or community therapeutic care provide additional opportunities for maintaining family structure and a less-costly service for Medicaid recipients.

- All state programs should continue to stress prevention--recognizing its cost/benefit advantages and the opportunity it offers to improve the general level of health in Virginia.

- The state code should be revised to require all local governments to participate in, and to adhere to state eligibility standards for, the State-Local Hospitalization (SLH) Program and the General Relief program, except when unusual local economic conditions exist. Further, the Governor's Task Force on Indigent Health Care recommended that administrative responsibility for the SLH Program be transferred to the state agency designated to coordinate indigent health care.

- The Medicaid program should be expanded to include the new Federal SOBRA option for pregnant women and children (up to one year of age). Funding of this option will serve more mothers and children during a critical period when uncompensated health costs can be significantly high, and when the proper prenatal care can make the difference for a healthy future as opposed to a life of chronic illness. Further, this option will significantly reduce the uncompensated care burden

shouldered by hospitals serving this population, and will maximize the use of federal funds, and reduce state-only dollars.

CERTIFICATE OF PUBLIC NEED

The Commission on the Medical Care Facilities Certificate of Public Need law was directed to analyze the extent to which the current regulatory program serves the public interest in controlling medical care costs while making good quality, accessible health care available to all Virginians. The Commission based its recommendations on the belief that government should foster free enterprise and greater economic competition among health care providers, while ensuring that high quality care be made financially and geographically available to all citizens, at reasonable prices. The Commission also specifically recognized that government has an obligation to ensure improved access to health care by the indigent, and that because Certificate of Public Need issues and Indigent Health Care are inextricably linked, any decisions regarding Certificate of Public Need must be evaluated in regard to their effect on health care for the indigent. Access to health care for the indigent should be improved, not hampered, by any changes in the COPN laws.

The Commission found that in the increasingly competitive health care environment, the Certificate of Public Need law no longer serves as a viable mechanism for containing the cost of health care provided by hospitals. That objective can best be served by increasing competition within the hospital industry, increasing the leverage which third party payors can use to influence providers to control costs, and by increasing consumer knowledge about hospital prices to allow consumers to make more informed choices about the setting in which to seek hospital care. The Commission noted that cost increases in states with heavily regulated hospital industries were not significantly greater than those in states with unregulated industries. The ability of a hospital to obtain access to rapidly evolving medical technology and services is for many hospitals synonymous with the provision of quality care, and the ability of hospitals to survive in an economically competitive environment.

The effect of the Certificate of Public Need law on quality of care is unclear, and the preferred mechanism by which the Commonwealth should ensure provision of quality hospital care is through an adequate licensure and inspection program, not through the Certificate of Public Need law.

Accordingly, the Commission recommends that hospitals be significantly deregulated from the Certificate of Public Need law, and that state approval for new services or technologies not be required. The Commission makes this recommendation contin-

gent, however, on the identification of adequate mechanisms to ensure access to health care for the indigent. The Commission fears that deregulation of hospital location, relocation, and expansion, would result in harm to the ability of inner-city and rural populations to obtain hospital care, a fear realistically based on numerous proposals currently under consideration in some of the Commonwealth's inner cities. Accordingly, the Commission recommends that establishment of new hospitals, and relocation of existing hospitals and most hospital expansions remain subject to regulation.

The Commission believes that the nursing home industry, in which two-thirds of the patient costs are borne by the Commonwealth through its Medicaid program, should continue to be subject to the Certificate of Public Need law. While the Commission strongly felt that the 97% occupancy rate currently present in the Virginia nursing home system represents an actual shortage of nursing home beds, the Commission expressed concern that too great, and too rapid, an increase in the number of beds, which would occur if the industry was immediately deregulated, would lead to an unacceptable increase in the cost of long-term care to the Medicaid budget. Although numerous benefits would derive from deregulation, such as increased consumer choice and greater ability for Medicaid to negotiate lower reimbursement rates, solutions other than immediate deregulation are suggested to achieve this objective. Instead, the Commission recommends that a more sophisticated methodology for projecting the number of beds which are needed to serve the elderly population, particularly poor persons, be developed. That methodology should result in an addition to the number of available beds, an increase in consumer choice, greater accessibility for low-income elderly persons to obtain long-term care, without negatively affecting the quality of care or the financial viability of the nursing home industry.

In order to assist consumers and third party payors in increasing their ability to negotiate lower rates for long-term care, and to provide the consumer with greater information with which to choose between nursing homes, the Commission strongly recommends that nursing homes be brought under the reporting and review requirements of the Virginia Health Services Cost Review Council. The work of the Council, which is widely praised as having been of assistance in controlling hospital cost increases, can be similarly effective regarding the nursing home industry.

The Commission also makes significant recommendations regarding improvements to the process by which COPN applications are reviewed. The Commission believes that much of the controversy over the existing system results from its present structure, which leads to a perception that the process is not objective. The Commission thus recommends that the State Board of Health, and the Commissioner of Health, assume responsibility for

health planning and for enacting the rules and regulations governing the Certificate of Public Need process. In addition, the Commission recommends that the responsibility for reviewing and commenting on applications, and the responsibility for holding hearings on those applications, should be vested in administratively separate offices within the Virginia Department of Health. The hearings should be held by a presiding officer who reports directly to the Commissioner of Health. The Commission recommends that while the Commissioner of Health should continue to be responsible for final decisions on applications, the independent nature of the presiding officer's role should be emphasized in order to relieve the Commissioner of some of the pressure he bears for these decisions which have significant economic value to the applicants.

Because of the economic significance in the marketplace of a Certificate of Public Need, the Commission recommends that fees be charged to applicants in an amount necessary to "self-fund" the Commonwealth's health planning process. Applications should be "batched" in order to increase competition between applications and to improve the Commonwealth's ability to foster the creation of the type of health care facilities it considers necessary to best serve its citizens.

The Commission recognizes that although its recommendations substantially deregulate much of the health care industry from the Certificate of Public Need law, the health planning capability of the Commonwealth should be increased. All those states which have deregulated their health care industries from COPN have advised the Commonwealth to increase its health planning and data collection capabilities if it makes substantial changes in its Certificate of Public Need program. This is necessary to ensure that the Commonwealth has sufficient data regarding health care costs and delivery systems should regulation of these industries again become necessary in future years.

CONCLUSION

The Reports of the Governor's Indigent Health Care Task Force and the Governor's Commission on Medical Care Facilities Certificate of Public Need have each addressed separate, but interrelated, facets of the health care delivery system.

The recommendations outlined in the Report of the Governor's Task Force on Indigent Health Care will assist the Commonwealth in initiating and implementing policy decisions for the future. Some recommendations will require further analysis and study to determine specific costs, and to measure long-term implications. Beginning now, and during the forthcoming biennium, specific proposals to address indigent health care issues will be developed by this office and forwarded for consideration.

The recommendations of the Governor's Commission on Medical Care Facilities Certificate of Public Need attempt to reduce regulation over those elements of the health care delivery system in which governmental regulation is inappropriate, while maintaining an active presence in those areas in which governmental intervention is essential to protect the public interest. It is essential that government ensure accessibility to quality, affordable health care for inner-city and rural residents, for the poor and the elderly. It is not, however, necessary for government to be involved in reviewing the private, market driven economic decisions of hospitals and other health care providers to purchase new technology or expand services. In this effort, the Commission sought to identify a balance between excessive governmental regulation and inadequate governmental protection of the public interest. For example, while many states have adopted rate setting mechanisms to control increases in health care costs, the Commission recommends instead that at present nursing homes, as well as hospitals, be subject only to Virginia's well-respected rate review program. We believe the Commission's recommendations will result in the creation of an efficient, objective regulatory mechanism which will assist in making affordable, quality health care available and accessible to all Virginians.

The simultaneous and mutually supportive Reports of the Governor's Task Force on Indigent Health Care and the Governor's Commission on Medical Care Facilities Certificate of Public Need form the basis for the development of a coordinated and coherent health care system for the Commonwealth. This is a unique opportunity to implement immediate improvements, and to begin to identify long-term solutions to the health care delivery system. Virginia's business leadership, and its health care providers, must join with Virginia's elected officials to ensure accessible and affordable health care in both the coming biennium and into the 1990's.

To fail to seize this opportunity will hinder Virginia's economic prosperity, reduce the quality of life for its citizens, and hamper its competitiveness in both national and world markets.

Sincerely,

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Secretary of Human Resources
Chair, Governor's Task Force
on Indigent Health Care

Maston T. Jacks
Deputy Secretary of Human
Resources
Chair, Governor's Commission
on the Medical Facilities
Certificate of Public Need Law

EXECUTIVE SUMMARY

Background

In accordance with Senate Joint Resolution No. 32, introduced by Senator Dudley J. Emick, Jr. in the 1986 General Assembly, the Governor of Virginia, the Honorable Gerald L. Baliles, appointed a Task Force to study all aspects of the Commonwealth's indigent health care problems. The study was expected to:

- consider the feasibility of establishing a special program to fund medical care necessary for indigent mothers and children;
- identify problems of the indigent which are specific to the Commonwealth; and
- recommend appropriate actions to resolve these problems.

After appointment by the Governor, the Task Force began its review of the problems associated with the provision of medical care for Virginians living in or near poverty. After all involved State agencies had provided details of their programs, an Interim Report was made by the Task Force in December 1986 on the history and current scope of medical services being provided to the indigent. The report also presented a broad assessment of the State policy questions to be faced. These related to:

- recognition of the need for better information on the characteristics of the medically indigent and those at risk of becoming indigent;
- identification of specific health service requirements of various segments of the indigent population;
- determination of the responsibilities for the delivery and of solutions for the problem of inequitable distribution of uncompensated health care;

- effectiveness of the organization of State efforts to render health care for the poor and near poor; and

- methods for controlling the growth of costs to the Commonwealth for its array of health-related programs.

In the Interim Report, the Task Force identified every State agency program which contributed health care services to the indigent, the funding sources for these programs, the number of clients utilizing State services, and the amount of Fiscal Year 1986 funds (General and Special) expended in each program and in total ($1,010,382,000). Fifty-seven percent of this total was provided from General Funds of the Commonwealth, 36 percent from federal appropriations, and 6 percent from local government and other sources.

The 1987 General Assembly, by Senate Joint Resolution No. 151, patroned by Senator Emick, recommended that the Governor continue the Indigent Health Care Task Force and add to its responsibilities determinations on what new actions the Commonwealth could take to:

- maximize the use of available resources in the provision of indigent health care services.

In its work, the Task Force benefited particularly from information provided in:

- House Document No. 29 (1986), "Alternatives for a Long-Term Indigent Health Care Policy"; and

- House Document No. 20 (1987), "The Degree of Health Care Insurance Coverage in Virginia".

It was handicapped in its efforts to develop specific action recommendations because of the unavailability of information on the size and needs of the indigent population. Collection of such data continues to be essential to allow a comprehensive assessment to be made of how Virginia resources should

be adjusted to meet the priority requirements of those most in need of medical care services.

Medical Indigency

The Task Force found that persons without means to obtain adequate medical care include more than those subsisting near or below the federal poverty income level. All uninsured and underinsured face becoming indigent in the event of serious illness and therefore must, potentially at least, be considered as part of the "medically indigent" population of the Commonwealth. Less obviously, nearly all Virginians face the potential for indigency in the event of major or catastrophic illness.

Current Situation

Nearly two-thirds of all expenditures now made by the Commonwealth to provide general health care for the poor are expended through its Medical Assistance Program (Medicaid). The severe health care problems of the elderly population and the ever increasing need for long-term care of this population are placing a heavy fiscal burden on the Medicaid Program. The dollar value of uncompensated care provided by the Commonwealth, its medical delivery system, businesses, and paying patients continues to increase. The burden of uncompensated care is not being equitably shared within the health care field and present trends indicate increasing reliance will be placed on the State for care of the poor. The health care industry should assist government in providing this care to the fullest extent of its capability.

Summary

The Task Force characterizes the general situation, in regard to the provision of adequate health care for the medically needy, as critical. It predicts that unless more reliable information on the needs of the poor is quickly obtained, and followed promptly by significant additional private and public resources for new initiatives and selected ongoing programs, the plight of the medically needy in Virginia will deepen and their numbers will continue to grow (see Preamble, p. 2).

Indigent health care problems are recognized to be a societal responsibility. If proper priority assessments are made and the cooperation of the private and public sectors is obtained, the Task Force believes sufficient resources exist in Virginia to resolve these problems.

Precise determination of solutions on some issues was beyond the capability of this Task Force because of data, time and resource limitations. Consequently, continuing State leadership on actions to improve the health of indigent citizens is essential.

Recommendations

General

The recommendations of the Governor's Task Force are intended primarily to define the path the State should take in policy decisions. Some recommendations will require further analyses to determine specific costs and long-term implications; other recommendations may warrant "pilot" efforts to prove the anticipated benefits. Nevertheless, the Task Force is confident that the major issues have been identified and that actions proposed under each will result in substantial improvements in State medical services for its indigent citizens. The Task Force was pleased to note that as the current status of problems and alternate courses were being reviewed, some agencies were motivated to begin Task Force Subcommittee-suggested improvement actions immediately if adequate resources were available.

Sixty-two recommendations were generated from the Task Force study of 21 major issues facing the Commonwealth. They are shown in this report following the issues which they address, and are also listed separately in Appendix A. Among the recommendations deserving of special attention by the Governor and/or the General Assembly of Virginia are:

INDIGENT MOTHERS AND CHILDREN

To provide the most urgently needed medical care for the indigent mothers and children, the Commonwealth should:

1. PROVIDE SUFFICIENT ADDITIONAL STATE FUNDING FOR IMMEDIATE EXPANSION OF THE MEDICAL ASSISTANCE SERVICES PROGRAM TO INCLUDE THE NEW FEDERAL OPTIONS FOR PREGNANT WOMEN AND CHILDREN (UP TO ONE YEAR OF AGE). EXPANSION IN SUBSEQUENT YEARS OF THE ELIGIBILITY AGE LIMIT FOR CHILDREN TO AGE FIVE SHOULD ALSO BE FUNDED (pp. 50 and 63).

Adoption of this option will result in additional federal funds being obtained, more mothers and children being served, and reduced amounts of State-only dollars being required for the State teaching institutions and the Health Department.

2. MODIFY THE MEDICAID PROGRAM TO ALLOW REIMBURSEMENT FOR IN-HOME USE OF APNEA MONITORS FOR HIGH-RISK INFANTS, SUCH AS THOSE DIAGNOSED AS HAVING APNEA PREMATURITY (p. 50).

High-risk infants are those identified as such only after a comprehensive medical workup that clearly demonstrates the need for cardiopulmonary monitoring which, if not provided, would necessitate continued hospitalization. No additional State funding should be required to implement this recommendatic as offsetting savings will occur from the reduction in necessary hospitalization for these infants.

MAXIMIZING UTILIZATION OF RESOURCES

To assure that available resources are effectively and efficiently used, the Commonwealth, in addition to the above, should:

3. COMPLETE A COMPREHENSIVE HEALTH PREVENTION PLAN AND PROVIDE FUNDING IN THE 1990-92 BIENNIUM FOR ITS PROPOSED PRIORITY ACTIONS (p. 20).

The economic and other benefits of health education and/or supportive actions on lifestyle changes, which provide avoidance of disease and illness, have been proven at all levels of society.

4. EXPAND MEDICAID PROGRAM COVERAGE TO INCLUDE ADULT DAY CARE AND OTHER COMMUNITY-BASED SERVICES WHICH CAN SERVE AS ALTERNATIVES TO INSTITUTIONALIZATION (pp. 26 and 50).

Before allowing admittance of Medicaid-eligible persons into nursing homes, a screening is conducted to determine if less-costly services are suitable and available. In some cases, families can and will keep elderly parents in their homes overnight and on weekends if substitute adequate care is available during daylight work hours. Community-based services such as adult day care, respite care and home or community therapeutic care provide additional opportunities for maintaining family structure and a less-costly service for Medicaid recipients.

5. REQUIRE CASE MANAGEMENT PROCEDURES TO BE FOLLOWED BY MEDICAID AND ALL OTHER STATE PROGRAMS WHICH ARRANGE OR PROVIDE OUTPATIENT CARE FOR INDIGENT CITIZENS (pp. 50 and 54).

Individual case management is a uniquely effective method for assuring maximum response to individual needs for non-institutional medical services. Under this concept, a designated medical coordinator, pursuing an objective of healthful living, assumes responsibility for focusing the utilization of services to the specific requirements of the patient.

6. HAVE THE SECRETARY OF HUMAN RESOURCES CONDUCT A STUDY TO IDENTIFY THE VALUES AND DETERMINE THE FEASIBILITY OF DESIGNATING ONE STATE AGENCY AS THE PRINCIPAL RESPONSIBLE AGENCY FOR ESTABLISHING STATE HEALTH CARE POLICY AND FOR COORDINATING MANAGEMENT OF ALL STATE FUNDS APPROPRIATED FOR INDIGENT HEALTH CARE (WITH THE EXCEPTION OF FUNDS APPROPRIATED TO THE TEACHING HOSPITALS AND THOSE PROVIDED SOLELY TO FUND VIRGINIA PARTICIPATION IN THE MEDICAID AND OTHER FEDERAL PROGRAMS) (pp. 34 and 45).

State institutions and departments now provide different health-related services for much of the same clientele. Coordinated objectives and service policies are important for assuring against fragmentation of effort, for promoting holistic care, and for preventing waste of resources. Having a lead

agency responsible for overall direction and general application of State appropriations for medical care of the indigent should result in more equitable distribution and better accountability of funds.

7. DESIGNATE ONE STATE AGENCY TO BE RESPONSIBLE FOR DETERMINING CLIENT ELIGIBILITY FOR ALL STATE HUMAN RESOURCES PROGRAMS WHICH OFFER SERVICES AT LOCAL GOVERNMENT LEVELS (p. 68).

Citizens face many different criteria and must travel to several locations in order to receive Human Resources program services. The Department of Social Services establishes the eligibility for the Department of Medical Assistance Services, but all other agency programs make their own evaluations of applicants. More efficient use of resources and better service to the public would be expected by having one agency required to determine eligibility for all State health and social programs.

OTHER SUBJECTS

In order to improve access and promote more effective services for the indigent, the Commonwealth should:

8. REVISE THE STATE CODE TO REQUIRE ALL LOCAL GOVERNMENTS TO PARTICIPATE IN, AND TO ADHERE TO STATE ELIGIBILITY STANDARDS FOR, THE STATE-LOCAL HOSPITALIZATION (SLH) PROGRAM AND THE GENERAL RELIEF PROGRAM (p. 67).

Virginians do not now have equal access to the services offered by these State programs because of the existing local option to participate and to determine who may be served. A local government decision not to participate in SLH or General Relief denies local citizens access to services which are being offered to citizens in other areas. It also places a special financial burden on area hospitals and accentuates the inequitable distribution of uncompensated care.

9. REQUIRE THE SECRETARY OF HUMAN RESOURCES TO DEVELOP A PLAN FOR PROVIDING MORE BALANCE AMONG ALL HOSPITALS IN SHOULDERING RESPONSIBILITY FOR THE BURDEN OF UNCOMPENSATED CARE (p. 73 and 74).

Several states have already reacted to obtain a more even distribution of the costs of indigent patient care in hospitals. Some have raised funds to offset the imbalance by imposing a tax on hospitals; others have assessed insurance premiums, taxed employers or made adjustments to State-controlled charges on hospital services. The various approaches taken by states to alleviate the growing problem of uncompensated care deserve thoughtful evaluation and consideration in regard to their possible value for emulation by the Commonwealth.

10. HAVE THE STATE CORPORATION COMMISSION'S BUREAU OF INSURANCE MAKE FORMAL STUDIES AND PREPARE RECOMMENDATIONS FOR LEGISLATION TO CREATE: A) TAX INCENTIVES FOR EMPLOYERS TO OFFER HEALTH INSURANCE BENEFITS TO ALL EMPLOYEES; AND B) A STATE-OPERATED HEALTH INSURANCE RISK POOL (p. 87).

More than half of the Virginians who do not have health insurance protection are employed and earn incomes in excess of the federal poverty level. Many of these work in service industries, are temporary workers, or receive minimum wage pay; others have applied for health insurance and have been rejected because of physical problems.

Additional proposals to assist the medically needy of Virginia are described in this report. They include actions to re-orient State services and increase their effectiveness, resolve specific problem areas, and/or promote a higher level of health. Steps taken toward better health for the medically indigent population will allow more Virginians to become employed, thereby reducing the future quantity of needed State assistance and promoting happier, more responsible, and productive citizens.

I. PREAMBLE

The objective of the Task Force was to address major issues associated with the provision of adequate health care for the uninsured and the underinsured in Virginia, and to seek ways to maximize the use of available financial resources in the delivery of public-funded health care. In working toward this objective, the Governor's Task Force became convinced that the level of attention and financial support devoted to this societal problem is inadequate if all citizens are to have reasonable access to health care, particularly in the event of catastrophic illness.

Nearly two-thirds of all expenditures now made by the Commonwealth to provide health care for the poor are expended through its Medical Assistance Program (Medicaid). While this is a worthy program, it reaches only the poorest of the poor and only those with special identifiable disabilities or limitations. Uncompensated care provided by physicians and hospitals and inpatient and outpatient care offered by State teaching institutions and public health clinics provide significant augmentation to the Medicaid Program. However, inequities in accessibility and in levels of services are evident.

Those in dire need of health care assistance in Virginia include far more than public welfare recipients served by Medicaid. The working poor and other marginally self-sufficient families of the Commonwealth cannot afford to purchase insurance for protection and cannot pay for preventive and medical care when required. Ten percent of Virginians do not have any health insurance and an additional eight percent have inadequate coverage. Service industries and smaller companies, which represent a significant portion of the employers in the Commonwealth, usually do not provide health insurance benefits. A sampling shows that 35 percent of businesses with fewer than 51 workers fail to offer health insurance protection for their employees. The costs of specialty care and of treatment for catastrophic illnesses are high and all Virginians, except for those who can afford to carry comprehensive insurance for protection, are at risk of becoming medically indigent.

The severe health care problems of the elderly population and the ever increasing need for long-term care of this population are already placing a heavy fiscal burden on the Medicaid Program. Although only 18 percent of the Medicaid recipients are aged, their care consumed more than 42 percent of total Medicaid expenditures in 1986. Seventy-six percent of Medicaid expenditures for the aged goes for institutionalization, three-fourths of which is intermediate and skilled nursing home care. Predictions are that those over 80 years of age will nearly double in number by the year 2000. The longer life spans, contributed to by technological advances which engender new expensive life saving procedures, presage increasing costs of health care. With public expectations for receipt of the best available care, a deepening of the crisis in health care in Virginia is likely.

The dollar value of uncompensated care being borne by the Commonwealth, Virginia's medical providers, businesses, and paying patients continues to increase. Virginia hospitals have seen the total value of their unpaid bills (excluding Medicare and Medicaid) double between 1981 and 1985 and, according to present trends, this amount will continue to increase. The effect may be a reduction in accessibility to sources of inpatient care in our inner cities and sparsely-populated rural areas. Across the Commonwealth, the burden of uncompensated care is not being equitably shared within the health care field and present trends indicate that is likely to be skewed further in the future, with greater and greater reliance being placed on the State for care of the poor.

The Task Force characterizes the general situation, in regard to the provision of adequate health care for the medically needy, as critical. It predicts that unless reliable data on needs are quickly obtained, and followed promptly by significant additional private and public resources which can be applied to new initiatives and selected ongoing programs, a substantial portion of the Commonwealth's population will go without necessary health care and the private and public dollar burden of uncompensated care will continue to rise.

The solutions for Virginia's indigent health care problems should be viewed as a societal responsibility and the Task Force believes that

sufficient resources exist in Virginia to resolve them if proper priori assessments are made and the cooperation of the private and public sectors is obtained. The continuing urgent need for State leadership is evident.

In recognition of the foregoing, the Task Force submits the following report to provide direction for the Governor and the General Assembly on interim actions to alleviate some of the more urgent needs of medically indigent Virginians, pending the development and funding of more adequate measures.

II. INTRODUCTION

A. Background

More than 33 million Americans are reported to be unable to afford necessary medical care for themselves or for their families because of personal economic status, lack of insurance, conditions of employment, or other reasons. Under these circumstances, and in the face of decreasing federal funding, relatively stable State appropriations and spiraling private health care costs, public health, and social programs are finding it more difficult to contend with continued demands for health-related services.

The term "medically indigent" has been generally used to describe those who are unable to afford necessary medical care and are uninsured, underinsured, or ineligible for public programs assistance. For Virginia, "medically indigent" was specifically defined by the State Corporate Commission (SCC) in its 1987 report on "The Degree of Health Insurance Coverage of the General Population of Virginia" as:

> A person with: 1) income under the federal poverty level, resources insufficient for self-care (includes individuals without health insurance, or with inadequate health insurance, or who are ineligible for public health care programs), and a need for health care; and 2) a catastrophic illness that generates expenses exceeding 50% of the household's gross annual income after any available insurance is exhausted.

A population sampling completed for this SCC study revealed that 36 percent of the citizens of the Commonwealth with incomes below the federal poverty status have no health insurance of any kind. Additionally, more than one-third of the elderly in families with incomes under $10,000 do not have comprehensive policies. Without adequate income or insurance, the poor must continue to rely on State government for health care when needed; thus, the issue of how best to provide and finance the delivery of necessary health care for those who do not have the resources to pay is of continued concern.

For many years, as specific problems surfaced, various individual State health care programs for the indigent have been evaluated and changed by

executive and/or legislative action. Recognizing the piecemeal manner i which a general problem had been treated in the past, the 1984 General Assembly adopted House Resolution No. 129 establishing a Joint Subcommittee to identify alternatives for a long-term indigent health care policy. This Joint Subcommittee's 1986 report, House Document No. 29, included the following recommendation: "A Governor's Task Force representing the public and private sectors should be established to provide a focal point for broad consideration of indigent health care issues." The report also highlighted ten basic problems relating to indigent health care policy and provided data on major public programs, past State appropriations, and other states' actions. Recognizing the need for more information on the problem of persons without medical insurance, the Joint Subcommittee recommended that the State Corporation Commission conduct a comprehensive analysis of the degree of health insurance coverage of the general population.

B. Purpose

Responding to the recommendations in House Document No. 29, the 198(General Assembly passed Senate Joint Resolution No. 32 (Appendix A) which requested the Governor of Virginia to establish a Task Force on Indigent Health Care. This Task Force was expected to:

> study all aspects of the indigent care issues, including the feasibility of establishing a special indigent health care program to fund necessary medical care of indigent mothers and children, identify problems specific to the Commonwealth, and recommend appropriate actions to resolve these problems.

The 1987 General Assembly, by Senate Joint Resolution No. 151 (Appendix B), authorized the continuation of the Task Force on Indigent Health Care and also directed it to include in its deliberations:

> a concentration on efforts to maximize the utilization of available resources in the provision of current health services to the indigent.

The Task Force was directed to submit its findings and recommendations by December 1, 1987.

III. RECOMMENDATIONS AND ANALYSES

Issue Analyses

The major issues affecting the Commonwealth's responsibilities and role in the provision of health care for its citizens were studied by the Governor's Task Force in order to determine solutions to the problems which they present. Each issue was analyzed, the background and current situation were reviewed, possible actions considered, and recommendations for action determined.

Value Statements

Being comprised of members of different perspectives and interests, the Task Force, before examining Subcommittee proposals, developed and adopted the following Value Statements for use as principles and guidelines in making its judgments:

A. General Principles

1. The Task Force believes that the financial burden of indigent health care should be shared by government, private health care providers, employers, third party payers, and individuals.

2. The Task Force expects individuals to assume personal responsibility for utilizing offered public health services in a manner which is most conducive to promoting maximum benefit from the services received, to minimizing government costs of the services, and to adopting lifestyles and behavior patterns most likely to reduce future needs for public health services. It is also expected that public health programs will provide incentives to citizens for maintaining healthy lifestyles and behaviors.

3. The ethical implications of decisions to provide or withhold health care are critically important and will be considered by the Task

Force as it assesses scientific, economic and political factors t may affect its decisions.

4. The Task Force is convinced that government can be an effective catalyst to bring together the various capacities and resources needed to meet public requirements.

5. Communicating information about health care services to the medically indigent is recognized by the Task Force as being an essential part of making those services accessible.

6. Preventive care programs and medical intervention after illness are of equal importance for the indigent population; therefore the Task Force assumes that public health programs will include educational activities to encourage individual responsibility for healthy lifestyles and behavior.

B. Guidelines for Determining Priorities

1. The Task Force will consider both actions that will improve the quality of life and those that are required primarily to maintain life.

2. The Task Force will evaluate the various needs of the medically indigent in relation to program effectiveness, costs, and feasibility.

3. In evaluating recommendations for changes in the delivery of health care, the Task Force will consider at least three factors: the relative needs of various population groups for improved health care, the realistic possibility of improving health care for one or more population groups, and the requirement that any change must result in the efficient use of public resources.

C. Guidelines for Evaluating Recommendations

1. The Task Force recognizes that incentives for individuals to remain healthy are essential for public well-being, as are incentives to use health systems as effectively as possible.

2. Task Force evaluation of any proposed changes in the delivery of health care will consider whether potential recipients will accept the changes and have better access to health care as a result of them.

3. Before a new policy is recommended, the Task Force will examine its relationship to other policies and to political, economic and social factors.

4. Before major revisions to current systems are recommended, the Task Force may propose that alternative service delivery systems and methods of payment be tested.

5. The Task Force will support actions that will provide increased federal dollars, avoiding actions that only shift costs among State agencies.

Recommendations

The agreed-upon recommendations are intended primarily to assist in State policy decisions on options for future actions which will provide more adequate health care for the Commonwealth's medically-indigent population. Special attention was given to opportunities for more effective use of available government resources and to those which respond to the more important perceivable needs of the poor.

Since lack of time, data, and staff precluded a detailed evaluation of the feasibility and costs of all desirable options, subsequent detailed study by agency staff and/or construction of demonstration models should be considered before implementation of the broader recommendations which follow.

The issue subjects with recommended actions fall under the following hea
ings:

- o Provision of more effective focus of efforts
- o Revision of the structure for providing services
- o Change in amount or scope of services
- o Amendment of program funding
- o Modification of client eligibility and responsibility
- o Alteration of private health insurance coverage

Although the Task Force did not attempt to establish the priority of recommendations, it did agree on desired dates for completion of action on problems which it considered to be most sensitive to time constraints.

1. PREVENTIVE versus RESTORATIVE

SHOULD THE COMMONWEALTH TRANSFER A PORTION OF THE FUNDS NOW UTILIZED FOR RESTORATIVE CARE INTO EXISTING OR NEW PREVENTIVE HEALTH CARE PROGRAMS?

Current Services

Restorative health services for the indigent and near indigent of Virginia are offered by the State medical schools, health department clinics in local jurisdictions, and mental health and mental retardation institutions. Additionally, health care services from private providers are made available to lower income persons from local, State and federal funding of the State Medical Assistance Services, Community Services Boards, Vocational Rehabilitation, General Relief and State-Local Hospitalization programs. Basic preventive health services for the indigent population are included as components of the total care offered.

Preventive services with special focus are funded under the programs directed by the Department of Medical Assistance Services, the Department of Rehabilitative Services, the Department for the Aging, the Department for Children, the Department for the Deaf and Hard of Hearing, and the Department for the Visually Handicapped.

A 1987 report by the Governor's Task Force on Coordinating Preventive Health, Education and Social Programs revealed that there are one hundred and five (105) Virginia State government programs which include prevention as a goal. Approximately one-fourth of these are directly related to improving personal health.

State expenditures are not identifiable according to preventive or restorative health care categories. However, a review of current program services indicates that most of the one billion dollars expended by Virginia

in Fiscal Year 1986 for health care for the indigent was for restorative curative care of lower-income citizens.

Value of Prevention

At all levels of society, changes to healthier lifestyles brought about through education and/or supportive actions are known to have a positive effect on the management or avoidance of many diseases and illnesses. Poor habits in diet, smoking, alcohol usage, and exercise can result in lower levels of general health, happiness and productivity.

Examples of effective preventive actions are evident from the State Health Department's Immunization Program for children and its Women, Infants and Children (WIC) Program in nutrition. Results from these and other efforts to promote more healthy living styles show that prevention is a cost-effective activity. Thus, from an economic as well as a humane perspective, preventive health measures are sound investments when compared to the extensive costs of curative treatment and rehabilitation.

Future Actions in Prevention

In general, the level of restorative health services being offered by Virginia now meets only the most dire personal needs of the low income persons and only certain segments of the indigent population are served. Transfer of State money from these services to allow expansion of preventive services would tend to jeopardize the Commonwealth's efforts to meet the most urgent needs of the sick poor.

Opportunities for expanding the State's preventive efforts were identified by the 1986 Governor's Task Force on Prevention. That Task Force's report cited the need to legally specify a State prevention policy, to form a Prevention Council, and to develop a Comprehensive Prevention Plan. These actions are essential to identify which specific activities and priorities deserve future State funding support. The potential for increasing preventive health services as a step toward reducing curative service demands on the State should not be ignored.

RECOMMENDATIONS

A. ALL STATE PROGRAMS SHOULD CONTINUE TO STRESS PREVENTION, RECOGNIZING ITS COST/BENEFIT ADVANTAGES AND THE OPPORTUNITY IT OFFERS FOR IMPROVING THE GENERAL LEVEL OF HEALTH IN VIRGINIA.

B. TRANSFER OF FUNDS FROM RESTORATIVE CARE TO PREVENTIVE CARE SHOULD NOT OCCUR BECAUSE THE LEVEL OF RESTORATIVE CARE SERVICES BEING OFFERED IS ONLY MARGINALLY ADEQUATE TO MEET THE MOST CRITICAL HEALTH NEEDS OF VIRGINIA'S POOR.

C. A VIRGINIA COMPREHENSIVE PREVENTION PLAN, AS RECOMMENDED BY THE 1986 GOVERNOR'S TASK FORCE ON COORDINATING PREVENTIVE HEALTH, EDUCATION AND SOCIAL PROGRAMS, SHOULD BE COMPLETED WITHIN THE NEXT YEAR AND SHOULD INCLUDE PROVISIONS FOR:

- o EDUCATION FOR ALL CITIZENS ON LIFESTYLES THAT PROMOTE GOOD HEALTH;
- o ENCOURAGEMENT FOR THE USE OF TRAINED FACILITATORS IN PATIENT MANAGEMENT;
- o PROMOTION OF GENERAL ACCESS TO CASE MANAGEMENT UPON ENTRY, AT ANY POINT, IN THE STATE ASSISTANCE NETWORK (See Community versus Institution, Pre-Paid Health Care - Medicaid, and Health Department Clinics); AND
- o DEVELOPMENT OF AGGRESSIVE OUTREACH FOR ALL PROGRAMS, ESPECIALLY THE BLOOD PRESSURE SCREENING, EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT FOR CHILDREN (EPSDT), AND WOMEN, INFANTS AND CHILDREN (WIC) PROGRAMS.

D. STATE FUNDING SHOULD BE PROVIDED, BEGINNING WITH THE 1990-1992 BIENNIUM, TO ALLOW THE ACTIONS ENVISIONED IN THE COMPREHENSIVE PREVENTION PLAN TO BE IMPLEMENTED.

2. PRIORITY OF CHILDREN

SHOULD THE COMMONWEALTH CONCENTRATE ITS FUNDING FOR INDIGENT HEALTH CARE ON SERVICES FOR CHILDREN, RECOGNIZING THE POTENTIAL EFFECT ON THE COSTLY HEALTH CARE SERVICES FOR THE ELDERLY?

Age Group Needs and Services

Demands on State government for health care assistance stem principally from the needs of children and the needs of the elderly. These age groups of the poor are most vulnerable to inadequate health care due to lack of personal funds or insurance.

National studies reveal that about one and a half million poor children do not have health insurance coverage, despite the fact that 73 percent of them are in families with an employed parent. Although most of the elderly in the United States have Medicare and/or Medicaid health insurance benefits, serious gaps exist in this coverage. Annual increases in co-payment and deductible requirements of the federal Medicare Program place added strain on the retired elderly's ability to buy adequate supplementary health insurance. In Virginia, a recent survey found that 17 percent of the children are not covered by any health insurance, and 29 percent of those over 65 years of age either have no insurance or are not entitled to receive comprehensive benefits.

Although the health status of American children has improved dramatically over the past two decades and federal/state programs such as Medicaid, Aid to Families and Dependent Children and Food Stamps have contributed significantly to this improvement, there remain critical, unmet needs. Among the needs for services are case management, screening to provide early detection of problems and better access to sources of care. Above all, because of their cost effectiveness, prevention actions are a very high priority because they can improve the health of children and allow them to become productive adults.

As the span of life continues to increase, greater pressure will be exerted on retirement savings due to of rising living costs and deteriorating health. The number of senior citizens in Virginia is growing. For example, 95,000 Virginians are now over the age of 80 and by the year 2000 that number will almost double. Health assistance requirements for older Virginians, now and in the future, include health education, screening, dental care, homemaker and personal care, adult day care, and better access to services and to different levels of institutional care.

Virginia Medical Assistance Services

Only certain categories of the poor are authorized under federal law to receive medical help from the Virginia Medical Assistance Program (Medicaid). Of the total number of currently eligible recipients, 40 percent are children and 18 percent are elderly. Of the children who used Medicaid services in 1986, at a cost of $18.5 million, less than 9 percent required institutionalized care. By contrast, of the Medicaid-eligible aged persons, 26 percent were in an inpatient hospital status at one time in 1986 and 33 percent were in a nursing home. The Medicaid expenditures last year for the elderly who were in an institutional setting totalled over $191 million. In terms of total Medicaid services costs in Fiscal Year 1986, $40.1 million were spent on children and $224.5 million on the elderly.

Priority Considerations

The priority of need for State assistance in health care cannot be resolved simply by age group as the obligation of government to help all those truly in need is difficult to ignore. Within each age group there are wide differences in requirements for assistance and in what the Commonwealth can do to provide relief. Individual characteristics including the state of health, prognoses for the problems, economic status, and availability/costs of services, demand consideration in determining the priorities for provision of State-sponsored health care services to Virginia citizens.

RECOMMENDATIONS

A. FUNDING PRIORITIES FOR STATE HEALTH-RELATED PROGRAMS SHOULD NOT BE ASSIGNED BY AGE GROUP, BUT INSTEAD BE BASED ON: 1) THE DEGREE OF NEED FOR SERVICES BY INDIVIDUALS WHO CANNOT OBTAIN THESE ELSEWHERE; AND 2) THE POTENTIAL FOR PROVIDING SIGNIFICANT RELIEF FOR THE PROBLEM PRESENTED.

B. INVESTMENTS IN HEALTH PROGRAMS WHICH INTERVENE IN THE EARLIER STAGES OF LIFE SHOULD CONTINUE TO BE SUPPORTED BY THE STATE BECAUSE THESE WILL PROMOTE QUALITY OF LIFE IMPROVEMENTS WHICH WILL ENDURE OVER THE LONGEST PERIOD OF TIME.

3. COMMUNITY versus INSTITUTION

WHAT STATE-SPONSORED HEALTH SERVICES NOW BEING RENDERED IN INSTITUTIONAL SETTINGS SHOULD BE CONSIDERED AS CANDIDATES FOR COMMUNITY-BASED DELIVERY?

Origin of Issue

In the past, government health care services for the sick elderly, machine-dependent, physically disabled or impaired, and mentally disturbed or retarded persons were largely delivered in institutional settings. A continued rise in health care costs, particularly inpatient costs, forced a review of alternatives. Community-based services can offer a viable option for many people, but government regulations and lack of community capability stood as deterrents to implementing policy changes.

State Services

All Virginia Human Resources agencies aggressively promote alternatives to inpatient care for their programs' clients. This approach is motivated by a desire to offer care more fitting to individual needs and to serve more constituents at less cost.

The Department of Health and each of its local health departments offer in-home health services to provide unwell citizens with more capability to remain in a family setting. The Department's local health directors serve the Department of Medical Assistance Services (Medicaid) by screening each new Medicaid applicant for nursing home admittance to ensure that other and more suitable alternatives do not exist.

The Department of Mental Health, Mental Retardation and Substance Abuse Services embarked several years ago on a course of deinstitutionalization, depending upon the newly-created Community Services Boards (CSB) system as a replacement health care capability for persons not requiring care at State

hospital facilities. The Community Services Boards located throughout the State provide generic outpatient mental health, substance abuse, and mental retardation services, including prevention and early intervention.

The Department of Rehabilitative Services, the Department for the Visually Handicapped, the Department for Children, and the Department for the Aging each offer a spectrum of services, including prevention, screening, training, and equipment, aimed at making or keeping persons self-sufficient.

The Department of Medical Assistance Services also promotes outpatient care by reimbursing for in-home care and encouraging early hospital discharge when appropriate to individual need.

New Services

The array of community-based services has grown in Virginia over the past few years, with outpatient surgery sites, adult day care centers, private home health agencies, and drug abuse treatment centers increasing in number and in the scope of services offered. More recently, community-based services are being developed to offer special habilitation therapy and care, or crisis intervention during daytime, weekday hours.

One of the more pronounced trends has been the rapid growth in the number of centers providing day care and services for the elderly who live alone or with working family members. As of August 1987, 24 adult day care centers were in operation. These centers, concentrated around the large- and medium-sized cities of the Commonwealth, are already serving more than 500 persons with a variety of health, social, and personal care services. Services primarily consist of nursing care, social services and activities, medication administration, family counseling, ambulation assistance, and case management. In the aggregate, the centers were last reported to be operating at 56 percent of licensed capacity for various reasons, one of which is a lack of funds to subsidize those who cannot afford the fee. No State program currently provides direct reimbursement for adult day care, although about half of the centers are benefiting to some extent from receipt of State-distributed

Federal Title XX funds. Local financial assistance is also provided to a few centers.

A uniquely effective method now used for assuring maximum response to individual needs for non-institutional medical services is the case management approach. Under this concept, a case coordinator plans and controls the utilization of services for each patient, minimizing fragmentation, reducing barriers, and linking clients with appropriate services to assure comprehensive and continuous care.

Care for AIDS Patients

Public health officials are warning that the nation's health care system may soon be overwhelmed with large numbers of AIDS patients. It is expected that many such patients will have meager resources to defray the costs of outpatient care and institutionalization. Requirements for financial assistance will affect Medicare, Medicaid, and other government-supported health programs heavily. California, New York, and Illinois are among the growing list of states which, because of deep concern over the potential need for new services or for significant additional state appropriations, are conducting formal analyses of the future utilization and cost of medical services for patients with AIDS. Demographic, social, cost and medical utilization data from hospital, clinic, and outpatient records are necessary to provide a basis for realistic planning to meet this anticipated public health burden. Recognizing the importance of the AIDS problem, the Virginia Secretary of Human Resources has initiated planning actions by State agencies to assess the future requirements of AIDS patients in the Commonwealth.

RECOMMENDATIONS

A. TO ALLOW REDUCTION IN COSTLY INSTITUTIONALIZATION, MEDICAID COVERAGE OF COMMUNITY-BASED CARE SHOULD BE EXPANDED BY ALLOWING REIMBURSEMENT FOR:

- ADULT DAY CARE
- DAY HABILITATION
- CRISIS MANAGEMENT
- RESPITE CARE
- HOME AND COMMUNITY THERAPEUTIC CARE

PRIOR TO INCLUSION OF THE FOREGOING SERVICES, THE SECRETARY OF HUMAN RESOURCES SHOULD MODEL PROGRAMS FOR THE EXTENSION OF EACH SERVICE AND ASCERTAIN SPECIFIC COST/BENEFIT VALUES. (See Recommendations, Amount, Duration and Scope).

B. MEDICAID AND OTHER STATE PROGRAMS SHOULD EMBRACE CASE MANAGEMENT AS A TECHNIQUE FOR ASSURING SERVICES WHICH ARE MORE RESPONSIVE TO PATIENT NEEDS AND WHICH MAKE THE BEST USE OF AVAILABLE RESOURCES.

C. THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES SHOULD RECONSIDER ITS POLICY ON THERAPEUTIC LEAVE DAYS ALLOWED FOR INTERMEDIATE CARE FACILITY RESIDENTS AND DETERMINE THE PROS AND CONS OF GRANTING GREATER FLEXIBILITY FOR RESIDENTS TO PARTICIPATE IN OFF-CAMPUS OVERNIGHT PROGRAMS ANTICIPATED TO BE OF THERAPEUTIC VALUE. A REPORT ON THIS SUBJECT SHOULD BE SUBMITTED BY THE DEPARTMENT TO THE SECRETARY OF HUMAN RESOURCES BEFORE SEPTEMBER 1988.

D. ALL STATE AGENCIES SHOULD COMPLETE, AS A MATTER OF URGENCY, THEIR CURRENT STUDY OF POLICIES AND ACTIONS TO RESPOND TO THE FUTURE IMPACT OF CARING FOR AIDS PATIENTS, PARTICULARLY THE REQUIREMENTS FOR GREATER PUBLIC EDUCATION AND THE COMMUNITY AND INSTITUTIONAL CARE TO BE NEEDED BY THESE PATIENTS.

E. STATE EFFORTS TO INCREASE PUBLIC KNOWLEDGE OF AVAILABLE SERVICES SHOULD BE EXPANDED BY DEVELOPMENT OF A PILOT PROGRAM IN AT LEAST THREE COMMUNITY SETTINGS TO EMPLOY THE CONCEPT OF LOCAL "HUMAN RESOURCE COUNSELLORS". THESE COUNSELLORS SHOULD COMPILE LISTS OF HUMAN SERVICES RESOURCES LOCALLY AVAILABLE FROM BOTH THE PUBLIC AND PRIVATE SECTORS AND TAKE ACTIONS WHICH WILL PROMOTE THIS INFORMATION REACHING POTENTIAL CLIENTS (See Recommendations, State Organization Structure).

4. OUTPATIENT versus INPATIENT

SHOULD THE COMMONWEALTH MANDATE THAT CERTAIN PROCEDURES WHICH ARE NOW BEING PROVIDED THROUGH THE VARIOUS INDIGENT HEALTH CARE PROGRAMS BE PERFORMED ON AN OUTPATIENT BASIS?

Basis for Concern

Federal, state, and local governments and other purchasers of health care services are faced with the challenge of slowing or reducing the rate of increase in health care costs using effective cost containment strategies without lowering the quality of care. In Virginia, legislative concern has been expressed for more than ten years over steady increases in the costs of public health-related services.

Private insurance companies also concerned by the rising health cost trends, particularly for inpatient care, have installed various incentives to encourage enrollees to utilize outpatient treatment whenever medically indicated and available. Since their efforts to persuade consumers to chose lower-cost care have produced positive results, consideration has been given to applying similar procedures to government programs.

State Programs

In Virginia, opportunities for the use of various strategies to reduce health care costs exist for the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, and the State teaching institutions.

The Department of Medical Assistance Services has already instituted actions to control the growth of expenses for inpatient services, including:

- o Imposition of limits on hospital payments;

- o Restriction of provider and recipient utilization; and

- o Employment of new methods of purchase and delivery.

Community Services Boards have been developed in 40 locations across the Commonwealth to provide more opportunities for outpatient care of those patients who formerly could seek such services only as inpatients at State mental health institutions.

The State teaching institutions (the University of Virginia and the Virginia Commonwealth University) have added new outpatient surgery services as capabilities and accreditation permit.

As yet, no State health-related program has required that outpatient care be substituted for inpatient care when such a choice is available. Instead, this decision remains with the patients and their physicians.

RECOMMENDATIONS

A. A REQUIREMENT FOR CERTAIN MEDICAL PROCEDURES TO BE PERFORMED ON AN OUTPATIENT BASIS SHOULD NOT BE MANDATED AS CAPABILITIES VARY BY REGION AND BY LOCALITY AND BECAUSE OF THE DIFFICULTY, AS MEDICAL SCIENCE ADVANCES, IN KEEPING A PROCEDURE LIST UP TO DATE. INSTEAD, MONETARY AND OTHER INCENTIVES SHOULD BE ADOPTED TO ENCOURAGE CONSUMER CHOICE OF LOWER-COST CARE WHEN MEDICALLY APPROPRIATE.

B. THE COMMONWEALTH SHOULD CONTINUE TO STRIVE TO ACHIEVE THE HIGHEST LEVEL OF ACCREDITATION FOR THE MEDICAL FACILITIES OF ITS TEACHING INSTITUTIONS SO THAT MORE OPPORTUNITY WILL BE AVAILABLE FOR OUTPATIENT CARE.

C. DIRECTORS OF STATE HEALTH-RELATED PROGRAMS SHOULD KEEP ABREAST OF EVOLVING STANDARDS OF CARE AND OF MODERN MEDICAL PRACTICES AND ENSURE THAT PROCEDURES FOR DETERMINING A PATIENT'S SUITABILITY FOR OUTPATIENT CARE ARE SUFFICIENTLY FLEXIBLE TO TAKE INTO ACCOUNT DIFFERENCES AMONG PATIENTS WITH

RESPECT TO UNDERLYING HEALTH STATUS, COMPLICATING CONDITIONS, AVAILABILITY OF INFORMAL SUPPORT SYSTEMS, HOME ENVIRONMENT CONDITIONS, AND REMOTENESS OF HOME FROM MEDICAL CARE SOURCES.

D. ALL STATE PROGRAMS WHICH COVER INPATIENT SERVICES SHOULD:

- o PROMOTE THE DEVELOPMENT OF SUBSTITUTE OR TRANSITIONAL LEVELS OF CARE;
- o ESTABLISH SPECIAL REIMBURSEMENT RATES FOR OVERNIGHT STAYS BY SURGICAL PATIENTS WHO, ALTHOUGH NOT SUFFICIENTLY RECOVERED TO PERMIT SAME-DAY DISCHARGE, REQUIRE A BED AND MINIMAL OBSERVATION FOR THE FOLLOWING NIGHT;
- o ENSURE THAT PRE-OPERATIVE ASSESSMENT IS INCLUDED AS AN ELEMENT OF OUTPATIENT SURGERY TO FACILITATE TRANSITION TO INDEPENDENCE AT HOME; AND
- o PROVIDE THE SAME QUALITY OF DISCHARGE PLANNING FOR OUTPATIENT AND INPATIENT SURGERY.

E. IN ADDITION TO BEING RELATED TO COSTS, STATE PROGRAM REIMBURSEMENT VALUES FOR OUTPATIENT SURGERY SHOULD ALSO PROVIDE INCENTIVE TO CHOOSE AN OUTPATIENT STATUS WHEN APPROPRIATE TO THE CARE REQUIREMENT.

5. INDIGENT HEALTH CARE POOL

SHOULD ALL STATE FUNDS CURRENTLY BEING APPROPRIATED TO VARIOUS AGENCIES AND TEACHING HOSPITALS FOR THE PURPOSE OF PROVIDING HEALTH CARE TO NON-MEDICAID INDIGENT CITIZENS BE PLACED IN A DESIGNATED POOL AGAINST WHICH PROVIDERS WOULD BILL AND BE PAID BASED ON CONSISTENT ELIGIBILITY AND REIMBURSEMENT CRITERIA?

National Responses

As competition increases in the industry, and as cost controls take on increasing effectiveness, health care providers are becoming less able to shift the costs of services for the indigent and uninsured to the private sector.

Several states have enacted laws to provide new ways to meet the inpatient health care needs of the uninsured and the indigent. Some acquired additional state appropriations to allocate to those providers who traditionally serve large amounts of charity care; others levied new taxes to create revenue pools used to distribute more state financial support for indigent care.

Virginia Funding of Indigent Care

In Virginia, legislative appropriations to pay for health care services for the non-Medicaid indigent are made available to the Medical College of Virginia, the University of Virginia, the Medical College of Hampton Roads (MCHR - formerly Eastern Virginia Medical Authority), and to two Children's Hospitals. Additional funds to provide for the hospital care of indigents throughout the Commonwealth are appropriated to the Department of Medical Assistance Services' Medicaid Program and to the Department of Social Services' State-Local Hospitalization (SLH) Program.

The Department of Health receives State and matching local government money to conduct public clinics which offer preventive and other health services to the poor and near poor in all localities.

According to the Joint Subcommittee Report, "Alternatives for Long-Term State Indigent Health Care Policy" (House Document No. 29, 1986), the breakdown of State appropriations for all types of indigent health care in Virginia during the 1984-86 biennium was:

Medicaid	-	68%
MCV/UVA/MCHR	-	18%
Local Health Clinics	-	12%
State-Local Hospitalization	-	2%

Service Eligibility Requirements

Because eligibility requirements to receive health services vary among the State-funded programs, different elements of the needy qualify for assistance under each of these programs. As a result, the availability and eligibility requirements of all available State assistance programs are not generally known or understood by the public.

Medicaid eligibility criteria which are established by federal law and by program policies restrict the medical care provided under that program to the poorest of the poor (whose incomes are well below the federal poverty level) provided they meet certain categorical qualifications. Other Virginia health programs and the medical schools supplement the Medicaid Program coverage by serving other persons who have limited economic resources. Health providers in the private sector and administrators of the government-operated institutions draw on many different Virginia programs to help defray their costs of providing health services to lower-income citizens.

Prior Concerns

The legislative and executive branches of Virginia's State government have previously considered ways to improve the effectiveness and the accessibility of the funded health care services. Much attention has been given to possible

changes in: 1) the administration of the State-Local Hospitalization (SLH) Program of the Department of Social Services; and 2) the ways the growing costs of indigent care can be separated from professional medical education expenses at the State medical schools.

For the SLH Program, local governments decide whether or not they wish to participate and, if they do so, they also determine the eligibility criteria and the services to be covered. Consequently, Virginians do not have equal access to the use of this State money which has been appropriated to assist with the costs of health care for the poor.

A similar situation exists with regard to the General Relief Program, which includes reimbursements to welfare recipients for their basic needs including medical maintenance and medical emergency care. General Relief, administered by the Department of Social Services, is designed to aid persons who are not eligible for the federal Aid to Families and Dependent Children (ADC) or Supplemental Security Income (SSI) programs. As with the SLH Program, whether or not State General Relief funds are to be available to help a citizen depends upon the local government's decision to participate and, if it has chosen to do so, the eligibility criteria it elects to use.

The Commonwealth provides general revenue funds to the State teaching hospitals to pay for medical care which they render to the indigent. The total hospital costs for patients who are unable to pay probably exceed State appropriations, but neither institution has as yet been able to separate the costs of indigent or uncompensated care from those being incurred to train physicians and other professionals.

Many thoughts have been expressed on ways to improve control or effective use of the State funds now being applied to indigent care. Proposals have been made to have SLH Program (or Rehabilitative Services or Visually Handicapped program) funds transferred to the Medicaid Program to enable expansion of Medicaid eligibility and to gain the assistance of the federal government in paying for the cost of additional services. A suggestion also has been made to have the indigent health care funds, now appropriated directly to the State teaching hospitals, combined in a pool with other State appropriations

in order to improve management control over all resources made available to serve indigent persons' health needs.

RECOMMENDATIONS

THE SECRETARY OF HUMAN RESOURCES, WITH THE ASSISTANCE OF THE SECRETARY OF EDUCATION, SHOULD CONDUCT A STUDY TO IDENTIFY AND DETERMINE THE FEASIBILITY OF OPTIONS TO CREATE MORE EQUITABLE DISTRIBUTION AND IMPROVED ACCOUNTABILITY OF STATE HEALTH CARE FUNDS, INCLUDING OPTIONS FOR:

- DESIGNATING A STATE AGENCY TO ESTABLISH HEALTH CARE POLICY AND COORDINATE MANAGEMENT OF ALL STATE FUNDS APPROPRIATED BY THE GENERAL ASSEMBLY FOR INDIGENT HEALTH CARE (EXCEPT FOR THOSE BEING PROVIDED TO FUND VIRGINIA'S PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS; E.G., MEDICAID) (See Recommendations, State Organization Structure and Local versus State Funding);

- TRANSFERRING ADMINISTRATIVE RESPONSIBILITY FOR THE STATE-LOCAL HOSPITALIZATION PROGRAM TO THE STATE AGENCY DESIGNATED TO COORDINATE MANAGEMENT OF INDIGENT HEALTH CARE (See Recommendations, State Organization Structure);

- REQUIRING THE SECRETARY OF EDUCATION TO HAVE THE STATE TEACHING HOSPITALS (MCV/UVA) IDENTIFY, AT A MACRO-ECONOMIC LEVEL, TEACHING EXPENSES SEPARATE FROM THEIR INDIGENT CARE COSTS;

- ESTABLISHING BY LAW A PROTOCOL TO REQUIRE LOCALITIES WHICH PARTICIPATE IN THE DEPARTMENT OF SOCIAL SERVICES' GENERAL RELIEF PROGRAM TO OBTAIN APPROVAL FROM THE LOCAL HEALTH DIRECTOR BEFORE EXPENDITURE OF PROGRAM FUNDS FOR MEDICAL MAINTENANCE AND MEDICAL EMERGENCY NEEDS OF WELFARE RECIPIENTS; AND

- IDENTIFYING ALL OTHER STATE HEALTH PROGRAMS FUNDED SOLELY BY STATE APPROPRIATIONS AND OPERATED BY OTHER AGENCIES SO THAT THESE MAY BE CONSIDERED, WHEN FEASIBLE, FOR RE-ASSIGNMENT TO THE DESIGNATED STATE SINGLE MANAGER OF INDIGENT HEALTH CARE SERVICES.

THIS STUDY SHOULD BE COMPLETED BY DECEMBER 1988 SO THAT NECESSARY LEGISLATIVE ACTIONS CAN BE CONSIDERED BY THE 1989 GENERAL ASSEMBLY.

6. PRIVATIZATION

SHOULD THE COMMONWEALTH LIMIT ITS ROLE IN THE DELIVERY AND PROMOTION OF HEALTH CARE AND TRANSFER CERTAIN OF THESE RESPONSIBILITIES TO THE PRIVATE SECTOR? SPECIFICALLY:

1. SHOULD MCV AND UVA HOSPITALS BE SOLD?

2. SHOULD THE STATE MEDICAL CENTERS BE REORGANIZED AS FREE-STANDING STATE AGENCIES SEPARATE FROM THE GENERAL ACADEMIC ELEMENTS OF THESE UNIVERSITIES?

Pressures on State Hospitals

Privatization of State-owned hospitals is an increasingly important issue nationally due to:

- Changes in Medicare's reimbursement formula aimed at making hospitals more cost efficient;

- Decreasing federal participation in the Medicaid Program requiring greater State funding;

- Growth of the uncompensated care burden on the states' budgets; and

- Increasing competition for the paying patient among health care providers.

A few states have recently initiated privatization plans of different forms for their state hospitals to contend with these conditions and with the inflexibility inherent in state-operated institutions. Examples are the leasing of a Tennessee state hospital to a for-profit hospital chain and the transfer of a Florida state hospital to a private non-profit corporation.

State-run hospitals are under great pressure to adjust their management style and organizational structure so they can deal with developments in the public and private sectors. However, of the approximately 110 hospital/ teaching institutions in the country, 65 are still owned by the states in which they are located. Among the reasons for this are:

- State and university identification is important to attract high-quality patient care;

- Medical schools or centers as teaching institutions usually provide a salutary environment in which research can be conducted, students can learn and, at the same time, quality patient care can be rendered; and

- Establishing and/or reorganizing medical schools to be free standing can be expensive.

Burdens of a Teaching Hospital

Funding requirements for specialty training of physicians and the clinical education of nurses and allied health professionals in the teaching hospitals have been covered largely by patient care fees charged through Medicare and other third-party payers. Now the federal Medicare Program, business, and industry are each reducing the amounts they will allow to be included for teaching costs in patients' bills.

The volume of uncompensated hospital care (bad debt and charity) in Virginia is increasing annually. In 1985, it was estimated to have exceeded $300 million. UVA and MCV hospitals accounted for 36.4 percent of this total, up 2 percent from the previous year. Of concern is the possibility that the State's teaching hospitals, if they acquire more and more of the overall uncompensated care totals, soon will be jeopardizing their financial positions and unable to continue to compete with other Virginia hospitals.

Appropriated indigent care funds are essential to the survival of the State's teaching hospitals, although the majority of their income comes from

paying patients. These hospitals must comply with all State personnel employment policies and pay scales, follow strict State procurement regulations for acquiring new equipment and contracting for services, and justify legislative appropriations several years in advance. If competition among all hospitals continues to intensify, as is expected, State teaching hospitals will require more flexibility to pursue changes in management policy and operating methods and all opportunities to develop innovative service procedures and competitive pricing on offered care. They, like health care industry everywhere, can expect greater competition for patients, employees, and dollars in the future, and capability to respond to these changes is essential if they are to retain general public patronage.

RECOMMENDATIONS

A. OWNERSHIP AND MANAGEMENT OF THE STATE TEACHING HOSPITALS SHOULD BE RETAINED BY THE STATE BECAUSE:

- o THE STATE HAS MADE SIZEABLE INVESTMENTS IN THESE INSTITUTIONS WHICH COULD NOT BE RECOUPED;
- o THEY PROVIDE A VALUABLE PUBLIC BENEFIT FROM THEIR RESEARCH AND EDUCATION ACTIVITY AND SERVICE TO INDIGENT PERSONS; AND
- o THERE IS APPARENTLY LITTLE MARKET DEMAND FOR ESTABLISHED PUBLIC SERVICE HOSPITALS.

B. THE HOSPITALS SHOULD BE GRANTED GREATER AUTONOMY AS WELL AS MORE FLEXIBILITY IN PERSONNEL, PROCUREMENT, AND OTHER ADMINISTRATIVE AREAS TO ENABLE THEM TO RESPOND TO THE OPPORTUNITIES AND THREATS ARISING IN THEIR COMPETITIVE HEALTH ENVIRONMENTS.

C. SPECIAL ADVISORY BOARDS SHOULD BE ESTABLISHED FOR THE MEDICAL COLLEGE OF VIRGINIA AND THE UNIVERSITY OF VIRGINIA HOSPITALS TO PROMOTE APPLICATION OF THEIR MEDICAL RESEARCH BENEFITS TO STATE HEALTH PROGRAMS AND TO INITIATE ACTIONS WHICH WILL ENCOURAGE THEIR MEDICAL STUDENTS TO PRACTICE IN THE COMMONWEALTH. THESE BOARDS, WHICH SHOULD MEET AT LEAST ONCE ANNUALLY,

SHOULD INCLUDE REPRESENTATIVES OF THE OFFICES OF THE SECRETARIES OF EDUCATION, FINANCE, AND HUMAN RESOURCES (See Recommendations, State Organization Structure).

7. PRE-PAID HEALTH CARE - MEDICAID

SHOULD THE COMMONWEALTH CONSIDER A STATEWIDE CAPITATED INDIGENT HEALTH CARE PROGRAM?

Definition

Prior to 1981, cost control approaches used for Medicaid programs usually involved freezing eligibility standards, lowering reimbursement rates and/or reducing covered benefits. In 1981, under the authority of the Omnibus Budget Reconciliation Act, federal Medicaid reforms were enacted to allow states, using waivers, to pursue alternative health care financing and delivery approaches as a means of containing costs and testing ways to improve access and quality. Allowable options included selective contracting with cost-effective providers, greater use of health maintenance organizations, and similar pre-paid/per-capita reimbursement arrangements.

States' Responses

By 1986, 22 states were contracting with Pre-Paid Health Plans (PHPs) or Health Maintenance Organizations (HMOs). Nationally, however, only four percent of all recipients (830,600) were actually enrolled under these types of pre-payment contracts. Texas and other states were using the Health Insurance Organization (HIO) concept, under which recipients were enrolled under an insurance contract. During 1986, two states (Alabama and New Hampshire) started new pre-payment contracts; three states (Florida, Washington and Wisconsin) expanded their HMO contracts; and several others reported significant growth in enrollment in existing plans.

The Virginia Medical Assistance Services Program, during the last five years, has continued in various ways to improve the efficiency of its operations and to control recipient and provider over utilization and abuse.

However, Virginia has as yet not chosen to pursue any of the pre-paid contract alternatives allowed under the 1981 federal Medicaid law changes.

Pros and Cons

In the traditional Medicaid system, there are no incentives to providers to discourage too-frequent use of office visits, prescriptions and test orders, or hospitalization. In contrast, each of the alternative pre-paid concepts embrace financial incentives to encourage providers to introduce effective preventive health services and to strive to minimize future use of all elements of the health care system.

Methods of quality assurance, which are elements of fee-for-service mechanisms, may not be appropriate to pre-paid systems. New quality assurance techniques must be carefully designed to assure that cost savings are not the result of new barriers to access.

Special problems exist in the statewide application of a pre-paid concept for indigent health care in Virginia. They include:

- An HMO-type of organization, because of the necessity for large client enrollment, fails to offer a solution for sparsely-populated rural areas; and

- Pre-paid plans, in striving for cost savings, can be overly restrictive in controlling client access to specialists.

Additionally, because the Virginia Program has for several years reimbursed providers at a low percentage of their usual and customary charges, it is unlikely that a potential per-capita contractor could achieve a cost savings for the State or gain a company profit without lowering quality of, or access to, medical care.

RECOMMENDATIONS

A. THE COMMONWEALTH SHOULD NOT, AT THIS TIME, INCORPORATE THE CAPITATED INDIGENT HEALTH CARE CONCEPT INTO ITS MEDICAID PROGRAM.

B. THE SECRETARY OF HUMAN RESOURCES, WITH THE DIRECTOR OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, SHOULD CONTINUE SURVEILLANCE OF THE SUCCESSES AND FAILURES OF PRE-PAID PLANS OPERATING IN OTHER STATES AND BE ALERT FOR PROCESSES AND ACCOMPLISHMENTS THAT MAY BE CONSIDERED BY VIRGINIA TO CONTROL MEDICAID COSTS WITHOUT DETERIORATION OF SERVICE QUALITY.

8. STATE ORGANIZATION STRUCTURE

SHOULD THE COMMONWEALTH REORGANIZE ITS AGENCY STRUCTURE OR AGENCY RESPONSIBILITIES TO MORE EFFECTIVELY AND EFFICIENTLY ADMINISTER PROGRAMS WHICH PROVIDE HEALTH CARE SERVICES FOR INDIGENTS?

Current Structure

Virginia's State government organizations providing health care services under the Governor's Secretary of Human Resources include: 1) separate subordinate departments, which are defined either according to the type of services to be rendered to the public or to the population group to be served; and 2) other commissions, councils, and departments which administer to issues or groups of special concern to government. A legislative mandate is the basis for the establishment of each department, council, and commission. Nine of the sixteen organization elements assigned to the Secretary have responsibilities concerning health-related services for indigent persons and other citizens of the Commonwealth. Some provide "hands on" care, some finance or provide the means for the provision of care, and others serve primarily as advocacy agencies, promoting access to services for their constituencies.

Human Resources organizations which provide or arrange health care for the indigent include: the Department for the Aging, the Department for Children, the Department for the Deaf and Hard of Hearing, the Department of Health, the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Rehabilitative Services, the Department of Social Services, and the Department for the Visually Handicapped.

In addition, there are two State organizations providing health care services under the responsibilities of the Secretary of Education. These are the University of Virginia and Virginia Commonwealth University, each of which has a school of medicine and hospitals which offer tertiary level inpatient

care and outpatient services. A significant portion of the medical care rendered by these State hospitals is for indigent persons living in central, south and southwestern Virginia.

Strengths and Weaknesses

The multiplicity of separate organizations within the Executive Branch, each having interests and responsibility for health services to the poor, intensifies the importance of constant communication and coordination among the different elements. Each of the agencies is expected to exhibit constant concern over coordination with other agencies of all activities and plans that affect the others. The small personal staff of the Office of the Secretary of Human Resources is augmented for special projects which overlap agency boundaries by temporary assignment of persons from the lead agency. Communication between the various departments in Human Resources and the medical schools/ hospitals which operate under the Secretary of Education is infrequent but arranged as special actions require.

One of the problems of having major indigent health care responsibilities among four departments (Health, Medical Assistance Services, Social Services, and Mental Health, Mental Retardation and Substance Abuse Services) is that local citizens seeking State assistance for personal medical care and advice must adhere to the unique eligibility rules of each department. Because of the existing organizational division of responsibility, coordination among and citizen referrals to different State agencies' programs are sometimes difficult at the service level. As a result, persons may occasionally go without needed services simply because of lack of knowledge as to where or how to seek them.

RECOMMENDATIONS

A. NO MAJOR CHANGES SHOULD BE MADE IN THE ORGANIZATION OF THE EXECUTIVE BRANCH OF STATE GOVERNMENT AS ALL INVOLVED AGENCIES NOW APPEAR TO MAINTAIN OPEN CHANNELS TO EVALUATE AND COORDINATE ACTIVITIES AIMED AT HEALTH CARE FOR THE INDIGENT.

B. THE SECRETARY OF HUMAN RESOURCES SHOULD STRENGTHEN THE NOW-INFORMAL COORDINATION PROCESS AMONG THE HEALTH SERVICES AGENCIES IN ORDER TO ASSURE MAXIMIZING GOVERNMENT RESOURCES BY:

- o DESIGNATING ONE STATE AGENCY AS RESPONSIBLE FOR ESTABLISHING BASIC HEALTH POLICY AND COORDINATION OF THE MANAGEMENT OF ALL STATE FUNDS APPROPRIATED FOR INDIGENT HEALTH CARE (See Recommendations, Indigent Health Care Pool); AND

- o STRENGTHENING THE INFORMATION AND REFERRAL SYSTEM AVAILABLE FOR CITIZENS AT THE LOCAL LEVEL BY THE INTRODUCTION OF HUMAN RESOURCES COUNSELLORS TO ENHANCE ACCESS TO SERVICES (See Recommendations, Community versus Institution).

C. THE SECRETARY OF EDUCATION SHOULD ESTABLISH NEW ADVISORY COUNCILS FOR EACH OF THE STATE MEDICAL SCHOOLS TO PROVIDE GUIDANCE ON ESTABLISHING LINKAGES BETWEEN THE BENEFITS ATTAINED FROM THE RESEARCH DONE AT THE STATE SCHOOLS AND THE STATE HEALTH PROGRAMS WHICH ARE SERVING THE POOR OF THE COMMONWEALTH (See Recommendations, Privatization).

9. ALTERNATIVES TO EMERGENCY ROOM CARE

SHOULD THE COMMONWEALTH REQUIRE ITS STATE TEACHING HOSPITALS TO OFFER ROUTINE CLINIC SERVICES AT OTHER THAN NORMAL BUSINESS HOURS IN ORDER TO REDUCE THE COSTS INCURRED FROM INAPPROPRIATE USE OF EMERGENCY ROOM SERVICES BY INDIGENT PATIENTS? WHAT ACTIONS SHOULD THE COMMONWEALTH TAKE TO ENCOURAGE OTHER HOSPITALS TO INSTALL EFFECTIVE ALTERNATIVES TO REDUCE INAPPROPRIATE USE OF EMERGENCY ROOM SERVICES?

Inappropriate Use of Hospital Emergency Rooms

Hospital emergency room services are maintained for the purpose of offering non-routine services. Because of the scope and levels of medical care to which they must be prepared to respond on short notice, emergency room services have relatively high costs.

Many poor and near-poor Virginians who rely on the local health departments and State hospital clinics for their outpatient health care are finding that these clinic services are only available during normal business hours on week days.

Persons with limited transportation, no family physician, restrictive employments, difficult financial situations, or lack of knowledge of existing alternatives turn, if organized clinics and doctors' offices are closed, to the State hospitals' emergency rooms to satisfy their immediate needs for medical service, even though the severity of their current health complaint may not warrant "emergency" attention.

New Clinic Plans

The University of Virginia and the Medical College of Virginia hospitals are aware of the volume of non-emergency care being provided to the poor in high-cost emergency rooms. Each has prepared plans to test lower cost

alternatives for treating patients, during non-business hours, who need less-than-urgent emergency treatment. As an example, the Medical College of Virginia administration is implementing a plan to operate a special primary care clinic which can serve as an alternative to emergency room use for routine care. Start-up of the new service is subject to success in the ongoing negotiation for medical school faculty resources. This proposed new MCV clinic would be open seven days a week, with evening service hours. The anticipated pricing structure on fees for the clinic should allow service to be offered at a lower cost than now being experienced for after-hours primary care delivered in the MCV emergency rooms.

Private After-Hours Clinics

In a few communities, notably those in the New River and the Lord Fairfax Planning Districts, private physicians and hospitals have reacted to the perceived need of the poor for after-hours primary care services by organizing free-standing clinics. These clinics are open at night to provide care for those who are ineligible for Medicare/Medicaid services and who, although they may be employed, are unable to afford personal physician care because of income limitations.

RECOMMENDATIONS

A. THE STATE TEACHING HOSPITALS SHOULD BE ENCOURAGED TO CONTINUE TO DEVELOP AND IMPLEMENT AFTER-HOURS PRIMARY CARE CLINICS.

B. THE COMMONWEALTH SHOULD ADOPT A POLICY TO PROMOTE AND TO OFFER FINANCIAL INCENTIVES FOR THE DEVELOPMENT OF PRIVATE AFTER-HOURS CLINICS IN COMMUNITIES/AREAS WHERE A NEED EXISTS FOR SUCH SERVICES TO INDIGENT PERSONS.

10. AMOUNT, DURATION, AND SCOPE

SHOULD THE COMMONWEALTH EXPAND OR REDUCE THE AMOUNT, DURATION, AND SCOPE OF SERVICES CURRENTLY PROVIDED BY MEDICAID AND OTHER INDIGENT HEALTH CARE PROGRAMS?

Medical Assistance Program Options

Since the inception of the Virginia Medical Assistance Program (Medicaid), the population authorized to be served has been limited by restrictive eligibility criteria and the amount of State appropriations available to match federal dollars. At the same time similar services for poor citizens unable to qualify for Medicaid are being given by other State agencies' programs, supported solely by State funds.

Recent changes in federal regulations allow more flexibility as to who may benefit and in the amount, duration, and scope of services which may be offered by a state Medicaid health care program. The Virginia Medical Assistance Services Program does not now cover all of the indigent population groups permitted under federal rules, nor does it provide all of the services that could be added with federal matching dollars if additional State funding should be obtained.

Needs for Services

Although no formal evaluation has been attempted to determine the degree of adequacy of the State's health services compared to the overall needs of the poverty population, there is a widespread belief that the amount of unmet needs for public health services in Virginia is large and growing.

Opportunities for Change

It can be assumed that some of the clients now being served at State (only) expense in prenatal, child, family planning, and other health care

clinics could qualify for federal/state funding support under the Medicaid Program if Medicaid eligibility criteria were broadened and/or new services were added to that Program. An exact calculation is not available of the potential cost savings to the Commonwealth of each of the opportunities for services expansion; however, staff analyses have begun of some of the federal Medicaid options.

One of the opportunities for expansion of Medicaid services relates to authorizing reimbursement for a new federal eligibility category, "coverage to pregnant women and children". This option, which became available under the federal Omnibus Budget Reconciliation Act of 1986, would allow special income limits to be adopted on eligibility for this population group, many of whom are now being served at State (only) expense in MCV, UVA, and Health Department clinics.

In order to make medical care more effective and assure optimal outcome for the patients, a case management process is now more widely used. In this process, clients benefit from risk assessments, care planning, and health counseling under the direction of a designated care coordinator.

Adult day care and in-home apnea monitors for high-risk newborns are among other federally permissible Medicaid services. These services are both cost- and health-effective and are now possible because of today's medical technology.

Although adult day care is a relatively new service, there are now 24 such centers in the Commonwealth and the number continues to grow. They offer an attractive alternative to institutionalization in dealing with the problem of caring for those who need assistance during daylight hours only.

Allowing Medicaid payments for in-home apnea monitors for high-risk newborn children could reduce inpatient costs for Medicaid children who remain hospitalized only to gain reimbursement by Medicaid. "High-risk infants" are only those identified as such after a comprehensive medical workup that clearly demonstrates the need for cardiopulmonary monitoring which, if not

provided, would necessitate continued hospitalization. Adequate professional assistance and necessary instruction for in-home monitors now exists sporadically throughout the state and it seems that similar capability can be developed for other areas if the requirement was recognized.

Another opportunity for improving Virginia's services for the indigent is the provision of eyeglasses. The value of eyeglasses for productive endeavor and/or for enjoyable lifestyles is undeniable, yet many of the poor cannot afford to purchase needed eyeglasses. This personal need area is frequently identified as a target for community fund-raising drives led by Lions Clubs and other local private organizations. Because of projected large additional costs, the Medicaid Program has so far limited this service to children who have a demonstrated need. No other State health-related programs assist in meeting this personal need.

RECOMMENDATIONS

A. ADDITIONAL STATE FUNDING SHOULD BE PROVIDED FOR THE MEDICAL ASSISTANCE SERVICES PROGRAM TO ALLOW EXPANSION OF THE SCOPE OF SERVICES TO INCLUDE:

- o THE FEDERAL OPTION FOR PREGNANT WOMEN AND CHILDREN (TO YEAR 1) AT 100 PERCENT OF POVERTY INCOME, AND EXTEND THE ELIGIBILITY AGE FOR CHILDREN TO YEAR 5 IN SUBSEQUENT YEARS (See Recommendations, Reallocation of State Funds);

- o IN-HOME APNEA MONITORS FOR HIGH-RISK INFANTS; AND

- o ADULT DAY CARE FOR RECIPIENTS WHO OTHERWISE MEET THE CRITERIA FOR ADMITTANCE TO INTERMEDIATE CARE FACILITIES (See Recommendations, Community versus Institution).

B. THE MEDICAL ASSISTANCE SERVICES PROGRAM SHOULD IMPLEMENT CASE MANAGEMENT TECHNIQUES FOR THE PREGNANT WOMEN AND CHILDREN CATEGORY OF RECIPIENTS TO ENSURE THEY RECEIVE THE MOST EFFECTIVE CARE.

C. THE MEDICAL ASSISTANCE SERVICES PROGRAM SHOULD BROADEN THE COVERAGE OF EYEGLASSES BY ALLOWING REIMBURSEMENT FOR DIAGNOSIS, PROCUREMENT, AND FITTING FOR THOSE PERSONS DEMONSTRATED TO HAVE A NEED: (1) TO PRECLUDE BECOMING LEGALLY BLIND; OR (2) TO CORRECT VISUAL IMPAIRMENTS SO SEVERE THAT LOSS OF MAJOR FUNCTIONING IS THREATENED.

11. HEALTH DEPARTMENT CLINICS

SHOULD THE VIRGINIA HEALTH DEPARTMENT'S PRESENT METHOD FOR PROVISION OF CLINIC SERVICES TO THE INDIGENT BE CHANGED IN ORDER TO IMPROVE SERVICES FOR THOSE IN NEED OR TO MAXIMIZE AVAILABLE STATE RESOURCES?

Public Clinic Services

The Health Department provides a variety of public health preventive services ranging from dental to family planning during scheduled clinics held in local health departments. General medical care is provided only in the local health departments of Virginia's eight largest cities. Though offered services may vary among the localities, all citizens, including Medicaid clients, will be seen at most sites. More than one million client contacts occur each year.

Because of continued limitations in State appropriations, consideration must be constantly given to options for making more efficient use of funds and other resources. The demand for health department clinic services is severe in many localities, and contracts with private physicians/nurses are arranged to the extent budgets allow for expanding service availability.

The cost of care provided in local health departments is shared by the State with local governments according to an agreed formula.

Challenges and Opportunities

Although for years all local health departments have utilized the State Board of Health approved uniform system for determining client eligibility and for collecting from patients a percentage of service costs, a standard method of calculating costs of delivered services has not been adopted. Differences in services costs are noted among local health departments, a situation which

can be attributed to the use of different factors and procedures. This handicaps efforts to determine the most economical use of State resources and makes it difficult to evaluate advantages in the use of alternate sources of care (such as contractual services) in localities where demand for services exceeds the current staff capabilities.

The Department of Health has recently directed the development of multi-year health plans to compare local and area needs for services, to determine shortfalls in existing capabilities, and to identify priorities for changing current public health services. If some local governments are unable to provide sufficient additional financial support, problems may arise in implementing local plans due to the necessity for local governments to match State funding.

In eastern Virginia and in other areas of the State, difficulties have been encountered in arranging continuity of care for health department prenatal clinic patients. An inability to assure financing for delivery of pregnant indigent mothers dependent upon the public health departments for prenatal care continues to plague efforts to lower the State infant mortality rate and creates public relations problems for the Department of Health as well as local health providers.

Poor persons who have inadequate knowledge as to the most effective ways for maintaining good health frequently fail to utilize available medical resources properly. Public health departments could contribute significantly toward more effective use of all available health services by the indigent population by adopting a patient case management approach in all local health departments. This approach has already been tried in a few localities where it has been found to be beneficial.

RECOMMENDATIONS

A. THE HEALTH DEPARTMENT SHOULD DEVELOP A UNIFORM COST ACCOUNTING SYSTEM FOR EACH OF ITS CLINIC SERVICES TO ENABLE ACCURATE COMPARISONS TO BE MADE WITH SIMILAR SERVICES PROVIDED AMONG ITS LOCAL DEPARTMENTS AND IN ALTERNATIVE SETTINGS.

B. THE HEALTH DEPARTMENT SHOULD CONTINUE AND INTENSIFY THE MULTI-YEAR PLANNING EFFORT NOW UNDER WAY, ASSESSING THE NEED FOR PUBLIC HEALTH SERVICES IN EACH LOCAL AREA AND EVALUATING ALTERNATE MEANS FOR PROVIDING MORE COMPREHENSIVE, EFFICIENT, AND EFFECTIVE SERVICES UTILIZING ALL AVAILABLE RESOURCES--INCLUDING VOLUNTARY AGENCIES, GOVERNMENT AGENCIES, TEACHING HOSPITALS, AND PRIVATE PROVIDERS.

C. THE HEALTH DEPARTMENT SHOULD FOCUS ON TRADITIONAL PUBLIC HEALTH SERVICES AND AVOID PROVISION OF CURATIVE SERVICES WHICH DUPLICATE PRIVATE MEDICINE CAPABILITIES.

D. EACH LOCAL HEALTH DEPARTMENT SHOULD ACCEPT RESPONSIBILITY FOR ARRANGING CONTINUITY AND COORDINATION OF CARE FOR ITS INDIGENT PATIENTS, UTILIZING CASE MANAGEMENT TO ASSURE THAT COMPREHENSIVE, EFFICIENT, AND EFFECTIVE USE IS MADE OF ALL AVAILABLE GOVERNMENT PROGRAM AND COMMUNITY RESOURCES WHEN MEDICAL CARE IS NECESSARY.

12. TRANSPORTATION

TO WHAT EXTENT SHOULD THE COMMONWEALTH ENSURE THAT TRANSPORTATION IS AVAILABLE TO THOSE FOR WHOM MEDICAL CARE SERVICES ARE BEING PROVIDED?

Importance of Transportation

Offering medical care services to the poor is of little benefit if they are unable to reach service sites. Public transportation is available only in major cities and bus/train service networks connecting rural areas to major medical facilities have diminished in recent years. For poor and near-poor families, an automobile is an essential possession to enable working member(s) to reach the employment location and may not be available to the at-home family members when they need health care. When severe medical emergencies occur and ambulance service is unavailable, arrangements may be made to ride with neighbors or friends; clinic visits for illness prevention services, except in urban areas, will often be restricted by the lack of transportation.

Current State Services

The Virginia Medical Assistance (Medicaid) Program and other State programs will arrange for transportation for the poor between home and sources for medical care. Medicaid reimburses contract providers for emergency and preauthorized routine movement of its recipients to and from enrolled medical providers. In Fiscal Year 1986, approximately $5.7 million was spent for transportation in behalf of Medicaid recipients.

The Department for the Aging's 25 Area Agencies operate or contract for a transportation service to allow eligible persons to receive agency services. The Department of Rehabilitative Services' Vocational Rehabilitation program and the Department for the Visually Handicapped's Independent Living Centers program pay transportation expenses for their clients who require it in order

to receive program services. Also, reimbursement for the costs of transportation to reach medical care service (as well as for the costs of the medical care itself) is an allowable charge under the Department of Social Services' General Relief program operated with local governments.

All State programs require clients to use public transportation to and from medical care when it is available. All of these programs also attempt to combine client trips when possible; however, this is difficult to arrange in many areas because client residences are dispersed and health services are needed at different times. Provision of bus tickets and reimbursement for mileage are the methods most used by State programs to assist the poor in reaching points of service.

Recent Changes

In July 1986, an agreement was reached among the Departments of Medical Assistance Services, Aging, and Health to establish a reimbursement system which provides an incentive for their different program clients to pool trips. Under this agreement, transportation is now more accessible to all program clients at an annual saving of $14,000 to $19,000 to the agencies. This system appears to be working well as all available local vehicles are being used at maximum capacity.

Recognizing the importance of adequate transportation to all Virginians who are in need of State services of all kinds, the Governor has now convened a special Transportation Commission to evaluate statewide need, arrange for coordination of available capabilities, and identify requirements for new arrangements. The Commission has completed its first year of work, collecting information and identifying major problem areas.

RECOMMENDATIONS

A. LOCAL TRANSPORTATION MODES SHOULD BE EXPANDED TO PROVIDE MORE EFFICIENT, AFFORDABLE, COST-EFFECTIVE AND CONVENIENT SYSTEMS FOR THE MEDICALLY INDIGENT THROUGHOUT THE COMMONWEALTH.

B. A PLAN TO EXPAND LOCAL TRANSPORTATION SHOULD BE DEVELOPED BY THE VIRGINIA DEPARTMENT OF TRANSPORTATION HUMAN SERVICES COORDINATOR AND HIS/HER ADVISORY COUNCIL INCORPORATING THE FOLLOWING PRINCIPLES:

- o COORDINATION OF SERVICES AT THE LOCAL LEVEL, UTLIZING BOTH STATE AND COMMUNITY-FUNDED SERVICES;

- o INTEGRATION, WHEREVER POSSIBLE, OF MEDICAL SERVICES TRANSPORTATION AS A PART OF A BROADER PUBLIC TRANSPORTATION SYSTEM THAT SERVES MANY NEEDS;

- o AVAILABILITY OF EMERGENCY AND OTHER EXTRAORDINARY MEDICAL TRANSPORTATION MODES (E.G., HELICOPTER, VAN SERVICE) THROUGHOUT THE COMMONWEALTH; AND

- o SPECIAL ATTENTION TO THE NEEDS OF ISOLATED RURAL COMMUNITIES.

13. TRANSPLANTATION

SHOULD THE COMMONWEALTH MODIFY THE AMOUNT, DURATION, AND SCOPE OF TRANSPLANTATION SERVICES CURRENTLY COVERED BY MEDICAID? OR SHOULD IT CREATE A SEPARATE PROGRAM FOR TRANSPLANTATION?

Origin of Issue

Recent technological advances have made a broad range of new transplant procedures possible and have improved the probability for successful outcome of such operations. However, tremendous cost, limited availability of donors/organs, and complex moral and ethical issues have limited states' policies for paying for transplant operations under their Medical Assistance Programs.

Transplant recipients' rates of survival for one year, as reported by the United Network for Organ Sharing, are: heart - 80 percent; liver - 70 percent; and kidney - 95 percent. National data indicate that survival for five years following a heart transplant is generally in the 50 percent range; for liver transplants, in the 13 to 50 percent range; and for kidney transplants, the 80 percent range. Virginia's Medicaid experience is that there may be less than a two year survival rate for liver and bone marrow transplants, with questionable quality of life preceding death.

The exacting medical regimens required of transplant recipients do not offer a lifestyle acceptable to some recipients. In national studies of kidney transplants, there appears to be a higher suicide rate among recipients than in the general population. Over time it has been shown that the condition of atherosclerosis develops in most heart transplant patients, which limits their survival and quality of life.

Virginia Medicaid Coverage

Federal legislation signed into law in 1986 required that effective January 1, 1987, any state wishing to cover organ transplantation under its

Medical Assistance (Medicaid) Program must describe in its State Plan the specific procedures to be followed. Virginia's procedures which control allowable Medicaid organ transplant services were derived from recommendations included in the 1985 Report of the Virginia Task Force on Organ Transplant to the Secretary of Human Resources.

Currently, Virginia's Medicaid Program allows reimbursement provisions only for transplant services related to kidneys and corneas; however, liver transplants also may be authorized for recipients under age 18 who have been diagnosed with extrahepatic biliary atresia. All transplant services, except for corneas, require pre-authorization by the Program director. Additionally, each patient must be identified as medically acceptable for the service, and the treatment facility and transplant staff must be recognized as being capable of providing high-quality care. Reimbursement values on transplant services, except for corneas, are negotiated with the providers on an individual case basis.

Other States

A May 1987 sampling of nine other states' Medicaid programs revealed the following in regard to program authorizations:

- All allow payments for liver replacement, but five offer this coverage only for children with biliary atresia;
- Seven states provide for bone marrow and for kidney transplants;
- Five allow heart replacements to be funded by their programs; and
- Three cover cornea transplants.

Decision Elements

Virginia's traditional concern for individual quality of life and the additional opportunities being afforded by medical science for dramatic actions to correct previously irreversible health conditions continue to exert

pressure on this state's Medical Assistance Program for more liberal coverage of organ transplantation.

Judgments on ethical questions are associated with each decision to allow or to deny State payment for an organ transplant to a critically ill citizen. The tremendous cost of each organ transplantation raises concern over the scope of public responsibility to pay for the costs of organ transplants for a selected few. Because of the complexity of this issue, agreement on the circumstances under which favorable decisions are rendered will remain difficult.

RECOMMENDATIONS

THE ORGAN TRANSPLANTATION ISSUE SHOULD BE KEPT UNDER ACTIVE SURVEILLANCE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND OPTIONS TO EXPAND MEDICAID COVERAGE SHOULD BE ADOPTED WHENEVER ETHICALLY APPROPRIATE AND WHEN FINANCIAL RESOURCES, INCLUDING FEDERAL DOLLARS, WILL PERMIT.

D. FUNDING

14. REALLOCATION OF STATE FUNDS

SHOULD SOME OR ALL OF THE FUNDS CURRENTLY ALLOCATED TO STATE AGENCIES FOR THE PURPOSE OF PROVIDING HEALTH CARE TO THE NON-MEDICAID INDIGENT POPULATION BE REALLOCATED TO MAKE A MORE EFFEC- TIVE AND EFFICIENT USE OF PUBLIC MONEY OR TO MAXIMIZE INFLOW OF AVAILABLE FEDERAL APPROPRIATIONS?

State Fund Appropriations

The State teaching hospitals, the Department of Health, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Rehabilitative Services, as well as the three advocacy state departments, receive state appropriations to provide services for the indigent who are not eligible for Medicaid support.

By far the largest State appropriation for indigent health care is provided to the Virginia Medical Assistance Services (Medicaid) Program, which follows federal law and regulation requirements and obtains a 53 percent (Fiscal Year 1986) match in federal funds to pay for allowed health care services to eligible Virginians. Services under the Medicaid Program are provided to all categories of citizens required by federal law and to some of the optional groups. The U.S. 1981 Consolidated Omnibus Budget Reconciliation Act (COBRA) added significant alternatives for states in terms of scope of services and in groups of persons who could be served. Virginia Medicaid has not yet obtained the additional State funds necessary to match federal monies and allow it to add any of the recent options for program expansion.

Possibilities for Changes

Among the more important provisions of the 1981 COBRA was an opportunity for State Medicaid programs to embrace a new special category of persons--pregnant women and infants and children up to age five whose family income is above current AFDC limits but below federal poverty levels. Some prenatal and

postnatal care for indigent women above Medicaid eligibility limits is now being provided from other (than Medicaid) State programs which are supported solely by State appropriations. To take advantage of the opportunity to embrace a new group of persons who are below the poverty income level, but above current Virginia Medicaid income limits, would require four to nine million dollars per year in additional State money, but would draw down approximately equal amounts of matching federal dollars. Exact costs will vary according to the selection of criteria for eligibility determination and actual utilization levels. It is likely that some of this group of potential Medicaid recipients are now obtaining services under the State-Local Hospitalization (SLH) Program or from the local health departments or nearby State hospitals. If so, demands on those programs now supported from State (only) funds, would be reduced.

One of the federal requirements for inclusion in Medicaid is the category of Supplemental Security Income (SSI) recipients. Income limits have been imposed by the Virginia Medicaid Program for SSI recipient eligibility and consequently all SSI recipients are not presently eligible to receive services. If funds were made available for the Medicaid Program to expand SSI eligibility to the limits allowed by federal law, other State programs now serving these elderly would require less State money appropriations.

It has also been suggested that if additional appropriations or reallocation of State funds to Medicaid from other State programs (such as State teaching hospitals) were to occur, Medicaid could set physician fees closer to usual and customary charges. If this were done, it might encourage private physicians to accept more Medicaid patients for primary care and result in fewer hospital admittances and fewer emergency room visits.

Since each program from which funds might be reallocated was developed to serve some valid purpose, any reallocation of funds could have multiple effects on the availability of services, on the people receiving the services, and on persons and institutions providing the services. Therefore, any reallocation must be carefully undertaken.

A serious problem that must be faced in assessing the costs of changing Medicaid or any other State health care program is that little is known in Virginia as to the number of indigent or near-indigent in the State, their locations, or their real needs. All estimates of costs of services lack specifics in this regard, thus making accurate dollar forecasts and choice of options for amending services difficult.

RECOMMENDATIONS

A. A STATE SURVEY SHOULD BE CONDUCTED AS SOON AS POSSIBLE TO ACQUIRE A HEALTH CARE DATA BASE FROM WHICH THE HEALTH CARE NEEDS OF VIRGINIA'S INDIGENT POPULATION CAN BE MORE ACCURATELY EVALUATED AND COSTS CAN BE DEVELOPED FOR ALTERNATE ACTIONS TO SATISFY UNMET NEEDS.

B. THE VIRGINIA MEDICAID PROGRAM SHOULD INCORPORATE THE 1986 FEDERAL OPTION FOR PREGNANT WOMEN AND CHILDREN WITH ELIGIBILITY UP TO THE FEDERAL POVERTY INCOME LEVEL. THE FUNDS NOW APPROPRIATED TO THE TWO STATE-SUPPORTED PUBLIC HOSPITALS AND TO STATE AGENCIES TO PROVIDE SIMILAR SERVICES TO THIS POPULATION CATEGORY SHOULD BE REALLOCATED TO MEDICAID.

C. THE VIRGINIA MEDICAID PROGRAM SHOULD UNDERTAKE A COST/BENEFIT ANALYSIS ON THE "209(b)" FEDERAL OPTION TO DETERMINE IF THE CURRENT RESTRICTIVE ELIGIBILITY INCOME CRITERIA FOR THE AGED, BLIND AND DISABLED, WHICH PREVENT MANY SUPPLEMENTARY SECURITY INCOME (SSI) RECIPIENTS FROM RECEIVING MEDICAID COVERED SERVICES, SHOULD BE AMENDED.

D. THE VIRGINIA MEDICAID PROGRAM SHOULD BE PROVIDED ADDITIONAL FUNDS TO INCREASE THE RATE OF REIMBURSEMENT TO PHYSICIANS, THEREBY IMPROVING RECIPIENTS' ACCESS TO PREVENTIVE SERVICES AND LOWER-COST PRIMARY CARE SERVICES.

15. LOCAL versus STATE FUNDING

SHOULD PARTICIPATION BY LOCAL GOVERNMENTS IN FUNDING OF DEPARTMENT OF HEALTH AND DEPARTMENT OF SOCIAL SERVICES HEALTH CARE PROGRAMS FOR INDIGENTS BE MANDATORY AND, IF SO, AT WHAT PERCENTAGE OF THE PROGRAMS' COSTS?

Department of Health

The Code of Virginia at §32.1-30 requires all jurisdictions to establish local health departments. For many years, local governments have entered into cooperative agreements with the State Health Department to share the costs of local public health services in exchange for which both State and local requirements for service are to be met. The 118 local health department locations now serve all independent cities and counties, with services tailored as funds will permit to meet local citizen needs and State law dictates.

Department of Social Services

The Code of Virginia at §63.1-106, as amended, allows a local board to elect to establish a social services program of general relief and to choose which specified assistance components will be provided. Assistance for medical care is allowable under a maintenance component and also under a short-term/emer- gency component of the General Relief Program. Assistance offered as main- tenance must be limited to the types of medical services covered by Medicaid; the emergency medical component has no such restriction. Eligibility for coverage is limited to those indigents who cannot qualify for Federal AFDC or SSI Program assistance.

The State-Local Hospitalization (SLH) Program, which is authorized by Title 63 of the Code of Virginia and operated by the Department of Social Services, offers hospital care and treatment for indigent residents of Virginia. Participation in this program by local jurisdictions is voluntary.

A recent study by the Virginia Hospital Association pointed out the effects of the geographic imbalance occurring in the distribution of SLH funds. Because local decisions determine the SLH distribution, some hospitals receive help from SLH with their bad debt/charity care financial burdens and some do not. For example, northern Virginia received 35 percent of the State SLH funds allocated last year although it has the smallest share (9.3 percent) of the statewide bad debt/charity care burden, and the lowest ratio of bad debt/charity care to revenue among the five State regions.

The following summarizes local government participation in the General Relief and the State-Local Hospitalization Programs:

Local Participation in State Social Services' Programs

(As of September 1987)

Of 138 Total Cities and Counties:

Program	Localities Participating
General Relief:	
Maintenance	57
Emergency	81
State-Local Hospitalization	101

Variances in Eligibility

Local health departments all use the criteria for service eligibility established by the Department of Health. Eligibility is determined on an income sliding-scale based on the federal poverty level. Both State hospitals also use this process.

By contrast, each of the localities participating in the General Relief and SLH Programs determines recipient eligibility criteria as it chooses. The Department of Social Services provides guidelines, but local option controls.

House Document No. 29 (1986)

The Report of the Joint Subcommittee Established to Study Alternatives for a Long-Term State Indigent Health Care Policy (House Document No. 29) recommended that the SLH Program be transferred to the Department of Medical Assistance Services, with eligibility to receive services being determined by the Department of Social Services. This was based on expectations for greater uniformity in eligibility criteria, screening processes, cost containment measures, and hospital reimbursement rates. It was concluded that to improve the combined impact of Medicaid and SLH, the two programs and their policies and procedures should be more complementary.

Cost Sharing Formulas

By law, the cost of the State-Local Hospitalization Program is shared: 75 percent by the State and 25 percent by the local government. Distribution of the annual State appropriation among the localities occurs semiannually according to population. After six months, those localities exceeding their initial allocation may request additional funding from the reserve fund. The reserve fund consists of monies designated through the Appropriation Act as a set-aside, in addition to monies which were allocated but not yet spent by localities. The major criticisms with this distribution system are:

- Distribution is based upon population totals with no adjustment for the size of the poverty population or the access of residents within certain localities to the teaching hospitals.

- The allocation formula distributes available funds to all localities regardless of whether they plan to participate in the program. Therefore, a pool of unexpended funds is automatically generated.

- Reserve funds are dispersed retrospectively on a reimbursement basis.

While there is apparent consensus that the above and other features of the SLH Program should be changed, as yet there have been no decisions or actions to modify the Program.

The cost sharing formula used for funding local health departments has undergone little change since it was established in 1954. Local match requirements are based on localities' fiscal capacity, measured by the estimated true value of real estate, and range between 18 and 45 percent. A 1979 report completed by the Joint Legislative Audit and Review Commission noted the following problem with the formula:

> The use of the estimated true value of real estate as a measure of fiscal capacity contributes to financial disparities among health departments. When the formula was established, local real estate taxes were by far the single most important source of locally-raised taxes. Today, both cities and counties depend upon a more diversified tax base.

The 1986 Report of the Joint Subcommittee Established to Study Alternatives for a Long-Term State Indigent Health Care Policy recommended that:

> the Joint Legislative Audit and Review Commission make a study of formulas used in the SLH Program and the State/Local Cooperative Health Department Program, and make recommendations on formula revisions.

That study has been undertaken with a report expected for the 1988 General Assembly.

RECOMMENDATIONS

A. ALL LOCAL GOVERNMENTS SHOULD BE REQUIRED TO PARTICIPATE IN THE STATE PUBLIC HEALTH, GENERAL RELIEF, AND SLH PROGRAMS, EXCEPT WHEN UNUSUAL LOCAL ECONOMIC CONDITIONS TEMPORARILY PRECLUDE PARTICIPATION.

B. THE TOTAL DOLLARS IN LOCAL HEALTH DEPARTMENTS' BUDGETS SHOULD CONTINUE TO BE BASED ON A PLAN DEVELOPED TO MEET THE NEEDS OF THE LOCALITY, AND THE REQUIRED LOCAL FUNDING SHOULD CONTINUE TO BE DETERMINED ACCORDING TO THE

HEALTH DEPARTMENT FORMULA ON ABILITY TO PAY, PENDING FINAL CONSIDERATION OF THE JLARC RECOMMENDATIONS.

C. ONE STATE AGENCY SHOULD BE DESIGNATED TO DETERMINE ELIGIBILITY FOR ALL PROGRAMS WHICH PROVIDE SERVICES AT LOCAL LEVELS, AND ALL LOCAL GOVERNMENTS SHOULD ADHERE TO STATE ELIGIBILITY CRITERIA UNLESS ONLY LOCAL GOVERNMENT FUNDING IS USED IN PAYMENT FOR SERVICES.

16. CHARITY CARE - MANDATORY

SHOULD ALL PROVIDERS LICENSED TO DO BUSINESS IN THE COMMONWEALTH BE REQUIRED TO PROVIDE A MINIMUM AMOUNT OF CHARITY CARE?

Uncompensated Care

Medical services providers for years have maintained a tradition of providing health care to the poor, as needed, despite expectations of little or no reimbursement. Information is not available on the current (or past) values of free care given by all providers in Virginia, but the Virginia Hospital Association (VHA), which studied the amount of bad debt and charity care given by non-profit and proprietary hospitals, has found the hospital volume to be steadily increasing.

VHA sampling of unpaid hospital bills showed that diagnoses and treatments were usually trauma or pregnancy related, with a few high-cost chronic cases also occurring. Half of these cases related to patients who had been admitted through the emergency room, and 2.6 percent of the cases made up 37 percent of the dollar total of unpaid bills.

In a recent study by the Virginia State Corporation Commission's Bureau of Insurance, it was concluded that family income was the most important predictor of the extent of health insurance coverage held by an individual. Unemployment and under-employment were also found to be closely associated with inadequate health insurance coverage. Slightly less than half of the Virginians living below the federal poverty level do not have comprehensive health insurance coverage, and one-third of them have no coverage at all.

While the number of uninsured persons who require medical services may have increased due to economic factors, hospitals are now less able to shift the costs of uncompensated care to those able to pay. Some are finding it necessary to decrease their amount of uncompensated care. In Virginia and

many other states, a smaller number of providers are shouldering the bulk of the responsibility for uncompensated care.

Virginia Trends

Although data are not available to allow a reliable separation of hospital charity care from bad debt, and its dollar values are based on charges rather than costs, it is clear that the total uncompensated care volume is increasing yearly. The following VHA data reflect this trend:

Bad Debt and Charity Care
All Virginia Hospitals

Fiscal Year	% of Total Charges	Amount (millions)
81	6.8	$ 147.8
82	7.0	175.9
83	8.2	241.4
84	8.5	267.7
85	9.0	302.5

The impact of bad debt/charity care costs is also not equally distributed among regions of the state. For example:

Bad Debt and Charity Care Burdens
Virginia Hospitals

Region	% Pop Below Poverty	1981	1982	1983	1984	1985
Northwest (Excluding UVA)	12.0%	4.7%	4.8%	5.6%	5.4%	6.0%
Northern	5.2%	4.1%	3.8%	5.6%	5.6%	5.3%
Southwest	13.2%	5.8%	6.2%	7.0%	6.5%	6.3%
Central (Excluding MCV)	12.7%	3.9%	3.6%	4.0%	4.4%	4.7%
Tidewater	13.7%	6.8%	6.7%	7.6%	8.5%	8.9%

Non-profit Virginia hospitals, excluding government hospitals, generally carry a heavier uncompensated care burden than do proprietary hospitals. The

proprietary hospitals, of course, contribute tax revenues which are used in part to support medical care needed by the poor.

There appears to be general philosophical agreement that the responsibility for caring for the health needs of the indigent population should be shared fairly, but the preferred method for achieving that objective is still an unsettled subject . Many individuals would accept that hospitals (and all other health providers) should make sensible and reasonably uniform efforts to collect on overdue bills for services so that bad debt could be differentiated from charity care, but agreement on the precise definitions of terms would be difficult.

In 1986, the U.S. Congress passed an "anti-dumping" provision which requires hospitals participating in Medicare to provide emergency care regardless of ability to pay, and prohibits hospitals from transferring patients until their conditions are stabilized.

State Institutions

Much of the non-Medicaid indigent health care in the Commonwealth is provided by the Medical College of Virginia and the University of Virginia hospitals, which receive State appropriations for this purpose. The gross dollar value of bad debt and charity care has more than doubled for these two institutions since 1981. In 1985, bad debt and charity care at State teaching hospitals were estimated to be 26 percent of their total potential patient revenue. As the growth rate for volume of uncompensated care at Virginia's medical schools increased, so has their portion of the overall State burden. In 1985 the State hospitals were carrying 36 percent of the State total bad debt and charity care.

SLH Impact

The purpose of the State-Local Hospitalization (SLH) Program is to assist counties and cities in voluntarily providing hospital care and treatment for indigent and medically indigent residents of Virginia. The State annually

distributes SLH appropriations to those local governments which agree to administer the program and provide a one-for-three dollar match of State funds.

Some of the poorer jurisdictions cannot afford the required match of State funding under the SLH Program and only 101 of the 137 localities have chosen to participate in SLH in Fiscal Year 1987. This accentuates the financial problem of uncompensated care for hospitals in the areas which do not receive SLH funds.

There is little correlation between the SLH appropriations distribution and families-in-poverty distribution. As an example, 35 percent of the SLH annual distribution goes to the northern Virginia planning district which has only slightly more than 9 percent of the States' poverty population.

Certificate of Public Need Program

Hospitals, nursing homes, and other other health providers are constrained by law in Virginia from making substantial new investments in facilities and major equipment (if aimed at increasing capacity or change of services) without receipt of a Certificate of Public Need (COPN) from the Virginia Commissioner of Health. In the recently completed study of the COPN law, it was recommended that hospitals be substantially deregulated from the law's requirements that nursing homes remain subject to it, and that the procedures by which COPN applications are processed be significantly streamlined. The Commission which conducted this survey has noted, however, that the regulation of capital expenditures by health care providers and the provision of health care to the medically indigent are inextricably linked. The hospital industry, which wishes to be deregulated, and the nursing home industry, which wishes to continue to be regulated, have an obligation to assist government in identifying mechanisms to ensure access to health care by indigent persons. Decisions affecting the COPN program should not be made without weighing their effect on indigent health care. The COPN program should not hamper and, if possible, should improve the ability of indigent persons to obtain health care.

Other States

Other states are exploring various ways to meet the health care needs of the uninsured, recognizing that their opportunities for obtaining health care services may be decreasing. Some states have created revenue pools to reimburse hospitals for more-than-average volumes of health care services provided to the indigent. These fund pools, intended for spreading the burden of uncompensated care more evenly, are usually generated by an addition to the State's sales or income tax, by a tax on health insurance premiums, or by a tax on hospitals' revenues. In cases where a state tax is being levied on hospitals, each hospital subsequently receives a portion from the tax-generated pool based on the volume of uncompensated care provided. Some states (New Jersey) use their hospital rate regulation program to adjust for varying indigent care loads, and others (Nevada) set a minimum hospital obligation, determined by a rate control commission, to provide care to the indigent. Such arrangements allow providers who traditionally serve a disproportionate share of medically indigent to receive adjusting revenue.

RECOMMENDATIONS

A. THE SECRETARY OF HUMAN RESOURCES SHOULD REVIEW CAREFULLY THE REPORT OF THE GOVERNOR'S COMMISSION ON THE MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED PROGRAM. THE SECRETARY SHOULD ENSURE THAT NONE OF THE RECOMMENDATIONS OF THAT COMMISSION HAMPER THE ABILITY OF INDIGENT PERSONS TO OBTAIN HEALTH CARE OR FOSTER GREATER INEQUALITY AMONG HEALTH CARE PROVIDERS REGARDING UNCOMPENSATED CARE. THE SECRETARY SHOULD DEVELOP PROPOSALS ON INCREASING ACCESSIBILITY TO CARE FOR INDIGENT PERSONS AND SUBMIT THESE FOR CONSIDERATION BY THE GENERAL ASSEMBLY WHILE THE RECOMMENDATIONS OF THE COPN COMMISSION ARE UNDER REVIEW BY THE GOVERNOR AND THE GENERAL ASSEMBLY.

B. THE SECRETARY OF HUMAN RESOURCES AND THE STATE CORPORATION COMMISSION'S BUREAU OF INSURANCE SHOULD DEVELOP A LONG-RANGE ADMINISTRATIVE AND FINANCIAL PLAN TO FUND HEALTH CARE NEEDS (PARTICULARLY FOR LONG-TERM CARE) FOR UNINSURED AND UNDERINSURED PERSONS. THE PLAN SHOULD SEEK TO OBTAIN MORE BALANCE AMONG HOSPITALS ACROSS THE STATE IN SHOULDERING THE UNCOMPENSATED

CARE BURDEN. THE PLAN SHOULD ALSO CONSIDER ADOPTING OTHER STATES' SUCCESSFUL ACTIONS, SUCH AS ESTABLISHING RISK POOLS OR TAX INCENTIVES, IN ORDER TO RECOGNIZE REQUIREMENTS OF ALL VIRGINIA CITIZENS FOR ACCESS TO ADEQUATE HEALTH CARE. MANDATORY INSURANCE COVERAGE FOR ALL EMPLOYEES, ALTHOUGH NOT RECOMMENDED AT THIS TIME BY THIS TASK FORCE, SHOULD BE RE-EVALUATED FOR INCLUSION IN THIS PLAN. THIS LONG-RANGE PLAN SHOULD BE COMPLETED IN TIME TO BE PRESENTED IN THE 1988-1990 BIENNIUM.

E. CLIENTS

17. CLIENT ELIGIBILITY

SHOULD THE COMMONWEALTH ESTABLISH UNIFORM ELIGIBILITY STANDARDS FOR THE PROVISION OF INDIGENT HEALTH CARE? SHOULD THE ELIGIBILITY DETERMINATION PROCESS USED BY INDIVIDUAL HEALTH SERVICES PROGRAMS BE CHANGED TO IMPROVE ACCESSIBILITY TO SERVICES?

Client Problems

Eight State agencies and two State hospitals establish the processes and criteria for determining who is eligible to receive free or partially-paid services from their programs. Requirements for establishing service eligibility differ among the State programs because of federal law provisions, State law mandates, or philosophy of the department controlling the offered services. Each agency now specifies the application forms to be used and the documentation to be furnished by its clients. With few exceptions, a citizen who seeks services from programs of more than one agency must appear, provide personal data to each, and face different standards on eligibility.

When applying for a State program health service, similar questions about financial resources must be answered at each service site. The Department of Health and the teaching hospitals are exceptions in that they will accept identifying Medicaid cards as adequate evidence of family income status. The Department of Health also will honor prior Social Services program eligibility determinations as to financial resources. Nevertheless, a person needing consultation from a local mental health/mental retardation community service, family planning assistance from a local health department, illness diagnosis from a State hospital outpatient clinic, and/or dental services from the Department for the Aging, would need to visit each local program location in order to establish eligibility to receive each service. Because indigent persons are usually not as mobile as are other citizens, the requirement to go to several sites to become eligible for each program service tends to discourage receipt of needed health services.

Some programs use the same income requirements statewide; others vary income limits according to geographical areas of the State. A few programs use a sliding income scale for charges. Some State programs (e.g., State-Local Hospitalization, General Relief and certain public health clinic services) are not available to citizens in all localities.

Movements Toward Uniformity

The State teaching hospitals and the Department of Health, several years ago, agreed to use uniform income categories, identical sliding scales for establishing fee-for-service outpatient charges, and the same general processes for determining eligibility. These procedures utilize the federal poverty level as the base for determining income/payment responsibility. Although there is consistency in client eligibility processing among UVA, MCV and the Department of Health, differences exist in guidelines used to evaluate applicant assets before making income level assignments.

RECOMMENDATIONS

A. THE SECRETARY OF HUMAN RESOURCES SHOULD REVIEW THE VISUALLY HANDICAPPED, VOCATIONAL REHABILITATION, STATE-LOCAL HOSPITALIZATION, GENERAL RELIEF, INDEPENDENT LIVING CENTER SERVICES, AND OTHER PROGRAMS INVOLVED IN PROVIDING HEALTH-RELATED SERVICES TO CLIENTS, TO REVISE THEIR ELIGIBILITY CRITERIA WHEN POSSIBLE SO AS TO BE MORE CONSISTENT WITH THE PROCESSES NOW USED BY UVA, MCV, AND THE DEPARTMENT OF HEALTH.

B. THE SECRETARIES OF HUMAN RESOURCES AND EDUCATION SHOULD REQUIRE THAT UVA, MCV, AND THE DEPARTMENT OF HEALTH MEET AND DEVELOP COMMON STANDARDS FOR INTERPRETING THE VALUE OF CLIENT ASSETS, CATASTROPHIC HEALTH COSTS, SPEND-DOWN, GEOGRAPHIC REGION VARIATIONS, AND OTHER COMPONENTS OF FAMILY INCOME ASSESSMENTS ASSOCIATED WITH ELIGIBILITY DETERMINATION.

C. A UNIFORM CLIENT DATA BASE SHOULD BE ESTABLISHED BY THE COMMONWEALTH FOR ACCESS BY ALL HEALTH PROGRAMS TO REDUCE REPETITIVE COLLECTION FROM CITIZENS OF IDENTICAL ELIGIBILITY INFORMATION.

D. ELIGIBILITY STAFF SHOULD BE PROVIDED FOR STATE INSTITUTIONS AND OTHER HIGH-VOLUME PROVIDERS TO ACCEPT, PROCESS, AND EXPEDITE ELIGIBILITY APPLICATIONS FOR MEDICAID AND OTHER STATE PROGRAMS.

E. ALL COMMONWEALTH HEALTH SERVICES PROGRAMS SHOULD AGREE TO UTILIZE THE FEDERAL POVERTY LEVEL AS THE BASIS FOR DETERMINING ELIGIBILITY TO RECEIVE FREE SERVICES AND SHOULD THEN TAKE PROGRESSIVE ACTIONS TOWARD THE IMPLEMENTATION OF THAT STANDARD AS ADDITIONAL FUNDING, IF REQUIRED, IS OBTAINED.

18. RECIPIENT CO-PAYMENTS

SHOULD ALL OF THE COMMONWEALTH'S INDIGENT HEALTH CARE PROGRAMS REQUIRE CO-PAYMENTS BY RECIPIENTS WITH INCOME ABOVE THE FEDERAL POVERTY LEVEL FOR EACH SERVICE OR ENCOUNTER?

Definition and Implications

One commonly used technique to control the utilization of health care services is the imposition of a co-payment whereby the person receiving a service shares in the cost. For public services, the amounts set for co-payment are frequently varied according to income levels or ability to pay.

Different philosophies exist as to the effects of requiring co-payments from those who receive public health and other human resources services. Some believe that one of the disadvantages of having a co-payment requirement is that it could cause persons to avoid seeking needed services because of inability to pay their share or to avoid embarrassment when explaining their financial plight. Others think that co-payments do not create an unreasonable barrier to receipt of services and, since they can provide revenue, should be utilized.

Co-payments do appear to be an effective mechanism for restraining unnecessary use of services. The use of co-payments is considered to be consistent with prevailing societal expectations regarding personal responsibility for participation in actions which relate to one's own well-being.

Current State Approaches

Virginia State agencies have different policies on co-payments by service recipients:

Agency		Co-Payment Required
Department of Health	-	For clients with income exceeding 100% of Federal poverty level
Department of Medical Assistance Services	-	For medically needy for some services
Department of Mental Health, Mental Retardation and Substance Abuse Services	-	For inpatient services based on "ability to pay" after evaluation of family resources
Department of Social Services:		
- General Relief	-	Not required
- State-Local Hosp.	-	Varies according to locality
UVA/MCV	-	For clients with income exceeding 100% of Federal poverty level

Program services offered by the Departments of Rehabilitative Services, Aging, Visually Handicapped, and Deaf and Hard of Hearing do not impose co-payment requirements, though voluntary contributions will be accepted from clients.

While there is appeal in the idea of a uniform co-payment policy for all State indigent health care programs, it may be impossible and highly impractical to apply a uniform co-payment mechanism across the many State programs which provide some form of health care service to indigent persons. This is because each State program has its own laws and regulations, many of which are derived from federal requirements that specify whether and how co-payments can be obtained. Furthermore, the co-payment policies and procedures which are found to be practical and reasonable for high-cost institutional services are not likely to be practical and reasonable for low-cost ambulatory care services.

RECOMMENDATIONS

A. A POLICY ENDORSING THE USE OF CO-PAYMENTS IN ALL HEALTH CARE SERVICE PROGRAMS SHOULD BE ISSUED BY THE SECRETARY OF HUMAN RESOURCES TO:

1. ENCOURAGE APPROPRIATE UTILIZATION OF SERVICES, INCLUDING PREVENTIVE HEALTH SERVICES;

2. PROMOTE MAXIMIZATION OF FEDERAL PARTICIPATION IN INDIGENT HEALTH CARE EXPENSES; AND

3. ENCOURAGE INDIVIDUAL RESPONSIBILITY.

EACH PROGRAM'S PROCEDURES ON CO-PAYMENT APPLICATION SHOULD BE TAILORED ACCORDING TO ITS SPECIAL NEEDS AND CIRCUMSTANCES.

B. STATE ORGANIZATIONS, INCLUDING STATE TEACHING HOSPITALS, SHOULD CONTINUE TO EXERCISE DILIGENCE IN:

1. COLLECTING CO-PAYMENTS WHICH ARE DUE FROM PATIENTS; AND

2. PROVIDING ACTIVE ASSISTANCE TO PATIENTS IN PROCESSING CLAIMS UNDER ANY THIRD-PARTY INSURANCE COVERAGE SO THAT APPROPRIATE REIMBURSEMENTS MAY BE OBTAINED.

19. PAYMENT RESPONSIBILITY

WHAT FINANCIAL SUPPORT SHOULD BE REQUIRED OF RELATIVES OR STEP-PARENTS BY THE COMMONWEALTH IN ORDER TO HELP PAY FOR THE COSTS OF HEALTH CARE SERVICES PROVIDED FROM STATE PROGRAMS TO INDIGENT AND NEAR-INDIGENTS?

Family Financial Responsibilities

In determining client eligibility for State-sponsored health services, evaluations are usually made of the income and of the assets of the immediate family. In many cases, young persons (over 18 years of age) are treated as financially independent adults, even though they are living in their parents' home. In such cases, the parents are not held legally responsible for payments toward the costs of health care needed by these children. A similar, but reverse, situation occurs when an elderly person is placed in a nursing home at State (Medicaid) expense, although the children may be financially able to contribute toward the costs being incurred for the care of their parents.

Obligations to assist in providing for the support and maintenance of family members have been addressed by the General Assembly and are covered by existing State statutes. These laws are: "Obligation of person to support certain children living in same home" (§63.1-90.1); and "Support of parents by children" (§20-88.01).

Medicaid and Other State Programs

A special problem was created for the Virginia Medical Assistance Program when it was informed by the federal government that the provisions of federal law override the Code of Virginia at §63.1-90.1 with regard to parents' responsibility for their adult children.

In some instances step-parents are not adopting children to avoid legal parental responsibility and to enable the child to become eligible to receive Medicaid services. Similar situations occur with the obligations of grandparents, acting in the absence of parents, step parents, and separated spouses.

The elderly experience traumatic problems when faced with an impending commitment to a long-term care facility. The prospect of heavy monthly nursing home bills may sometimes prompt them to transfer assets, at less than market value, to their family members in order to qualify for Medicaid eligibility. The Code of Virginia at §20-88.01 prohibits receipt of public benefit program eligibility if such transfers occur in less than four years before receiving public benefits; however, the Virginia Medicaid program again must, in these circumstances, follow federal law provisions which permit disallowance of asset transfers only in the previous two years. Even so, current Virginia Medicaid policy allows for a recoupment of payments from the recipient of transferred assets for up to four years after the transfer occurs.

Medicaid eligibility can be obtained after medical charges accumulate sufficiently to reduce prospective income down to Medicaid levels. In such cases, if institutionalization continues for an elderly married person, the spouse at home is required to contribute as long as he or she has resources to do so, toward the cost of care for the institutionalized spouse. This frequently reduces the remaining at-home spouse to living in near poverty conditions.

The Department of Mental Health, Mental Retardation and Substance Abuse Services and other State agencies follow Virginia Code requirements but utilize different procedures regarding interpretation of family financial responsibilities for the cost of services.

RECOMMENDATIONS

A. ALL STATE POLICIES AND PROCEDURES SHOULD BE AIMED AT ENCOURAGING ACCEPTANCE OF FAMILY RESPONSIBILITY FOR THE COST OF MEDICAL CARE.

B. THE MEDICAID AND OTHER STATE PROGRAMS WHICH PROVIDE MEDICAL CARE SHOULD, IN REGARD TO RESPONSIBILITIES OF PARENTS FOR THEIR CHILDREN:

- o STRENGTHEN THE PROCESSES USED FOR HOUSEHOLDS WITH MINOR CHILDREN AND ONLY ONE NATURAL PARENT IN OBTAINING THE OTHER NATURAL PARENT'S FINANCIAL ASSISTANCE ON MEDICAL CARE COSTS AND OTHER CHILD SUPPORT REQUIREMENTS; AND

- o TAKE AGGRESSIVE ACTIONS TO ENSURE CHILD SUPPORT ENFORCEMENT, INCLUDING MEDICAL SUPPORT, IN HOUSEHOLD SITUATIONS INVOLVING AN ABSENT PARENT.

C. THE DEPARTMENTS OF SOCIAL SERVICES, MEDICAL ASSISTANCE SERVICES AND AGING SHOULD REVIEW THE CURRENT MEDICAID POLICIES ON FAMILY RESPONSIBILITY FOR AN INSTITUTIONALIZED MEMBER AND SEEK WAYS TO MODIFY THESE POLICIES TOWARD:

- o LENGTHENING THE CURRENT TIME PERIOD WHICH RESTRICTS TRANSFER OF ASSETS AT LESS THAN MARKET VALUE; AND

- o PROVIDING FOR A MORE ADEQUATE FINANCIAL MAINTENANCE ALLOWANCE FOR REMAINING AT-HOME SPOUSES WHEN THE HUSBAND OR WIFE IS COMMITTED TO LONG-TERM CARE.

D. THE VIRGINIA GENERAL ASSEMBLY SHOULD MEMORIALIZE THE U.S. CONGRESS TO CONSIDER IN ITS FUTURE ENACTMENT OR AMENDMENT OF HUMAN SERVICES PROGRAMS THE NEED OF PROVISIONS WHICH WILL SERVE TO STRENGTHEN FAMILY UNITS AND TO ENCOURAGE PERSONS TO MAINTAIN RESPONSIBILITY FOR THEIR FAMILY MEMBERS AND THE UNDESIRABILITY OF POLICIES AND PROCEDURES WHICH LEAD TOWARD FAMILY UNIT DISINTEGRATION.

F. INSURANCE

20. INSURANCE - VOLUNTARY/MANDATORY

SHOULD THE COMMONWEALTH MANDATE THAT ALL EMPLOYERS (INCLUDING THE SELF-EMPLOYED) PROVIDE A STATED MINIMUM LEVEL OF HEALTH CARE INSURANCE PROGRAM FOR ALL WORKERS? IF SO, IN ORDER TO MAKE COVERAGE AFFORDABLE FOR SMALL BUSINESSES, SHOULD ALL HEALTH INSURANCE COMPANIES DOING BUSINESS IN VIRGINIA BE REQUIRED TO PARTICIPATE IN A RISK POOL FOR SMALL EMPLOYERS?

The National Perspective

A Robert Wood Johnson Study (1982) revealed that nationally more than 7 percent of the employed and 8.2 percent of the total population are uninsured for medical expenses.

While statistics vary greatly among states, it is likely that of the approximately 35 million Americans who had no health insurance in 1985, more than 86 percent lived in families with a working head of household, and more than two-thirds lived in households whose heads worked full-time and year-round. Some studies cite as many as 50 percent of the uninsured as being in families with an employed head of household. Many of these employed uninsured are in low wage positions and are therefore unable to afford health insurance premiums on their own. In recent years, health service providers have become less willing to provide care to the uninsured indigent due to rapidly escalating health care costs and increasing competition among providers. Evidently it has become more important for all Americans to have adequate health insurance if they are to receive appropriate health care when they need it.

Small businesses have special difficulty obtaining affordable insurance for their employees. Because of the higher insurance premiums for a small organization where the risk cannot be spread over a large group, lower profit margins, and limited opportunity to take advantage of tax credits, small employers frequently cannot include health insurance in their employee benefit packages.

ERISA

The Federal Employee and Income Security Act (ERISA, 1974) substantially restricted states' ability to regulate employee insurance coverage. The Act has been amended only slightly to expand the discretion of the states to regulate insurance plans. States may regulate the type of mandated benefits and they may regulate the funding arrangement in plans that are not fully insured. In the present state of the law, however, it is unclear whether ERISA would allow a state to mandate that employers offer health insurance.

Members of Congress have now recognized that the ERISA restrictions limit state options too severely and prevent states from alleviating the problems of access to health insurance by small businesses and high-risk individuals. Bills have been introduced in the 100th Congress to grant more flexibility and to allow states to adopt systems which encourage cost sharing of health care risk insurance; however, none have yet been enacted.

Health Insurance in Virginia

Much concern has been expressed in Virginia over the inability of low-income citizens to receive health care in the face of rising health care costs. It is evident that there is potential for those who are uninsured to become medically indigent.

Because of its unique mix of industries, Virginia was assumed to have a higher rate of uninsured workers than many other states. To obtain specific information on Virginia's situation, the 1986 General Assembly asked the State Corporation Commission's Bureau of Insurance to conduct a comprehensive analysis of the degree of health insurance coverage of the general population. Findings from the directed study were reported to the Governor and the General Assembly in House Document No. 20, 1987.

According to the Bureau of Insurance report, 18 percent of Virginians do not have comprehensive health insurance coverage, Ten percent of these are totally uninsured. This means that more than one million Virginians are without adequate health insurance. Family income and type of employment were

found to be the most important predictors of the extent of coverage held by an individual. Only about half of those below the poverty threshold have a comprehensive health policy and 36 percent of the poor have no health insurance of any kind.

Over half of the individuals with no insurance had family incomes in excess of the poverty level. Of those without any health insurance, 7 percent had applied for but been rejected for coverage.

Most private health insurance policies held by Virginians are obtained through employers, but the likelihood of obtaining employer health coverage differs among various industries. Workers in agriculture, forestry, fishing, construction, wholesale and retail trade, and services are those least likely to have access to employer-sponsored health insurance plans.

From small employers interviewed during the Bureau of Insurance study, it was found that: 53 percent of those with less than 6 employees, 42 percent of those with less than 11 employees, and 35 percent of those with less than 51 employees do not provide health insurance benefits for permanent personnel. None of the surveyed employers offered health insurance for temporary workers.

Payment Inequities

At times, persons who require medical care because of injury resulting from the negligence of others will subsequently receive a court judgment requiring the persons at fault to pay damages, which include the cost of necessary hospitalization and physician/nurse care. If the injured are also covered by accident or health insurance, they can receive duplicate reimbursement for the cost of their care. Should the injured not pay the medical facility and/or practitioner for the care provided, State law now prohibits those providers from obtaining liens against the injured in excess of $500 in the case of hospitals, or $100 for physicians/nurses (§8.01-66.2). Because of this unique restriction, bad debts of Virginia hospitals are increased and these unpaid bill values are added to bills of other patients.

State Pools and Other Initiatives

State-sponsored health insurance risk pools are intended to meet the needs of uninsured employed persons and to assist those who are uninsurable due to previous or existing physical conditions. As of April 1987, 12 states, (including Tennessee) had established risk pools and another 13 were considering similar action. Risk pools are of no value to poor people in obtaining insurance because they cannot afford to pay the premiums; however, they can help prevent middle income people in bad health from becoming impoverished because of high medical expenses. As such, risk pools may play a valuable, if limited, role in state strategies to reduce the number of medically indigent people and the amount of uncompensated care.

RECOMMENDATIONS

A. THE COMMONWEALTH SHOULD SEEK MEANS, OTHER THAN MANDATING EMPLOYERS TO PROVIDE WORKER HEALTH CARE INSURANCE, TO MAKE COVERAGE MORE ACCESSIBLE FOR SMALL BUSINESSES AND HIGH-RISK INDIVIDUALS.

B. THE SECRETARY OF HUMAN RESOURCES SHOULD COMPLETE A FORMAL STUDY TO EVALUATE ACHIEVEMENTS AND COSTS IN THE STATES WHICH HAVE INITIATED STATE HEALTH INSURANCE RISK POOLS AND MAKE RECOMMENDATIONS ON THIS SUBJECT TO THE GOVERNOR AND TO THE GENERAL ASSEMBLY FOR CONSIDERATION DURING THE 1989 LEGISLATIVE SESSION.

C. THE SCC'S BUREAU OF INSURANCE SHOULD BE REQUIRED TO DEVELOP, IN COORDINATION WITH THE DEPARTMENT OF TAXATION, PROPOSALS TO CREATE:

- AN INCENTIVE THROUGH TAX CREDITS FOR ALL EMPLOYERS TO PROVIDE A MINIMUM LEVEL OF HEALTH CARE INSURANCE, INCLUDING COVERAGE OF CATASTROPHIC ILLNESS, FOR THEIR TEMPORARY AND PERMANENT EMPLOYEES; AND

- A STATE OPERATED RISK POOL TO ALLOW PERSONS TO PURCHASE HEALTH INSURANCE EVEN THOUGH THEY WERE PREVIOUSLY DENIED COVERAGE BECAUSE OF PHYSICAL CONDITION OR MEDICAL HISTORY.

THESE PROPOSALS SHOULD BE PRESENTED TO THE GENERAL ASSEMBLY FOR CONSIDERATION AT ITS 1989 SESSION.

D. THE VIRGINIA CONGRESSIONAL DELEGATION SHOULD BE MADE AWARE OF VIRGINIA'S CONCERN OVER THIS PROBLEM AND BE ENCOURAGED TO INTRODUCE AND/OR SUPPORT: 1) FEDERAL LEGISLATION WHICH WOULD PROVIDE CREDITS ON FEDERAL TAXES FOR BUSINESSES WHICH PROVIDE EMPLOYEE HEALTH INSURANCE; AND 2) FEDERAL LEGISLATION TO EASE THE ERISA RESTRICTIONS ON STATE AUTHORITY TO REACT TO THIS ISSUE.

E. THE LIMITS ON TORT CLAIM STATUTORY LIENS NOW IMPOSED BY STATE LAW ON ALL HEALTH CARE PROVIDERS SHOULD BE ELIMINATED BY THE GENERAL ASSEMBLY TO REDUCE COST SHIFTING.

21. PRE-EXISTING INSURANCE EXCLUSION FOR PREGNANCY

SHOULD THE COMMONWEALTH PROHIBIT HEALTH INSURERS FROM INCLUDING PRE-EXISTING CLAUSES FOR PREGNANCY?

Insurance Practices

Most group health insurance plans, and virtually all individual health insurance policies, include pre-existing conditions exclusion clauses. Pregnancy is usually identified as one of such pre-existing conditions. From the insurer/employer perspective, these clauses are essential to avoid potentially large claims and to eliminate the possibility of an individual seeking employment for the primary purpose of obtaining health insurance to cover anticipated medical expenses.

Effect on the Poor

The financial implications of not having health insurance to cover prenatal and obstetrical care are significant for low-income patients, the provider, and the insurer. Lack of prenatal care has been associated with complications during delivery and is a factor in low infant birth weight and higher infant mortality rates. Additionally, premature deliveries resulting from inadequate prenatal care frequently lead to prolonged hospital stays in costly neonatal units, and the risk of permanent physical and/or mental damage to an infant.

Women aged 18-24 account for about 40 percent of all births in the United States, yet more than 25 percent of the women in that group have no health insurance. It is estimated that 9.3 million women in the United States between the ages 15 and 44 have no medical insurance.

States' Responses

According to the State Corporation Commission's Bureau of Insurance, no state has as yet enacted an outright prohibition on pre-existing exclusions for pregnancy. However, a number of states have taken other initiatives to provide health care coverage to pregnant women, justifying the action on the cost savings that come from adequate prenatal care. Twenty-four states have added the federal option offered for coverage of pregnant women and children to their Medicaid programs. Michigan, Massachusetts, and Maryland have set up programs using state-appropriated funds for low-income pregnant women who are ineligible for Medicaid.

The Problem in Virginia

In Virginia, according to Health Department estimates, about 7,000 women without insurance coverage give birth each year. A Virginia Hospital Association sampling of unpaid patient claims at ten hospitals indicated that most bad debt/charity care cases are usually young and female, with diagnoses which tend to be trauma and pregnancy related. In Fiscal Year 1986, nearly 14 percent of the persons requiring SLH program assistance were between the ages of 20 and 24, and almost 35 percent were between 20 and 35 years of age. The most frequent use of SLH assistance has been for obstetrical and accident injury care.

It is difficult to project how many pregnant women would benefit if the pre-existing clauses for pregnancy were prohibited in health insurance policies. Many employed women can now afford to, and do, pay for their own prenatal care and delivery. Eliminating the pre-existing clauses for pregnancy would certainly result in an increase in premium costs for employers. Dropping this special exclusion might also lead the way toward a general reduction in waiting periods for coverage of other special conditions, causing health insurance claims and premiums to skyrocket.

RECOMMENDATION

THE COMMONWEALTH SHOULD NOT PROHIBIT INCLUSION OF PRE-EXISTING CLAUSES ON PREGNANCY WITHIN HEALTH INSURANCE POLICIES. IT SHOULD INSTEAD SEEK OTHER MEANS, SUCH AS EXPANDING MEDICAID PROGRAM ELIGIBILITY/SERVICES AND PROVIDING FINANCIAL INCENTIVES TO EMPLOYERS, TO ADD EMPLOYMENT HEALTH INSURANCE BENEFITS THAT WILL ASSIST LOW INCOME FAMILIES IN PAYING FOR PRENATAL CARE AND DELIVERY.

IV. UNRESOLVED ISSUES

In its study of potential actions to increase the effectiveness of the Commonwealth's efforts to meet the medical care needs of its indigent population, the Governor's Task Force identified significant issues which could not be resolved.

First, there has been no action as yet in Virginia to acquire information on who constitute the medically indigent, how many there are, where they live, and what their needs may be. Within the past five years, at least eight states (Arizona, Colorado, Florida, Missouri, South Carolina, Texas, Washington, and Wisconsin) have completed surveys of their indigent population's health needs and used the information to initiate legislation to change or authorize new State programs. The information obtained from these surveys was found to be important in validating the scope of perceived services requirements and in identifying others which had not before been addressed. The Task Force is convinced that Virginia needs similar data to ensure that limited State resources are applied in proper quantities toward the areas of greatest need and, until it is provided, health program budget values will represent unconfirmed assumptions on requirements. A design for a survey of Virginia's indigent population was developed by the Academic Consortium which supported this study, but funding to allow its completion was not available in Fiscal Years 1987 or 1988. (See Recommendation No. 1 under Reallocation of State Funds.)

Second, the Task Force, regretfully, was unable in the time available to develop specific costs on all of its recommended actions. However, in a few cases State agency program directors have already estimated costs for the recommended actions which previously had been considered. For other initiatives, it will be necessary for responsible State agencies to develop models, conduct tests, and/or calculate cost factors to obtain cost estimates before implementing Task Force recommendations. The accuracy of all cost projections will, however, be limited until an actual survey on the characteristics of the indigent population is completed.

Third, an important but unresolved philosophical question was raised throughout the Task Force study: What are the limits of government obligation for citizens who are demonstratively irresponsible? For example, after medical advice is obtained some patients, because of ignorance or lack of motivation, fail to follow that advice. In these cases, how many times should government seek them out and attempt to help them? More specifically, when prevention instruction is ignored over and over again, at what point should curative measures be curtailed? The level of education and the general status of mental or physical health will, of course, affect a person's ability to do what should be done or what he or she is told to do, but at what point should the Commonwealth stop its services and say to a medically indigent citizen, "You can have no more assistance because. . ."? The Task Force did not attempt to answer this question.

Finally, in addressing the questions under each policy issue, the Task Force concentrated on looking for solutions from within the existing State programs. Except for Charity Care - Mandatory, no specific attention was given to how private medicine might alter its practice to benefit the poor, although private physicians are doing much and can do more to alleviate the health problems of low-income persons. Consequently, State agencies should continue to work closely with medical professional associations in order to encourage and coordinate private and public efforts toward mutually acceptable goals.

LISTING OF RECOMMENDATIONS

1. PREVENTIVE versus RESTORATIVE

A. ALL STATE PROGRAMS SHOULD CONTINUE TO STRESS PREVENTION, RECOGNIZING ITS COST/BENEFIT ADVANTAGES AND THE OPPORTUNITY IT OFFERS FOR IMPROVING THE GENERAL LEVEL OF HEALTH IN VIRGINIA.

B. TRANSFER OF FUNDS FROM RESTORATIVE CARE TO PREVENTIVE CARE SHOULD NOT OCCUR BECAUSE THE LEVEL OF RESTORATIVE CARE SERVICES BEING OFFERED IS ONLY MARGINALLY ADEQUATE TO MEET THE MOST CRITICAL HEALTH NEEDS OF VIRGINIA'S POOR.

C. A VIRGINIA COMPREHENSIVE PREVENTION PLAN, AS RECOMMENDED BY THE 1986 GOVERNOR'S TASK FORCE ON COORDINATING PREVENTIVE HEALTH, EDUCATION AND SOCIAL PROGRAMS, SHOULD BE COMPLETED WITHIN THE NEXT YEAR AND SHOULD INCLUDE PROVISIONS FOR:

- o EDUCATION FOR ALL CITIZENS ON LIFESTYLES THAT PROMOTE GOOD HEALTH;
- o ENCOURAGEMENT FOR THE USE OF TRAINED FACILITATORS IN PATIENT MANAGEMENT;
- o PROMOTION OF GENERAL ACCESS TO CASE MANAGEMENT UPON ENTRY, AT ANY POINT, IN THE STATE ASSISTANCE NETWORK (See Community versus Institution, Pre-Paid Health Care - Medicaid, and Health Department Clinics); AND
- o DEVELOPMENT OF AGGRESSIVE OUTREACH FOR ALL PROGRAMS, ESPECIALLY THE BLOOD PRESSURE SCREENING, EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT FOR CHILDREN (EPSDT), AND WOMEN, INFANTS AND CHILDREN (WIC) PROGRAMS.

D. STATE FUNDING SHOULD BE PROVIDED, BEGINNING WITH THE 1990-1992 BIENNIUM, TO ALLOW THE ACTIONS ENVISIONED IN THE COMPREHENSIVE PREVENTION PLAN TO BE IMPLEMENTED.

2. PRIORITY OF CHILDREN

A. FUNDING PRIORITIES FOR STATE HEALTH-RELATED PROGRAMS SHOULD NOT BE ASSIGNED BY AGE GROUP, BUT INSTEAD BE BASED ON: 1) THE DEGREE OF NEED FOR SERVICES BY INDIVIDUALS WHO CANNOT OBTAIN THESE ELSEWHERE; AND 2) THE POTENTIAL FOR PROVIDING SIGNIFICANT RELIEF FOR THE PROBLEM PRESENTED.

B. INVESTMENTS IN HEALTH PROGRAMS WHICH INTERVENE IN THE EARLIER STAGES OF LIFE SHOULD CONTINUE TO BE SUPPORTED BY THE STATE BECAUSE THESE WILL PROMOTE QUALITY OF LIFE IMPROVEMENTS WHICH WILL ENDURE OVER THE LONGEST PERIOD OF TIME.

3. COMMUNITY versus INSTITUTION

A. TO ALLOW REDUCTION IN COSTLY INSTITUTIONALIZATION, MEDICAID COVERAGE OF COMMUNITY-BASED CARE SHOULD BE EXPANDED BY ALLOWING REIMBURSEMENT FOR:

- o ADULT DAY CARE
- o DAY HABILITATION
- o CRISIS MANAGEMENT
- o RESPITE CARE
- o HOME AND COMMUNITY THERAPEUTIC CARE

PRIOR TO INCLUSION OF THE FOREGOING SERVICES, THE SECRETARY OF HUMAN RESOURCES SHOULD MODEL PROGRAMS FOR THE EXTENSION OF EACH SERVICE AND ASCERTAIN SPECIFIC COST/BENEFIT VALUES. (See Recommendations, Amount, Duration and Scope).

B. MEDICAID AND OTHER STATE PROGRAMS SHOULD EMBRACE CASE MANAGEMENT AS A TECHNIQUE FOR ASSURING SERVICES WHICH ARE MORE RESPONSIVE TO PATIENT NEEDS AND WHICH MAKE THE BEST USE OF AVAILABLE RESOURCES.

C. THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES SHOULD RECONSIDER ITS POLICY ON THERAPEUTIC LEAVE DAYS ALLOWED FOR INTERMEDIATE CARE FACILITY RESIDENTS AND DETERMINE THE PROS AND CONS OF GRANTING GREATER FLEXIBILITY FOR RESIDENTS TO PARTICIPATE IN OFF-CAMPUS OVERNIGHT PROGRAMS ANTICIPATED TO BE OF THERAPEUTIC VALUE. A REPORT ON THIS SUBJECT SHOULD BE SUBMITTED BY THE DEPARTMENT TO THE SECRETARY OF HUMAN RESOURCES BEFORE SEPTEMBER 1988.

D. ALL STATE AGENCIES SHOULD COMPLETE, AS A MATTER OF URGENCY, THEIR CURRENT STUDY OF POLICIES AND ACTIONS TO RESPOND TO THE FUTURE IMPACT OF CARING FOR AIDS PATIENTS, PARTICULARLY THE REQUIREMENTS FOR GREATER PUBLIC EDUCATION AND THE COMMUNITY AND INSTITUTIONAL CARE TO BE NEEDED BY THESE PATIENTS.

E. STATE EFFORTS TO INCREASE PUBLIC KNOWLEDGE OF AVAILABLE SERVICES SHOULD BE EXPANDED BY DEVELOPMENT OF A PILOT PROGRAM IN AT LEAST THREE COMMUNITY SETTINGS TO EMPLOY THE CONCEPT OF LOCAL "HUMAN RESOURCE COUNSELLORS". THESE COUNSELLORS SHOULD COMPILE LISTS OF HUMAN SERVICES RESOURCES LOCALLY AVAILABLE FROM BOTH THE PUBLIC AND PRIVATE SECTORS AND TAKE ACTIONS WHICH WILL PROMOTE THIS INFORMATION REACHING POTENTIAL CLIENTS (See Recommendations, State Organization Structure).

4. OUTPATIENT versus INPATIENT

A. A REQUIREMENT FOR CERTAIN MEDICAL PROCEDURES TO BE PERFORMED ON AN OUTPATIENT BASIS SHOULD NOT BE MANDATED AS CAPABILITIES VARY BY REGION AND BY LOCALITY AND BECAUSE OF THE DIFFICULTY, AS MEDICAL SCIENCE ADVANCES, IN KEEPING A PROCEDURE LIST UP TO DATE. INSTEAD, MONETARY AND OTHER INCENTIVES SHOULD BE ADOPTED TO ENCOURAGE CONSUMER CHOICE OF LOWER-COST CARE WHEN MEDICALLY APPROPRIATE.

B. THE COMMONWEALTH SHOULD CONTINUE TO STRIVE TO ACHIEVE THE HIGHEST LEVEL OF ACCREDITATION FOR THE MEDICAL FACILITIES OF ITS TEACHING INSTITUTIONS SO THAT MORE OPPORTUNITY WILL BE AVAILABLE FOR OUTPATIENT CARE.

C. DIRECTORS OF STATE HEALTH-RELATED PROGRAMS SHOULD KEEP ABREAST OF EVOLVING STANDARDS OF CARE AND OF MODERN MEDICAL PRACTICES AND ENSURE THAT PROCEDURES FOR DETERMINING A PATIENT'S SUITABILITY FOR OUTPATIENT CARE ARE SUFFICIENTLY FLEXIBLE TO TAKE INTO ACCOUNT DIFFERENCES AMONG PATIENTS WITH RESPECT TO UNDERLYING HEALTH STATUS, COMPLICATING CONDITIONS, AVAILABILITY OF INFORMAL SUPPORT SYSTEMS, HOME ENVIRONMENT CONDITIONS, AND REMOTENESS OF HOME FROM MEDICAL CARE SOURCES.

D. ALL STATE PROGRAMS WHICH COVER INPATIENT SERVICES SHOULD:

- PROMOTE THE DEVELOPMENT OF SUBSTITUTE OR TRANSITIONAL LEVELS OF CARE;
- ESTABLISH SPECIAL REIMBURSEMENT RATES FOR OVERNIGHT STAYS BY SURGICAL PATIENTS WHO, ALTHOUGH NOT SUFFICIENTLY RECOVERED TO PERMIT SAME-DAY DISCHARGE, REQUIRE A BED AND MINIMAL OBSERVATION FOR THE FOLLOWING NIGHT;
- ENSURE THAT PRE-OPERATIVE ASSESSMENT IS INCLUDED AS AN ELEMENT OF OUTPATIENT SURGERY TO FACILITATE TRANSITION TO INDEPENDENCE AT HOME; AND
- PROVIDE THE SAME QUALITY OF DISCHARGE PLANNING FOR OUTPATIENT AND INPATIENT SURGERY.

E. IN ADDITION TO BEING RELATED TO COSTS, STATE PROGRAM REIMBURSEMENT VALUES FOR OUTPATIENT SURGERY SHOULD ALSO PROVIDE INCENTIVE TO CHOOSE AN OUTPATIENT STATUS WHEN APPROPRIATE TO THE CARE REQUIREMENT.

5. INDIGENT HEALTH CARE POOL

THE SECRETARY OF HUMAN RESOURCES, WITH THE ASSISTANCE OF THE SECRETARY OF EDUCATION, SHOULD CONDUCT A STUDY TO IDENTIFY AND DETERMINE THE FEASIBILITY OF OPTIONS TO CREATE MORE EQUITABLE DISTRIBUTION AND IMPROVED ACCOUNTABILITY OF STATE HEALTH CARE FUNDS, INCLUDING OPTIONS FOR:

- DESIGNATING A STATE AGENCY TO ESTABLISH HEALTH CARE POLICY AND COORDINATE MANAGEMENT OF ALL STATE FUNDS APPROPRIATED BY THE GENERAL ASSEMBLY FOR INDIGENT HEALTH CARE (EXCEPT FOR THOSE BEING PROVIDED TO FUND VIRGINIA'S PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS; E.G., MEDICAID) (See Recommendations, State Organization Structure and Local versus State Funding);

- TRANSFERRING ADMINISTRATIVE RESPONSIBILITY FOR THE STATE-LOCAL HOSPITALIZATION PROGRAM TO THE STATE AGENCY DESIGNATED TO COORDINATE MANAGEMENT OF INDIGENT HEALTH CARE (See Recommendations, State Organization Structure);

- REQUIRING THE SECRETARY OF EDUCATION TO HAVE THE STATE TEACHING HOSPITALS (MCV/UVA) IDENTIFY, AT A MACRO-ECONOMIC LEVEL, TEACHING EXPENSES SEPARATE FROM THEIR INDIGENT CARE COSTS;

- ESTABLISHING BY LAW A PROTOCOL TO REQUIRE LOCALITIES WHICH PARTICIPATE IN THE DEPARTMENT OF SOCIAL SERVICES' GENERAL RELIEF PROGRAM TO OBTAIN APPROVAL FROM THE LOCAL HEALTH DIRECTOR BEFORE EXPENDITURE OF PROGRAM FUNDS FOR MEDICAL MAINTENANCE AND MEDICAL EMERGENCY NEEDS OF WELFARE RECIPIENTS; AND

- IDENTIFYING ALL OTHER STATE HEALTH PROGRAMS FUNDED SOLELY BY STATE APPROPRIATIONS AND OPERATED BY OTHER AGENCIES SO THAT THESE MAY BE

CONSIDERED, WHEN FEASIBLE, FOR RE-ASSIGNMENT TO THE DESIGNATED STATE SINGLE MANAGER OF INDIGENT HEALTH CARE SERVICES.

THIS STUDY SHOULD BE COMPLETED BY DECEMBER 1988 SO THAT NECESSARY LEGISLATIVE ACTIONS CAN BE CONSIDERED BY THE 1989 GENERAL ASSEMBLY.

6. PRIVATIZATION

A. OWNERSHIP AND MANAGEMENT OF THE STATE TEACHING HOSPITALS SHOULD BE RETAINED BY THE STATE BECAUSE:

- o THE STATE HAS MADE SIZEABLE INVESTMENTS IN THESE INSTITUTIONS WHICH COULD NOT BE RECOUPED;
- o THEY PROVIDE A VALUABLE PUBLIC BENEFIT FROM THEIR RESEARCH AND EDUCATION ACTIVITY AND SERVICE TO INDIGENT PERSONS; AND
- o THERE IS APPARENTLY LITTLE MARKET DEMAND FOR ESTABLISHED PUBLIC SERVICE HOSPITALS.

B. THE HOSPITALS SHOULD BE GRANTED GREATER AUTONOMY AS WELL AS MORE FLEXIBILITY IN PERSONNEL, PROCUREMENT, AND OTHER ADMINISTRATIVE AREAS TO ENABLE THEM TO RESPOND TO THE OPPORTUNITIES AND THREATS ARISING IN THEIR COMPETITIVE HEALTH ENVIRONMENTS.

C. SPECIAL ADVISORY BOARDS SHOULD BE ESTABLISHED FOR THE MEDICAL COLLEGE OF VIRGINIA AND THE UNIVERSITY OF VIRGINIA HOSPITALS TO PROMOTE APPLICATION OF THEIR MEDICAL RESEARCH BENEFITS TO STATE HEALTH PROGRAMS AND TO INITIATE ACTIONS WHICH WILL ENCOURAGE THEIR MEDICAL STUDENTS TO PRACTICE IN THE COMMONWEALTH. THESE BOARDS, WHICH SHOULD MEET AT LEAST ONCE ANNUALLY, SHOULD INCLUDE REPRESENTATIVES OF THE OFFICES OF THE SECRETARIES OF EDUCATION, FINANCE, AND HUMAN RESOURCES (See Recommendations, State Organization Structure).

7. PRE-PAID HEALTH CARE - MEDICAID

A. THE COMMONWEALTH SHOULD NOT, AT THIS TIME, INCORPORATE THE CAPITATED INDIGENT HEALTH CARE CONCEPT INTO ITS MEDICAID PROGRAM.

B. THE SECRETARY OF HUMAN RESOURCES, WITH THE DIRECTOR OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, SHOULD CONTINUE SURVEILLANCE OF THE SUCCESSES AND FAILURES OF PRE-PAID PLANS OPERATING IN OTHER STATES AND BE ALERT FOR PROCESSES AND ACCOMPLISHMENTS THAT MAY BE CONSIDERED BY VIRGINIA TO CONTROL MEDICAID COSTS WITHOUT DETERIORATION OF SERVICE QUALITY.

8. STATE ORGANIZATION STRUCTURE

A. NO MAJOR CHANGES SHOULD BE MADE IN THE ORGANIZATION OF THE EXECUTIVE BRANCH OF STATE GOVERNMENT AS ALL INVOLVED AGENCIES NOW APPEAR TO MAINTAIN OPEN CHANNELS TO EVALUATE AND COORDINATE ACTIVITIES AIMED AT HEALTH CARE FOR THE INDIGENT.

B. THE SECRETARY OF HUMAN RESOURCES SHOULD STRENGTHEN THE NOW-INFORMAL COORDINATION PROCESS AMONG THE HEALTH SERVICES AGENCIES IN ORDER TO ASSURE MAXIMIZING GOVERNMENT RESOURCES BY:

- DESIGNATING ONE STATE AGENCY AS RESPONSIBLE FOR ESTABLISHING BASIC HEALTH POLICY AND COORDINATION OF THE MANAGEMENT OF ALL STATE FUNDS APPROPRIATED FOR INDIGENT HEALTH CARE (See Recommendations, Indigent Health Care Pool); AND

- STRENGTHENING THE INFORMATION AND REFERRAL SYSTEM AVAILABLE FOR CITIZENS AT THE LOCAL LEVEL BY THE INTRODUCTION OF HUMAN RESOURCES COUNSELLORS TO ENHANCE ACCESS TO SERVICES (See Recommendations, Community versus Institution).

C. THE SECRETARY OF EDUCATION SHOULD ESTABLISH NEW ADVISORY COUNCILS FOR EACH OF THE STATE MEDICAL SCHOOLS TO PROVIDE GUIDANCE ON ESTABLISHING LINKAGES BETWEEN THE BENEFITS ATTAINED FROM THE RESEARCH DONE AT THE STATE SCHOOLS

AND THE STATE HEALTH PROGRAMS WHICH ARE SERVING THE POOR OF THE COMMONWEALTH (See Recommendations, Privatization).

9. ALTERNATIVES TO EMERGENCY ROOM CARE

A. THE STATE TEACHING HOSPITALS SHOULD BE ENCOURAGED TO CONTINUE TO DEVELOP AND IMPLEMENT AFTER-HOURS PRIMARY CARE CLINICS.

B. THE COMMONWEALTH SHOULD ADOPT A POLICY TO PROMOTE AND TO OFFER FINANCIAL INCENTIVES FOR THE DEVELOPMENT OF PRIVATE AFTER-HOURS CLINICS IN COMMUNITIES/AREAS WHERE A NEED EXISTS FOR SUCH SERVICES TO INDIGENT PERSONS.

10. AMOUNT, DURATION, AND SCOPE

A. ADDITIONAL STATE FUNDING SHOULD BE PROVIDED FOR THE MEDICAL ASSISTANCE SERVICES PROGRAM TO ALLOW EXPANSION OF THE SCOPE OF SERVICES TO INCLUDE:

- o THE FEDERAL OPTION FOR PREGNANT WOMEN AND CHILDREN (TO YEAR 1) AT 100 PERCENT OF POVERTY INCOME, AND EXTEND THE ELIGIBILITY AGE FOR CHILDREN TO YEAR 5 IN SUBSEQUENT YEARS (See Recommendations, Reallocation of State Funds);

- o IN-HOME APNEA MONITORS FOR HIGH-RISK INFANTS; AND

- o ADULT DAY CARE FOR RECIPIENTS WHO OTHERWISE MEET THE CRITERIA FOR ADMITTANCE TO INTERMEDIATE CARE FACILITIES (See Recommendations, Community versus Institution).

B. THE MEDICAL ASSISTANCE SERVICES PROGRAM SHOULD IMPLEMENT CASE MANAGEMENT TECHNIQUES FOR THE PREGNANT WOMEN AND CHILDREN CATEGORY OF RECIPIENTS TO ENSURE THEY RECEIVE THE MOST EFFECTIVE CARE.

C. THE MEDICAL ASSISTANCE SERVICES PROGRAM SHOULD BROADEN THE COVERAGE OF EYEGLASSES BY ALLOWING REIMBURSEMENT FOR DIAGNOSIS, PROCUREMENT, AND FITTING FOR THOSE PERSONS DEMONSTRATED TO HAVE A NEED: (1) TO PRECLUDE BECOMING LEGALLY BLIND; OR (2) TO CORRECT VISUAL IMPAIRMENTS SO SEVERE THAT LOSS OF MAJOR FUNCTIONING IS THREATENED.

11. HEALTH DEPARTMENT CLINICS

A. THE HEALTH DEPARTMENT SHOULD DEVELOP A UNIFORM COST ACCOUNTING SYSTEM FOR EACH OF ITS CLINIC SERVICES TO ENABLE ACCURATE COMPARISONS TO BE MADE WITH SIMILAR SERVICES PROVIDED AMONG ITS LOCAL DEPARTMENTS AND IN ALTERNATIVE SETTINGS.

B. THE HEALTH DEPARTMENT SHOULD CONTINUE AND INTENSIFY THE MULTI-YEAR PLANNING EFFORT NOW UNDER WAY, ASSESSING THE NEED FOR PUBLIC HEALTH SERVICES IN EACH LOCAL AREA AND EVALUATING ALTERNATE MEANS FOR PROVIDING MORE COMPREHENSIVE, EFFICIENT, AND EFFECTIVE SERVICES UTILIZING ALL AVAILABLE RESOURCES--INCLUDING VOLUNTARY AGENCIES, GOVERNMENT AGENCIES, TEACHING HOSPITALS, AND PRIVATE PROVIDERS.

C. THE HEALTH DEPARTMENT SHOULD FOCUS ON TRADITIONAL PUBLIC HEALTH SERVICES AND AVOID PROVISION OF CURATIVE SERVICES WHICH DUPLICATE PRIVATE MEDICINE CAPABILITIES.

D. EACH LOCAL HEALTH DEPARTMENT SHOULD ACCEPT RESPONSIBILITY FOR ARRANGING CONTINUITY AND COORDINATION OF CARE FOR ITS INDIGENT PATIENTS, UTILIZING CASE MANAGEMENT TO ASSURE THAT COMPREHENSIVE, EFFICIENT, AND EFFECTIVE USE IS MADE OF ALL AVAILABLE GOVERNMENT PROGRAM AND COMMUNITY RESOURCES WHEN MEDICAL CARE IS NECESSARY.

12. TRANSPORTATION

A. LOCAL TRANSPORTATION MODES SHOULD BE EXPANDED TO PROVIDE MORE EFFICIENT, AFFORDABLE, COST-EFFECTIVE AND CONVENIENT SYSTEMS FOR THE MEDICALLY INDIGENT THROUGHOUT THE COMMONWEALTH.

B. A PLAN TO EXPAND LOCAL TRANSPORTATION SHOULD BE DEVELOPED BY THE VIRGINIA DEPARTMENT OF TRANSPORTATION HUMAN SERVICES COORDINATOR AND HIS/HER ADVISORY COUNCIL INCORPORATING THE FOLLOWING PRINCIPLES:

- COORDINATION OF SERVICES AT THE LOCAL LEVEL, UTLIZING BOTH STATE AND COMMUNITY-FUNDED SERVICES;

- o INTEGRATION, WHEREVER POSSIBLE, OF MEDICAL SERVICES TRANSPORTATION AS A PART OF A BROADER PUBLIC TRANSPORTATION SYSTEM THAT SERVES MANY NEEDS;

- o AVAILABILITY OF EMERGENCY AND OTHER EXTRAORDINARY MEDICAL TRANSPORTATION MODES (E.G., HELICOPTER, VAN SERVICE) THROUGHOUT THE COMMONWEALTH; AND

- o SPECIAL ATTENTION TO THE NEEDS OF ISOLATED RURAL COMMUNITIES.

13. TRANSPLANTATION

THE ORGAN TRANSPLANTATION ISSUE SHOULD BE KEPT UNDER ACTIVE SURVEILLANCE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND OPTIONS TO EXPAND MEDICAID COVERAGE SHOULD BE ADOPTED WHENEVER ETHICALLY APPROPRIATE AND WHEN FINANCIAL RESOURCES, INCLUDING FEDERAL DOLLARS, WILL PERMIT.

14. REALLOCATION OF STATE FUNDS

A. A STATE SURVEY SHOULD BE CONDUCTED AS SOON AS POSSIBLE TO ACQUIRE A HEALTH CARE DATA BASE FROM WHICH THE HEALTH CARE NEEDS OF VIRGINIA'S INDIGENT POPULATION CAN BE MORE ACCURATELY EVALUATED AND COSTS CAN BE DEVELOPED FOR ALTERNATE ACTIONS TO SATISFY UNMET NEEDS.

B. THE VIRGINIA MEDICAID PROGRAM SHOULD INCORPORATE THE 1986 FEDERAL OPTION FOR PREGNANT WOMEN AND CHILDREN WITH ELIGIBILITY UP TO THE FEDERAL POVERTY INCOME LEVEL. THE FUNDS NOW APPROPRIATED TO THE TWO STATE-SUPPORTED PUBLIC HOSPITALS AND TO STATE AGENCIES TO PROVIDE SIMILAR SERVICES TO THIS POPULATION CATEGORY SHOULD BE REALLOCATED TO MEDICAID.

C. THE VIRGINIA MEDICAID PROGRAM SHOULD UNDERTAKE A COST/BENEFIT ANALYSIS ON THE "209(b)" FEDERAL OPTION TO DETERMINE IF THE CURRENT RESTRICTIVE ELIGIBILITY INCOME CRITERIA FOR THE AGED, BLIND AND DISABLED, WHICH PREVENT MANY SUPPLEMENTARY SECURITY INCOME (SSI) RECIPIENTS FROM RECEIVING MEDICAID COVERED SERVICES, SHOULD BE AMENDED.

D. THE VIRGINIA MEDICAID PROGRAM SHOULD BE PROVIDED ADDITIONAL FUNDS TO INCREASE THE RATE OF REIMBURSEMENT TO PHYSICIANS, THEREBY IMPROVING RECIPIENTS' ACCESS TO PREVENTIVE SERVICES AND LOWER-COST PRIMARY CARE SERVICES.

15. LOCAL versus STATE FUNDING

A. ALL LOCAL GOVERNMENTS SHOULD BE REQUIRED TO PARTICIPATE IN THE STATE PUBLIC HEALTH, GENERAL RELIEF, AND SLH PROGRAMS, EXCEPT WHEN UNUSUAL LOCAL ECONOMIC CONDITIONS TEMPORARILY PRECLUDE PARTICIPATION.

B. THE TOTAL DOLLARS IN LOCAL HEALTH DEPARTMENTS' BUDGETS SHOULD CONTINUE TO BE BASED ON A PLAN DEVELOPED TO MEET THE NEEDS OF THE LOCALITY, AND THE REQUIRED LOCAL FUNDING SHOULD CONTINUE TO BE DETERMINED ACCORDING TO THE HEALTH DEPARTMENT FORMULA ON ABILITY TO PAY, PENDING FINAL CONSIDERATION OF THE JLARC RECOMMENDATIONS.

C. ONE STATE AGENCY SHOULD BE DESIGNATED TO DETERMINE ELIGIBILITY FOR ALL PROGRAMS WHICH PROVIDE SERVICES AT LOCAL LEVELS, AND ALL LOCAL GOVERNMENTS SHOULD ADHERE TO STATE ELIGIBILITY CRITERIA UNLESS ONLY LOCAL GOVERNMENT FUNDING IS USED IN PAYMENT FOR SERVICES.

16. CHARITY CARE - MANDATORY

A. THE SECRETARY OF HUMAN RESOURCES SHOULD REVIEW CAREFULLY THE REPORT OF THE GOVERNOR'S COMMISSION ON THE MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED PROGRAM. THE SECRETARY SHOULD ENSURE THAT NONE OF THE RECOMMENDATIONS OF THAT COMMISSION HAMPER THE ABILITY OF INDIGENT PERSONS TO OBTAIN HEALTH CARE OR FOSTER GREATER INEQUALITY AMONG HEALTH CARE PROVIDERS REGARDING UNCOMPENSATED CARE. THE SECRETARY SHOULD DEVELOP PROPOSALS ON INCREASING ACCESSIBILITY TO CARE FOR INDIGENT PERSONS AND SUBMIT THESE FOR CONSIDERATION BY THE GENERAL ASSEMBLY WHILE THE RECOMMENDATIONS OF THE COPN COMMISSION ARE UNDER REVIEW BY THE GOVERNOR AND THE GENERAL ASSEMBLY.

B. THE SECRETARY OF HUMAN RESOURCES AND THE STATE CORPORATION COMMISSION'S BUREAU OF INSURANCE SHOULD DEVELOP A LONG-RANGE ADMINISTRATIVE AND

FINANCIAL PLAN TO FUND HEALTH CARE NEEDS (PARTICULARLY FOR LONG-TERM CARE) FOR UNINSURED AND UNDERINSURED PERSONS. THE PLAN SHOULD SEEK TO OBTAIN MORE BALANCE AMONG HOSPITALS ACROSS THE STATE IN SHOULDERING THE UNCOMPENSATED CARE BURDEN. THE PLAN SHOULD ALSO CONSIDER ADOPTING OTHER STATES' SUCCESSFUL ACTIONS, SUCH AS ESTABLISHING RISK POOLS OR TAX INCENTIVES, IN ORDER TO RECOGNIZE REQUIREMENTS OF ALL VIRGINIA CITIZENS FOR ACCESS TO ADEQUATE HEALTH CARE. MANDATORY INSURANCE COVERAGE FOR ALL EMPLOYEES, ALTHOUGH NOT RECOMMENDED AT THIS TIME BY THIS TASK FORCE, SHOULD BE RE-EVALUATED FOR INCLUSION IN THIS PLAN. THIS LONG-RANGE PLAN SHOULD BE COMPLETED IN TIME TO BE PRESENTED IN THE 1988-1990 BIENNIUM.

17. CLIENT ELIGIBILITY

A. THE SECRETARY OF HUMAN RESOURCES SHOULD REVIEW THE VISUALLY HANDICAPPED, VOCATIONAL REHABILITATION, STATE-LOCAL HOSPITALIZATION, GENERAL RELIEF, INDEPENDENT LIVING CENTER SERVICES, AND OTHER PROGRAMS INVOLVED IN PROVIDING HEALTH-RELATED SERVICES TO CLIENTS, TO REVISE THEIR ELIGIBILITY CRITERIA WHEN POSSIBLE SO AS TO BE MORE CONSISTENT WITH THE PROCESSES NOW USED BY UVA, MCV, AND THE DEPARTMENT OF HEALTH.

B. THE SECRETARIES OF HUMAN RESOURCES AND EDUCATION SHOULD REQUIRE THAT UVA, MCV, AND THE DEPARTMENT OF HEALTH MEET AND DEVELOP COMMON STANDARDS FOR INTERPRETING THE VALUE OF CLIENT ASSETS, CATASTROPHIC HEALTH COSTS, SPEND-DOWN, GEOGRAPHIC REGION VARIATIONS, AND OTHER COMPONENTS OF FAMILY INCOME ASSESSMENTS ASSOCIATED WITH ELIGIBILITY DETERMINATION.

C. A UNIFORM CLIENT DATA BASE SHOULD BE ESTABLISHED BY THE COMMONWEALTH FOR ACCESS BY ALL HEALTH PROGRAMS TO REDUCE REPETITIVE COLLECTION FROM CITIZENS OF IDENTICAL ELIGIBILITY INFORMATION.

D. ELIGIBILITY STAFF SHOULD BE PROVIDED FOR STATE INSTITUTIONS AND OTHER HIGH-VOLUME PROVIDERS TO ACCEPT, PROCESS, AND EXPEDITE ELIGIBILITY APPLICATIONS FOR MEDICAID AND OTHER STATE PROGRAMS.

E. ALL COMMONWEALTH HEALTH SERVICES PROGRAMS SHOULD AGREE TO UTILIZE THE FEDERAL POVERTY LEVEL AS THE BASIS FOR DETERMINING ELIGIBILITY TO RECEIVE

FREE SERVICES AND SHOULD THEN TAKE PROGRESSIVE ACTIONS TOWARD THE IMPLEMENTATION OF THAT STANDARD AS ADDITIONAL FUNDING, IF REQUIRED, IS OBTAINED.

18. RECIPIENT CO-PAYMENTS

A. A POLICY ENDORSING THE USE OF CO-PAYMENTS IN ALL HEALTH CARE SERVICE PROGRAMS SHOULD BE ISSUED BY THE SECRETARY OF HUMAN RESOURCES TO:

1. ENCOURAGE APPROPRIATE UTILIZATION OF SERVICES, INCLUDING PREVENTIVE HEALTH SERVICES;

2. PROMOTE MAXIMIZATION OF FEDERAL PARTICIPATION IN INDIGENT HEALTH CARE EXPENSES; AND

3. ENCOURAGE INDIVIDUAL RESPONSIBILITY.

EACH PROGRAM'S PROCEDURES ON CO-PAYMENT APPLICATION SHOULD BE TAILORED ACCORDING TO ITS SPECIAL NEEDS AND CIRCUMSTANCES.

B. STATE ORGANIZATIONS, INCLUDING STATE TEACHING HOSPITALS, SHOULD CONTINUE TO EXERCISE DILIGENCE IN:

1. COLLECTING CO-PAYMENTS WHICH ARE DUE FROM PATIENTS; AND

2. PROVIDING ACTIVE ASSISTANCE TO PATIENTS IN PROCESSING CLAIMS UNDER ANY THIRD-PARTY INSURANCE COVERAGE SO THAT APPROPRIATE REIMBURSEMENTS MAY BE OBTAINED.

19. PAYMENT RESPONSIBILITY

A. ALL STATE POLICIES AND PROCEDURES SHOULD BE AIMED AT ENCOURAGING ACCEPTANCE OF FAMILY RESPONSIBILITY FOR THE COST OF MEDICAL CARE.

B. THE MEDICAID AND OTHER STATE PROGRAMS WHICH PROVIDE MEDICAL CARE SHOULD, IN REGARD TO RESPONSIBILITIES OF PARENTS FOR THEIR CHILDREN:

- o STRENGTHEN THE PROCESSES USED FOR HOUSEHOLDS WITH MINOR CHILDREN AND ONLY ONE NATURAL PARENT IN OBTAINING THE OTHER NATURAL PARENT'S FINANCIAL ASSISTANCE ON MEDICAL CARE COSTS AND OTHER CHILD SUPPORT REQUIREMENTS; AND

- o TAKE AGGRESSIVE ACTIONS TO ENSURE CHILD SUPPORT ENFORCEMENT, INCLUDING MEDICAL SUPPORT, IN HOUSEHOLD SITUATIONS INVOLVING AN ABSENT PARENT.

C. THE DEPARTMENTS OF SOCIAL SERVICES, MEDICAL ASSISTANCE SERVICES AND AGING SHOULD REVIEW THE CURRENT MEDICAID POLICIES ON FAMILY RESPONSIBILITY FOR AN INSTITUTIONALIZED MEMBER AND SEEK WAYS TO MODIFY THESE POLICIES TOWARD:

- o LENGTHENING THE CURRENT TIME PERIOD WHICH RESTRICTS TRANSFER OF ASSETS AT LESS THAN MARKET VALUE; AND

- o PROVIDING FOR A MORE ADEQUATE FINANCIAL MAINTENANCE ALLOWANCE FOR REMAINING AT-HOME SPOUSES WHEN THE HUSBAND OR WIFE IS COMMITTED TO LONG-TERM CARE.

D. THE VIRGINIA GENERAL ASSEMBLY SHOULD MEMORIALIZE THE U.S. CONGRESS TO CONSIDER IN ITS FUTURE ENACTMENT OR AMENDMENT OF HUMAN SERVICES PROGRAMS THE NEED OF PROVISIONS WHICH WILL SERVE TO STRENGTHEN FAMILY UNITS AND TO ENCOURAGE PERSONS TO MAINTAIN RESPONSIBILITY FOR THEIR FAMILY MEMBERS AND THE UNDESIRABILITY OF POLICIES AND PROCEDURES WHICH LEAD TOWARD FAMILY UNIT DISINTEGRATION.

20. INSURANCE - VOLUNTARY/MANDATORY

A. THE COMMONWEALTH SHOULD SEEK MEANS, OTHER THAN MANDATING EMPLOYERS TO PROVIDE WORKER HEALTH CARE INSURANCE, TO MAKE COVERAGE MORE ACCESSIBLE FOR SMALL BUSINESSES AND HIGH-RISK INDIVIDUALS.

B. THE SECRETARY OF HUMAN RESOURCES SHOULD COMPLETE A FORMAL STUDY TO EVALUATE ACHIEVEMENTS AND COSTS IN THE STATES WHICH HAVE INITIATED STATE HEALTH INSURANCE RISK POOLS AND MAKE RECOMMENDATIONS ON THIS SUBJECT TO THE

GOVERNOR AND TO THE GENERAL ASSEMBLY FOR CONSIDERATION DURING THE 1989 LEGISLATIVE SESSION.

C. THE SCC'S BUREAU OF INSURANCE SHOULD BE REQUIRED TO DEVELOP, IN COORDINATION WITH THE DEPARTMENT OF TAXATION, PROPOSALS TO CREATE:

- AN INCENTIVE THROUGH TAX CREDITS FOR ALL EMPLOYERS TO PROVIDE A MINIMUM LEVEL OF HEALTH CARE INSURANCE, INCLUDING COVERAGE OF CATASTROPHIC ILLNESS, FOR THEIR TEMPORARY AND PERMANENT EMPLOYEES; AND

- A STATE OPERATED RISK POOL TO ALLOW PERSONS TO PURCHASE HEALTH INSURANCE EVEN THOUGH THEY WERE PREVIOUSLY DENIED COVERAGE BECAUSE OF PHYSICAL CONDITION OR MEDICAL HISTORY.

THESE PROPOSALS SHOULD BE PRESENTED TO THE GENERAL ASSEMBLY FOR CONSIDERATION AT ITS 1989 SESSION.

D. THE VIRGINIA CONGRESSIONAL DELEGATION SHOULD BE MADE AWARE OF VIRGINIA'S CONCERN OVER THIS PROBLEM AND BE ENCOURAGED TO INTRODUCE AND/OR SUPPORT: 1) FEDERAL LEGISLATION WHICH WOULD PROVIDE CREDITS ON FEDERAL TAXES FOR BUSINESSES WHICH PROVIDE EMPLOYEE HEALTH INSURANCE; AND 2) FEDERAL LEGISLATION TO EASE THE ERISA RESTRICTIONS ON STATE AUTHORITY TO REACT TO THIS ISSUE.

E. THE LIMITS ON TORT CLAIM STATUTORY LIENS NOW IMPOSED BY STATE LAW ON ALL HEALTH CARE PROVIDERS SHOULD BE ELIMINATED BY THE GENERAL ASSEMBLY TO REDUCE COST SHIFTING.

21. PRE-EXISTING INSURANCE EXCLUSION FOR PREGNANCY

THE COMMONWEALTH SHOULD NOT PROHIBIT INCLUSION OF PRE-EXISTING CLAUSES ON PREGNANCY WITHIN HEALTH INSURANCE POLICIES. IT SHOULD INSTEAD SEEK OTHER MEANS, SUCH AS EXPANDING MEDICAID PROGRAM ELIGIBILITY/SERVICES AND PROVIDING FINANCIAL INCENTIVES TO EMPLOYERS, TO ADD EMPLOYMENT HEALTH INSURANCE BENEFITS THAT WILL ASSIST LOW INCOME FAMILIES IN PAYING FOR PRENATAL CARE AND DELIVERY.

SP1865114

1986 SESSION
ENGROSSED

SENATE JOINT RESOLUTION NO. 32

Senate Amendments in [ ] - February 12, 1986

Establishing the Governor's Task Force on Indigent Health Care.

Patron--Emick

Referred to Committee on Rules

WHEREAS, many Virginians are unable to afford necessary medical care due to varied employment and economic reasons, or because they are uninsured, underinsured or are ineligible for certain public social and health programs, such as Medicaid; and

WHEREAS, State and federal cut backs in programs, spiraling health care costs,and the increasing financial difficulties of hospitals providing uncompensated care to large indigent populations have necessitated the reassessment of indigent health care policies; and

WHEREAS, providing and financing health care for indigent Virginians continues to be of great concern to the Commonwealth; and

WHEREAS, the Joint Subcommittee Studying Alternatives for a Long-Term Indigent Health Care Policy, during the interim of the 1985 Session of the General Assembly, studied the question of how best to provide and finance delivery of necessary health care for indigent Virginians, resolving that the problem was multi-faceted and required further investigation; and

WHEREAS, to fully address all aspects of the indigent health care issue, to identify problems specific to Virginia, and to recommend appropriate actions to resolve the problems, the Joint Subcommittee recommended the establishment of a Governor's Task Force for this purpose; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Honorable Gerald L. Baliles, Governor of Virginia, is hereby requested to establish a Task Force on Indigent Health Care to study all aspects of the indigent health care issue, [including the feasibility of establishing a special indigent health care program to fund necessary medical care of indigent mothers and children,] identify problems specific to the Commonwealth, and recommend appropriate actions to resolve these problems.

The Task Force shall consist of the following members: the Secretary of Human Resources, the Secretary of Education, [the Director of the State Council of Higher Education,] the Commissioner of Health, the Director of the Department of Medical Assistance Services, the Director of the Health Services Cost Review Council, one member each of the Senate Committees on Education and Health and on Finance, and the House Committees on Health, Welfare and Institutions and on Appropriations, one representative each of the insurance community, the Virginia Hospital Association, the Medical Society of Virginia, the State Chamber of Commerce, and three executives to represent large and small private employers in the Commonwealth.

All reports recommended by the Joint Subcommittee Studying Alternatives for a Long-Term Indigent Health Care Policy in its 1986 report to the Governor and the General Assembly shall be submitted to the Task Force; and be it

RESOLVED FURTHER, That all agencies of the Commonwealth shall provide assistance upon request and in the manner deemed appropriate by the Task Force.

The Task Force shall complete its work in time to submit its findings, recommendations and policy proposals to the Governor and the General Assembly by December 1, 1986.

LD7366506

SENATE JOINT RESOLUTION NO. 151

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Rules on February 23, 1987)

(Patron Prior to Substitute–Senator Emick)

Requesting a continuation of the Governor's Task Force on Indigent Health Care.

WHEREAS, the 1986 Session of the General Assembly established the Governor's Task Force on Indigent Health Care to study the access, availability and cost of the delivery of health care services to the medically indigent, and other issues regarding the Commonwealth's policy for such services; and

WHEREAS, as designated the Task Force membership includes representatives of the Executive and Legislative branches of Virginia government as well as appointments from the private sector; and

WHEREAS, the Task Force met during 1986 for presentations and discussions of the full scope of its mission and the requirements inherent in fulfilling its charge resulting in the generation of an interim report describing the Commonwealth's current indigent health care program; and

WHEREAS, the federal government is increasingly unable or unwilling to assume its fair share of the burden of providing adequate medical care for the indigent, and the Commonwealth has limited financial resources available to address the health care needs of its indigent citizens; and

WHEREAS, indigent health care remains a critical issue facing the Commonwealth; and

WHEREAS, it is alleged that there is unequal access to health care services for indigents among the different areas of Virginia; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Honorable Gerald L. Baliles is requested to continue his Task Force on Indigent Health Care, including in its deliberations a concentration on efforts to maximize the utilization of available resources in the provision of current health care services to the indigent. The Secretary of Human Resources should provide appropriate staffing from the agencies under the aegis of that office.

The composition of the Task Force should continue with the addition of one representative of the Coalition for the Aging and vacancies should be filled in the manner in which the original appointments were made.

The Task Force should submit its findings and recommendations to the Governor and the General Assembly by December 1, 1987.

Official Use By Clerks	
Agreed to By The Senate	**Agreed to By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

STUDY PROCESS

Organization

As requested by the Virginia General Assembly in 1986, the Governor appointed members to a Task Force on Indigent Health Care. This Task Force was comprised of representatives of the legislative and the executive branches of State government, representatives of health-related associations, and distinguished private citizens. A total of seventeen persons were initially chosen to serve; an additional member was added in 1987. The members of the Governor's Task Force are shown in Appendix D.

Subcommittees were organized under the Task Force to investigate the background and current conditions affecting issues and to draft recommendations for actions. These subcommittees and their missions were:

> Finance Subcommittee - to thoroughly examine alternative financing methods to: a) control the State's cost of providing indigent health care; b) maximize the acquisition of available federal dollars without compromising access to, or the provision of, services; and c) identify alternative private/public sector financing mechanisms to meet indigent health care needs.
>
> Policy, Recipients and Service Delivery Subcommittees - jointly and individually to examine services, delivery systems and eligibility criteria to determine how the Commonwealth can provide the most cost-effective health care services to the maximum number of indigent citizens through, but not limited to, existing resources, either as currently structured or modified to achieve objectives.

A list of the Members of the subcommittees to the Governor's Task Force on Indigent Health Care is attached, Appendix E.

An Academic Consortium was formed to conduct the research aspects of the Task Force's study. Virginia Polytechnic Institute and State University (VPI and SU) was selected to serve as leader. VPI-SU's Institute for Public Management was identified as the basic responsible organization, with Dr. Richard E. Zody and Dr. John Dickey serving as Director and Co-Director. Staff expertise from Virginia's State and private universities and colleges was invited and acquired. Members of the Consortium are shown in Appendix F.

In order to provide the basis for an orientation for the Task Force and a means of channelling specific information on State programs which offer health-related services to Virginia's indigent population, a Study Group was formed. The Study Group was comprised principally of persons from the State government organizations involved in rendering services to the poor, augmented by representatives from the AFL-CIO Appalachian Council and the Eastern Virginia Medical Authority. A listing of the Indigent Health Care Study Group is attached as Appendix G.

The entire Indigent Health Care study effort was under the direction of the Secretary of Human Resources, the Honorable Eva S. Teig, with the assistance of the Director of Medical Assistance Services, Mr. Ray T. Sorrell. Staff assistance was provided by Mr. Herbert W. Oglesby and Ms. Leslie M. Darby, and by volunteers from different organizations as shown in Appendix H.

Process

After the Indigent Health Care Task Force and its subcommittees were formed and organized in late July 1986, the study process began. A work plan, created by the Indigent Health Care Study Group with the assistance of the Higher Education Consortium, was reviewed, amended and accepted. The Honorable Gerald L. Baliles, Governor of Virginia, addressed the Task Force at its September 1986 meeting and emphasized the importance of the study to the Commonwealth.

The Study Group and the Higher Education Consortium being formed, the research phase of the study began with preparation of the draft issue subjects for Task Force consideration, creation of State agency networks for collection of basic data on State programs and services, and development of plans for field surveys of the Virginia population to obtain information on all relevant features of the health care system in Virginia. Members of the Study Group provided support throughout the study process, acting as agency liaison and feeding material and data appropriate to subjects to the Subcommittees. An indigent population survey, proposed by the Consortium, was subsequently deferred due to lack of available funding. The Consortium leader from VPI and SU made valuable personal contributions during the work of the Task Force and the Subcommittees in regard to instruction on policy analysis techniques and general procedures.

The Governor's Task Force considered the ten general subjects identified in House Document No. 29 and compiled a list of twenty-three issue subjects as the current most critical areas for evaluation, consistent with the objectives contained in its legislative directives. For each subject, specific questions were appended to direct the inquiry and subsequently focus the recommendations. During the course of the study, the number of issues was reduced to twenty-one as the result of a consolidation of similar or related problems and their proposed solutions.

An Interim Report was prepared and submitted by the Task Force to the Governor and to the General Assembly in December 1986. This report defined the Commonwealth's indigent health care organizational structure, summarized the national perspective in regard to indigent health care, and detailed the funding, services and eligibility criteria for each of the State agency programs which provide health care for low-income persons. The Interim Report and more than thirty other documents were provided for subcommittee review and use as reference material.

The Task Force's subcommittees were convened on twenty-four different occasions to complete their work. Using a uniform process for policy issue analysis, each Subcommittee reviewed applicable reference material, called on testimony from agencies and private interest groups, debated courses of action

and developed a draft for the Task Force to report background, current status, options and recommendations on each assigned issue.

The Governor's Task Force developed "Value Statements" to express publicly its criteria for the subsequent judgments to be made on Subcommittee recommendations. As Subcommittee recommendations were reviewed by the Task Force, comparisons were made against these value standards to ensure consistency in policy approach.

The Task Force held a public hearing on the Subcommittees' reports and also submitted their reports to interested State agencies for comment.

HEALTH CARE FINANCING SUBCOMMITTEE

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Peter C. Clendenin
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HIGHER EDUCATION CONSORTIUM

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Dr. Bruce Herrick
Washington and Lee University

Dr. Shen-Yung Li
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Dr. Moses Newsome
Norfolk State University

Dr. Robert H. Nicholson
University of Richmond

Dr. Dennis Poole
Virginia Commonwealth University

Dr. Lindsay L. Rettie
Old Dominion University

Dr. Leonard G. Schifrin
The College of William and Mary

Dr. Richard E. Zody, Consortium Director
Virginia Polytechnic Institute and State University

CONSORTIUM RESEARCH INVESTIGATORS

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Dr. Judy Bradford
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Dr. Judy Collins
Virginia Commonwealth University

Dr. John Dickey, (Consortium Co-Director for Technology)
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Dr. Patricia K. Edwards
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Dr. Julie Honnold
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Dr. Daniel M. Johnson
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Virginia Commonwealth University

STUDY GROUP

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Professor of Urban Affairs and
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Appendix H

OTHER STAFF AND VOLUNTEERS

Other Staff

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Georgia R. Short
Office of the Secretary of Human Resources

Volunteers

Phyllis Ellenbogen

Beth Hayes

Bryan K. Lacy, Esquire

J. John McMahon

Geraldine Pendlebury

Sue Rowland

Ruth Ann Wall