REPORT OF THE
JOINT SUBCOMMITTEE ON

Financing Maternal and Child Health Care

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

Senate Document No. 15

COMMONWEALTH OF VIRGINIA
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Report of the
Joint Subcommittee on Financing
Maternal and Child Health
to
The Governor and the General Assembly of Virginia
Richmond, Virginia
December, 1987

TO: Honorable Gerald L. Baliles, Governor of Virginia,
and
The General Assembly of Virginia

AUTHORITY FOR STUDY

During the 1987 Session of the General Assembly, Senator Clarence A. Holland was the chief patron of Senate Joint Resolution No. 172 (Appendix A). The resolution created an eight-member joint subcommittee to assess the extent of the problem of uncompensated prenatal care and delivery services and to develop statewide solutions. The joint subcommittee was requested to complete its work prior to the 1988 General Assembly.

The membership of the joint subcommittee was appointed as follows: The Senate Privileges and Elections Committee appointed Senators Clive L. DuVal and William A. Truban from the Senate Finance Committee and Senator Clarence A. Holland from the Senate at large; and, the Speaker of the House appointed Delegates Robert S. Bloxum, Frederick H. Creekmore, George H. Heilig, Jr., and A. Victor Thomas from the House Appropriations Committee and Delegate Joan H. Munford from the House of Delegates at large.

ACTIVITIES OF THE JOINT SUBCOMMITTEE

The joint subcommittee was created to determine what steps could be taken to improve the financing of maternal and child health care services in Virginia. In particular, the joint subcommittee was directed to review certain new options available under Medicaid to expand coverage for services to lower income, pregnant women and their children.

The joint subcommittee held its organizational meeting in Richmond on June 29, 1987. Senator Clarence A. Holland was elected Chairman and Delegate Joan H. Munford was elected Vice Chairman. Dick Hickman and Jane Kusiak presented a background report on the problem of uncompensated prenatal and delivery care. This report is included as Appendix B.

The joint subcommittee held its second meeting in Virginia Beach on July 27. Presentations were made at that meeting by the Commissioner of Health, Dr. C.M.G. Buttery, local health department directors from Eastern Virginia, the Medical College of Hampton Roads, and the Virginia Medical Society. Mary Devine of the Division of Legislative Services summarized the activities of the joint subcommittee on tort reform.

The third meeting was held in Lynchburg on September 21. At that time Maston T. Jacks, Deputy Secretary of Human Resources, presented the results of a secretarial task force which analyzed the costs of expanding Medicaid for prenatal and delivery care. This report, as amended, is included as Appendix C. Stephen Pace, a consultant to the Virginia Hospital Association, also presented his report on the extent of uncompensated deliveries in selected hospitals. The text of this report is included as Appendix D.

Other speakers included represenatives of local health departments in Western Virginia, the Medical College of Virginia Hospital, the University of Virginia Hospital, local area hospitals in Lynchburg and Roanoke, the Perinatal Services Advisory Board, and the Virginia Primary Care Association.

The final meeting of the joint subcommittee was held in Richmond on November 9. At that time staff presented a draft report which was amended and adopted, as follows:

FINDINGS AND RECOMMENDATIONS

The joint subcommittee recommends that the Commonwealth expand Medicaid coverage for lower income pregnant women and their children. Evidence has been presented to suggest such coverage would, in the long run, reduce medical expenses related to low birth weight deliveries. In particular, expanded coverage for prenatal and delivery services could reduce expenses for specialized neonatal intensive care, special education and other life long support services for low birth weight infants.

Virginia has the option of expanding Medicaid eligibility to cover pregnant women and children with family income up to the federal poverty level. This option was approved as part of the 1986 Omnibus Budget Reconciliation Act, in October, 1986. A report to the joint subcommittee by the Virginia Hospital Association suggests that such coverage might offset as much as 20 percent of the current burden of uncompensated delivery care now placed on hospitals by women who have neither public nor private insurance coverage.

At the same time, the joint subcommittee recognizes that simply expanding Medicaid coverage for prenatal and delivery services will not by itself reduce the number of low birth weight infants and the infant mortality rate.

In order to improve pregnancy outcomes we must recognize that our greatest problem is the persistence of a high-risk target group of young women who are not as likely to use available services in the absence of outreach and support.

In order to help this target group we must encourage improved prenatal health through a comprehensive effort to identify barriers to services, develop outreach programs to overcome these barriers, and evaluate their effectiveness in improving access to prenatal care. Such a comprehensive effort should include expanded case management and support services. Evidence from various local health departments indicates that such efforts can have a substantial impact on reducing infant mortality and morbidity.

The joint subcommittee recognizes the need for increased reimbursement for obstetricians who deliver infants of Medicaid patients. Recognition must also be given to the need to strengthen the capacity of our local health departments to prevent unwanted pregnancies and to provide necessary outreach and prenatal care services for the indigent.

Action Steps to Improve the Medicaid Program

The joint subcommittee therefore urges the Governor, in preparing his budget recommendations for the 1988-90 biennium, to set aside General Funds for the following purposes:

1. Expand Medicaid eligibility to cover pregnant women and children up to age one whose family income falls below the federal poverty level ($11.1 million GF).

2. Expand Medicaid services to include prenatal care for pregnant women whose family income falls below the federal poverty level ($1.7 million GF);

3. Expand Medicaid services to include targeted case management ($3.7 million GF);

4. Expand outreach efforts through the Departments of Health and Medical Assistance Services to increase the likelihood that increased public expenditures will have the desired outcome ($494,000 GF); and,

5. Increase Medicaid reimbursement rates for obstetricians from the 25th to the 35th percentile to assure access to care by increasing the number of obstetricians participating in the Medicaid program ($3.4 million GF).

The total cost to the General Fund of this series of options is estimated at $20.3 million for the 1988-90 biennium. This takes into account all of the available offsets of current General Fund expenditures which could be transferred to Medicaid to take full

advantage of federal matching funds. In particular, the two state teaching hospitals have provided estimates of indigent care funds which could be transferred to Medicaid. A detailed analysis of the cost of each option is included as Appendix C.

Action Steps to Prevent Illegitimate Pregnancies

The joint subcommittee recognizes that Virginia's number of low birth weight infants does not occur in a vacuum, apart from other social and economic factors. While the physical health of young Virginians is very good overall, there is increasing concern for a "new morbidity" of health concerns which were not so prominent just a generation ago.

These new concerns are interrelated. They include teenage and out-of-wedlock pregnancies, drug and alcohol abuse, dropping out of school, violence, suicide, depression and other mental health problems. Each of these concerns can be identified with a similar high risk, lower income group. While these concerns are not limited to non-whites, the incidence and severity of these concerns are of particular concern to the black community.

The likelihood of creating stable, self-sufficient, two-parent families under these circumstances is very low. Young, lower-income women are at particular risk today of becoming pregnant out-of-wedlock, experiencing a poor outcome of their pregnancy, dropping out of school and becoming dependent upon public assistance. Young men from similar backgrounds are also less likely to succeed in school and obtain regular, steady employment. They are more likely to become involved in drug and alcohol trafficking and abuse as well as violent crime.

All of these factors underscore the very high correlation between teenage and out-of-wedlock pregnancies and infant mortality and morbidity. Virginia pays a high price for the poor outcomes of pregnancies -- a price which is all the more unacceptable because it is avoidable.

The joint subcommittee hesitates to set forth a single broad recommendation to address the problems of teenage and out-of-wedlock pregnancies, because there is certainly no single, easy solution. Even the action steps we recommend to improve pregnancy outcomes among the high risk group will be insufficient if they do not encourage responsible behavior.

The joint subcommittee does, however, wish to set forth the point of view that the present and future health and well-being of Virginia's children depend upon the ability and the willingness of the Commonwealth and its public and private institutions to encourage responsible behavior with respect to the fundamental roles of creating and supporting families.

The joint subcommittee recognizes that this is a longer term problem that will require increased emphasis on prevention. For the next biennium, however, the joint subcommittee believes that certain program enhancements in the area of prevention can have a beneficial impact. For this reason, the joint subcommittee affirms its support for the following budget addendum requests submitted by the Department of Health:

6. Increase support for voluntary sterilization services to adults through local health departments.

7. Increase support for family planning services through local health departments, as authorized under existing Virginia law.

8. Increase support for conversion of part-time to full-time positions in local health departments, in order to reduce staff turnover and reduce waiting times for prenatal care and family planning services.

The joint subcommittee does not attach a General Fund cost to each of these last three items because the actual figures may be adjusted prior to submission of the Governor's budget recommendations for 1988-90.

CONCLUSION

The joint subcommittee believes these action steps will have the intended effect of reducing Virginia's rate of infant mortality and other problems associated with poor pregnancy outcomes. These actions will also help to reduce the number of teenage and out-of-wedlock pregnancies. The expenditure of public funds to accomplish these objectives is a sound investment in Virginia's future.

The joint subcommittee wishes to express its sincere appreciation to all of the officials and representatives of various agencies, institutions and associations who generously contributed their time and effort to this study.

Respectfully submitted,

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APPENDICES

SENATE JOINT RESOLUTION NO. 172

Creating a joint subcommittee to study the feasibility of financing maternal and child health care.

Agreed to by the Senate, February 27, 1987
Agreed to by the House of Delegates, February 25, 1987

WHEREAS, Virginia's infant mortality rate in 1986 declined slightly to 11.8 per 1,000 births, but still remains higher than the rate in 38 other states; and

WHEREAS, since 1982 the General Assembly has assigned a high priority within the State Health Department to programs which improve pregnancy outcomes; and

WHEREAS, since 1982 the General Assembly has directed the State Health Commissioner to assure that adequate prenatal care services are available to low-income pregnant women; and

WHEREAS, the State Health Commissioner has estimated that approximately 7,000 pregnant women in Virginia in 1985 below 167 percent of the federal poverty level were not covered by Medicaid or private health insurance; and

WHEREAS, the November 1985 report of the Virginia Hospital Association documented that twenty-two percent of all hospital admissions for uncompensated care were related to obstetrical care; and

WHEREAS, the September 1986 report of the U. S. General Accounting Office, using the most recent data available from the American Medical Association, documented that malpractice insurance costs for obstetricians and gynecologists rose seventy-two percent from 1982 to 1984, which was the highest rate of increase for any category of physicians; and

WHEREAS, obstetricians in many parts of Virginia have reported a significant increase in the number of patients who are unable to pay for the costs associated with pregnancy and delivery, and a corresponding reluctance to accept additional patients for uncompensated services; and

WHEREAS, situations arose in 1986 in which indigent women were denied access to obstetrical care due to obstetricians who refused to deliver additional infants without compensation; and

WHEREAS, Congress adopted the Omnibus Budget Reconciliation Act of 1986, which provides states with authority to extend Medicaid coverage for pregnant women and young children, up to the federal poverty level; and

WHEREAS, careful study is now required to assess the extent of the problem of uncompensated prenatal care, pregnancy and delivery and to develop statewide solutions to this problem; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee is created to study the feasibility of financing maternal and child health care. The subcommittee shall consist of eight members: two members from the Senate Finance Committee and one other member of the Senate to be appointed by the Committee on Privileges and Elections of the Senate; and three members from the House Appropriations Committee and two other members from the House of Delegates to be appointed by the Speaker of the House.

The Governor's Task Force on Indigent Health Care, as well as all agencies of the Commonwealth, shall provide assistance upon request as the joint subcommittee deems appropriate. The joint subcommittee shall complete its work in time to submit its report to the Governor and to the 1988 Session of the General Assembly.

The indirect costs of this study are estimated to be $13,815; the direct costs shall not exceed $9,000.

FINANCING MATERNAL AND CHILD HEALTH CARE

(Background Staff Report)

The 1987 General Assembly adopted Senate Joint Resolution 172 which created a joint subcommittee to consider the feasibility of adopting a new financing plan for maternal and child health. The purpose of this background staff report is to provide members of this joint subcommittee with pertinent information to initiate the study.

I. PURPOSE OF THE STUDY

SJR 172 was adopted to study the feasibility of financing maternal and child health care. Specifically, the study is intended to focus on several related issues which relate to the need to improve the outcome of pregnancy among indigent women:

Continued progress in reducing Virginia's rate of infant mortality has been slowed by the increasing numbers of women at risk of poor pregnancy outcome who are having children out of wedlock. Most women at greatest risk lack the resources to pay for needed pre-natal, delivery and related services, and many are not covered by Medicaid.

Prenatal care is available to indigent women in most parts of Virginia through local health department clinics, but there are wide variations in the level and quality of care. In some cases, women at greatest risk may not utilize services which are available in their locality. For those who do attend the local clinics, continuity of care is lost because clinic patients are referred to local hospitals for delivery and postpartum care. An increasing proportion of indigent women are then referred from these local hospitals to the state teaching hospitals. As a result, the delivery of care is uncoordinated and fragmented.

Obstetricians are increasingly reluctant to accept indigent women as patients due to the increased risks associated with their pregnancy and delivery. Many obstetricians are also reluctant to accept additional Medicaid patients for the same reason, even though they will be reimbursed for services. This reluctance is associated with the current climate of tort liability in the medical profession and the rapid increase in malpractice insurance premiums.

Hospitals are increasingly concerned about the level of uncompensated care which is related to pregnancy and delivery of indigent women, and the impact of such care on their

competitive position in the market. However, much of this financial burden has been shifted to the state teaching hospitals. General funds are provided to the teaching hospitals to cover 100 percent of indigent care costs. As a result, there are economic incentives for local hospitals to refer high risk, indigent women to the teaching hospitals.

One of the potential actions to be considered to address these concerns is a proposal to expand Medicaid eligibility. Recent federal legislation permits States to cover pregnant women and children whose incomes exceed current eligibility criteria, but fall below the poverty level. However, the many recent reports on this subject would suggest that a variety of different strategies are required to rsolve these issues. **The joint subcommittee may wish to review the proposed expansion of Medicaid in the larger context of Virginia's overall efforts in maternal and child health care.**

SJR 172 was introduced to address these issues in greater detail than would have been possible during the 1987 session of the General Assembly. The purpose of the study is to review actions which have been taken previously and to assess their effectiveness, as well as to recommend such additional actions as may be appropriate.

Such actions should be designed to continue to improve the service delivery system for pregnant women and children who are socially and economically at risk. At the same time, these actions should help reduce the rate of infant mortality, and address the concerns of obstetricians and hospitals with respect to payment for services.

Previous Studies

There is no shortage of studies addressing the issues raised in SJR 172. In the past two years alone, infant mortality has been the subject of a Southern Regional Task Force Report (1985); a Virginia Legislative Task Force Report (Senate Document 26, 1986); a Governor's Conference in September, 1986 (a copy of the conference recommendations is attached to this report); and a follow-up report by the Departments of Health and Medical Assistance. In addition, legislation adopted by the 1987 General Assembly created an Infant Mortality Council which will meet for the first time in July.

Currently a Governor's Task Force on Indigent Health Care (pursuant to SJR 42 of 1986) is developing recommendations which will follow up on more than a decade of legislative studies dealing with health care cost control and indigent care issues. In addition, a joint subcommittee (pursuant to HJR 280) is currently studying ways to reduce the rate of teen-age pregnancy. A major legislative study of tort reform (pursuant to SJR 109/HJR 221) is also underway and several significant recommendations were adopted by the 1987 General Assembly (Senate Document 11, 1987).

It is essential that the joint subcommittee not duplicate the efforts of these previous and ongoing studies. Instead, the joint subcommittee may wish to suggest specific program enhancements which might be included in the Governor's budget for 1988-90. The work of the subcommittee may be timed to provide these suggestions to the Governor as he prepares his budget during the fall of 1987.

II. PROBLEMS ASSOCIATED WITH POOR PREGNANCY OUTCOME

A number of problems are associated with the poor outcome of pregnancy. Most visible is the rate of infant mortality (the number of deaths of infants under one year per 1,000 live births). In addition to infant deaths, many surviving infants require expensive treatment in neonatal intensive care units. In addition to the tragic human costs, the problems associated with poor pregnancy outcome result in years of indirect expenditures for mental retardation, special education and long term custodial care. Many of these costs are avoidable.

The factor most frequently identified as a cause of poor pregnancy outcome is low birth weight. However, low birth weight itself is an outcome -- not a fundamental cause. The joint subcommittee may wish to address the fundamental reasons why Virginia's infant mortality rate exceeds the national average.

Infant Mortality

Infant mortality rates in Virginia and the United States have declined steadily during most of the twentieth century, due to advances in medical science and technology and improved access to health care services:

> From 1966 to 1985 the number of infant deaths (that is, deaths of infants under one year of age) declined 54 percent -- from 25.2 deaths per 1,000 live births in 1966 to 11.5 deaths per 1,000 live births in 1985. Preliminary data for 1986 suggests that this long term decline will continue.

While the rate of infant mortality has declined dramatically over the past twenty years Virginia's infant mortality rate continues to exceed the national average.

> In 1984 the overall infant mortality rate for the United States was 10.8 deaths per 1,000 live births, while Virginia's overall rate was 12.1.

While many areas of Virginia have infant mortality rates below the national average, other areas continue to have unacceptably high rates:

In 1985 sixteen localities in Virginia reported rates in excess of 20 deaths per 1,000 live births. Many of these localities are in rural Southside or Southwestern Virginia. Several of Virginia's larger central cities reported rates in excess of 15, including the Cities of Richmond (18.4); Portsmouth (18.2); Norfolk (17.8); Petersburg (15.5); and Roanoke (15.5).

A number of studies have documented those factors which tend to increase the risk of poor pregnancy outcome. In general, younger, nonwhite, lower income women with lower levels of educational achievement, who have births out of wedlock, are less likely to obtain prenatal care and are most at risk of poor pregnancy outcome. **The joint subcommittee may wish to request the Commissioner of Health to document the extent to which these factors are related to poor pregnancy outcomes.**

Virginia's Population of Women at Risk. Virginia's infant mortality rate may exceed the national average, in part, because Virginia's population includes a larger percentage of those groups which are most at risk of delivering low birth weight babies. For example, Virginia's population may reflect a higher than average proportion of younger, nonwhite women. This particular group is most at risk today of having children out of wedlock, and is also most likely to deliver low birth weight babies.

In 1983, Virginia's infant mortality rate was 12.2. For whites the rate was 9.6, which was slightly below the national rate of 9.7. However, for nonwhites the rate in Virginia was 19.7. This was above the national rate of 16.8 for nonwhites. This disparity may be magnified in Virginia's overall rate due to the racial composition of our population.

In 1985, Virginia may have had a greater percentage of its population in higher risk categories than the nation as a whole. For example, while 0.75 percent of the national population consisted of nonwhite women between the ages of 20 and 24, in Virginia, 1.0 percent of the population was found in this category -- a difference of 33 percent. Such differences in the makeup of Virginia's population, combined with racial disparities in infant mortality which are experienced in all states, may help to explain the statistical problem Virginia faces in reducing its infant mortality rate in relation to the national average.

The proportion of births out of wedlock also reflects a high disparity between whites and nonwhites. In 1984, for example:

For nonwhite women aged 20 to 24, over 62 percent of all births were out of wedlock. For nonwhite women under age 18, over 93 percent of all births were out of wedlock.

> For white women aged 20 to 24, only 15 percent of all births were out of wedlock. For white women under age 18, over 40 percent of all births were out of wedlock.

The proportion of births out of wedlock has increased significantly over the past two decades for both nonwhites and whites. For all age groups in Virginia, the nonwhite proportion of births out of wedlock increased from 25.9 percent in 1964 to 52.2 percent in 1984. For whites the proportion increased from 3.3 percent in 1964 to 9.9 percent in 1984.

Few statistics can offer a more dramatic illustration of the fundamental change in the status of mothers and children. In Virginia, the pregnancies of young, nonwhite women tend to be out of wedlock, and they result more frequently in low birth weight deliveries, with a higher risk of infant mortality. Outside of the institution of marriage younger women may have less incentive to obtain regular prenatal care, and they may have less ability to obtain transportation for medical care. Once their children are born, they have a high likelihood of becoming trapped in a cycle of poverty, neglect, and lower educational achievement.

The incidence of births out of wedlock to young women today represents not just a breakdown, but a more fundamental dissolution of the family structure which a society must rely on for its long term survival. Virginia's high rate of infant mortality is one of the most significant results of this dissolution of the family.

It is recognized that preventing unwanted pregnancies is the key to reducing infant mortality. **The joint subcommittee addressing teen-age pregnancy (HJR 280) will play a critical role in defining an appropriate response to this issue for the General Assembly.**

Economic and Social Costs of Poor Pregnancy Outcome.

The economic and social costs associated with poor pregnancy outcome have been well documented in previous studies. A baby born too small or too soon will most likely need costly neonatal intensive care. The cost of this high technology care far exceeds the cost of prevention. According to the February, 1985 report of the Southern Regional Task Force on Infant Mortality:

> The annual cost of neonatal intensive care in the United States exceeds $1.5 billion.
>
> The average cost to "graduate" a sick infant from a neonatal intensive care unit is estimated to be between $20,000 and $100,000 per infant. For babies weighing under 2 pounds, 8 ounces, the cost averages $140,000 per patient.

The average cost for specialized care has been estimated at $339 per day for survivors and as much as $607 per day for non survivors. The average length of stay is between eight and 18 days, although some babies need to stay as long as 22 months.

Overall lifetime custodial care may cost as much as $300,000 to $400,000 per child.

In Virginia, an estimated 23 percent of the total hospital cost of neonatal intensive care was not reimbursed, according to a May, 1983 report of the Perinatal Services Advisory Council. Total write-offs for neonatal intensive care were estimated to be $12 million per year at that time.

The indirect cost of low birth weight cannot be estimated. However, it has been suggested that low birth weight may contribute to later behavioral problems, learning difficulties, poor performance in school and work, and criminal behavior. **The joint subcommittee may wish to review the direct and indirect costs associated with poor pregnancy outcome.**

III. OBSTACLES TO IMPROVING THE DELIVERY OF CARE

Great improvements in maternal and child health outcomes have been achieved in recent years but a number of obstacles remain which hinder Virginia's efforts to improve access to care. These obstacles include:

A fragmented and uncoordinated service delivery system,

The current climate of tort liability and increasing malpractice insurance premiums for physicians and other health care professionals; and,

The burden of uncompensated care related to pregnancy and delivery which has been imposed on hospitals, and in particular on our teaching hospitals.

A number of comments have been made to staff to the effect that increasing Medicaid eligibility alone will not necessarily improve health outcomes. Supportive services offered through local health departments are viewed as critical to ensure that more women at risk take advantage of services available. In responding to these suggestions, the joint subcommittee may wish to request the Commissioner of Health to report on the roles and responsibilities of local health departments in improving the outcome of pregnancy.

A Fragmented and Uncoordinated System

Despite the high economic and social costs associated with poor pregnancy outcome, there is no system in place to assure continuity of care for indigent, pregnant women. In fact, there are at least four different systems through which women may or may not receive care. The delivery of care through these systems is fragmented and uncoordinated:

Local health department clinics;

Local for-profit or non-profit hospitals;

Regional perinatal centers, including the state teaching hospitals; and,

Private physicians.

Local Health Department Clinics. While prenatal care is available through local health departments in most parts of Virginia, the level and quality of care varies. The use of public health nurses, nurse midwives, and physicians varies, as do clinic hours and outreach efforts. Only about one fourth of the local health departments have trained Obstetrician- Gynecologists on staff and some of these may have other duties, according to a 1985 report of the Virginia Perinatal Association. Some departments refer patients to prenatal clinics within a local hospital or an adjacent local health department.

As a result, access to prenatal care varies from locality to locality. Even in those localities which offer appropriate services, many women at greatest risk may not take advantage of services which are readily available.

The value of these services is indicated by the difference in pregnancy outcome for nonwhite clinic patients compared to nonwhite patients in general.

In 1985, for nonwhites, clinic patients had a lower incidence of low birth weight deliveries (10.5 percent) than for all patients in general (11.2 percent).

The joint subcommittee may wish to request the Commissioner of Health to report on the level of financial support and staffing currently available to the local health department clinics to provide prenatal care and related support services.

Variations in Financing Delivery Services. Local health department clinics provide prenatal care regardless of ability to pay, on a sliding scale basis. However, these clinics do not provide delivery services. As a result, a variety of formal and informal arrangements have been developed in recent years to refer

clinic patients to hospitals for delivery and to pay for services. In many of these cases the physician may not have seen the patients prior to their arrival at the hospital for delivery. These arrangements were described in the 1985 report of the Virginia Perinatal Association:

> In some areas the local health department refers patients to physicians on a rotating basis during the last month of pregnancy. These physicians then deliver the patients previously sent to them. Some physicians expect no payment from clinic patients while others reduce their fees. Those charging full fees may collect only a portion, depending on the circumstances.
>
> In a few areas the local health department participates directly or indirectly in physician payment. In one area a local fund was established to pay a small sum to cover several office visits and delivery. In another area a variety of funds are used to cover more comprehensive arrangements with certain local hospitals.
>
> In certain areas, state and local matching funds have been appropriated to pay physicians for delivery of indigent patients. These projects will be described in Section IV.

The joint subcommittee may wish to request the Commissioner of Health to report on these various financing arrangements in greater detail, and to determine whether all funds are being utilized appropriately and effectively.

Refusal of Local Hospitals to Accept Patients. Instances have occurred in which patients were not accepted by obstetricians at local community hospitals. In fact, patients were actually referred from the local hospitals to a state teaching hospital for routine deliveries. According to the 1985 report of the Virginia Perinatal Association, one third of all local health departments rely on the Medical College of Virginia or University of Virginia Hospitals to deliver all or part of their indigent patients. Since the two state teaching hospitals each receive a state appropriation which is intended to cover 100 percent of indigent care costs, there is a clear economic incentive for local health departments and local hospitals to refer patients to these institutions.

The Medical Society of Virginia found in a recent survey that during 1986, 43 percent of obstetricians had sent Medicaid or indigent patients elsewhere for treatment due to the patients' inability to pay. Each obstetrician who had done so reported referring an average of 15 patients to other locations averaging 13 miles away. About seven percent of the patients referred elsewhere were sent over 50 miles away. **The joint subcommittee may wish to request the Commissioner of Health, the Medical Society of Virginia, the Virginia Hospital Association, and the teaching hospitals to address this concern.**

Liability of Obstetricians

Complicating the delivery of care is the current climate of tort liability in the practice of obstetrics and gynecology. In recent years there has been a significant increase in litigation in which physicians have been found liable for negative outcomes of pregnancies, including infant deaths and disabling conditions. As a result, malpractice insurance premiums for obstetricians have increased dramatically in comparison with rates for other medical specialties.

> According to the September, 1986 report of the U.S. General Accounting Office, based on the most recent data available from the American Medical Association, malpractice insurance costs for obstetricians and gynecologists rose 72 percent from 1982 to 1984, which was the highest rate of increase for any category of physicians.

At the same time in many parts of Virginia physicians have noted a significant increase in the proportion of their caseloads which are consumed by delivering the children of indigent mothers who have no means of paying for the cost of services rendered. There is no evidence that indigent mothers are more likely to bring suit over the negative outcome of a pregnancy. However, because of the risk factors associated with the pregnancies of lower income mothers, many obstetricians are expressing an increased reluctance to accept charity patients. **The joint subcommittee may wish to request the Medical Society of Virginia to address these concerns.**

Medical Society Survey. In late 1986 the Medical Society of Virginia conducted a survey of the approximately 630 practicing obstetrician/gynecologists across the Commonwealth. The Medical Society received 175 responses (27 percent). While the survey response was limited and there is not sufficient data to conclude whether there were any significant differences between respondents and non-respondents, it does highlight some disturbing trends.

Essentially the survey suggests that obstetricians across Virginia are limiting their practices due to their concerns for liability, and are in many cases referring patients elsewhere for delivery. **The joint subcommittee may wish to request the Medical Society of Virginia to present the findings of its survey.**

Recent Legislative Actions. The 1987 General Assembly took certain actions to address some of the other the concerns of obstetricians, including an exemption from civil liability any physician who provides emergency obstetrical care (SB 408) and establishment of a no-fault compensation program for infants who suffer catastrophic brain injuries at birth (HB 1216). In addition, the 1987 General Assembly decreased from 20 to 10 years the deadlines for filing medical malpractice claims on behalf of minors. Sanctions were also placed on lawyers who file frivolous lawsuits and motions.

The 1987 General Assembly adopted a $350,000 cap on punitive damage awards, although recent decisions in federal court raise the question of whether such caps will withstand challenge. These and other actions will continue to be the focus of legislative tort reform efforts. **The joint subcommittee may wish to request a briefing by the Division of Legislative Services on the current status of tort reform as it affects the medical malpractice issues facing obstetricians and related professions.**

The Financial Burden of Uncompensated Care

Hospitals are concerned today that their rates be competitive with other hospitals in their market area. Large scale purchasers of hospital services, including large employers, health maintenance organizations, and preferred provider organizations, are bargaining for lower rates. In this environment, hospitals are very aware of the extent to which they are absorbing costs associated with non-paying customers -- including indigent mothers.

State Teaching Hospitals. Over one third of the cost of uncompensated care in Virginia is absorbed by the two state teaching hospitals, and much of this is paid directly through a general fund appropriation. As a result of referrals from obstetricians in other hospitals, the Medical College of Virginia and the University of Virginia Hospitals have determined that about 90 percent of their deliveries are to indigent mothers. **The joint subcommittee may wish to request the teaching hospitals to provide more detailed information concerning this issue.**

Other Hospitals. This is not to suggest, however, that other hospitals are not assuming part of the burden of indigent care. According to a report of the Virginia Hospital Association, the total amount of bad debt and charity care absorbed by hospitals (other than the state teaching hospitals) was $192.5 million in 1985. This represented a 9.1 percent increase over 1984. The hospitals' share accounted for 63.6 percent of the total burden of bad debt and charity care. As indicated above, the remaining 36.4 percent of the burden was absorbed by the state teaching hospitals.

The Virginia Hospital Association has estimated that 22 percent of all hospital admissions for uncompensated care were related to obstetrical care, pregnancy and related conditions. If this estimate is accurate, then the cost to non-state hospitals for deliveries and related services to indigent mothers may have exceeded $42 million in 1985.

In its 1985 study, the VHA documented that many persons who were provided uncompensated care were in fact employed, but in occupations which did not provide employee health insurance as a benefit. VHA is conducting further research at this time to

determine the proportion of obstetrical patients whose incomes were in fact below the poverty level. The joint subcommittee may wish to request the Virginia Hospital Association to update its 1985 report with more detailed information concerning obstetrical care at a subsequent meeting.

IV. RECENT BUDGET ACTIONS IN VIRGINIA

Concern over Virginia's high infant mortality rate is not new. Well over $40 million in general funds is spent each year on Maternal and Child Health Programs. Most of these funds are spent for hospitalization services through Medicaid and the State teaching hospitals. In addition, a total of 774 full time equivalent employees are currently working in local health departments in maternal and child health programs. Of these, 186 are not full time state employees.

Despite these efforts, large sums are spent each year on neo-natal and pediatric care for infants and children as a direct result of inadequate pre-natal care. However, the Commonwealth has recognized over the past several years that it has a very important role to play in improving the service delivery system for at-risk mothers. In fact, since 1982 the General Assembly has included specific language in the appropriations act directing the Department of Health to assign high priority to programs which improve pregnancy outcomes. Recent budget actions which have established new policy and program initiatives fall into four main areas:

Expansion of Medicaid Eligibility for Women and Children;

Increase in Physician fees under Medicaid;

Designation of Regional Perinatal Centers and development of a perinatal grant system; and,

Local maternal and child pilot programs.

A funding history of recent infant mortality initiatives is included as an appendix to this report. The joint subcommittee may wish to request the Commissioner of Health to assess the impact of these initiatives on improving the outcome of pregnancy among high risk groups.

Expansion of Medicaid for Women and Children

The 1985 General Assembly expanded Medicaid eligibility to cover several new groups of women and children at an estimated cost of $3.6 million in general funds (with matching federal support). These changes were made in response to the federal Deficit Reduction Act of 1984 (DEFRA). Specifically, DEFRA required States to cover:

- Pregnant women who would be eligible if the child had been born and living with the mother;

- Pregnant women in two-parent families where the principal wage earner is unemployed and the family meets income and resource requirements; and,

- Children under the age of five who were born after September 30, 1983 and whose family's income and resources meet the appropriate guidelines.

In addition, the 1985 General Assembly adopted the optional coverage under DEFRA for pregnant women in intact families where the husband is employed, but the family meets income and resource criteria. This amendment totaled $1.9 million in general funds with matching federal support.

As a result of these initiatives, approximately 3,500 women and 2,500 children are now receiving Medicaid benefits. However, the actual cost of these initiatives is more difficult to determine. **The joint subcommittee may wish to request the Department of Medical Assistance Services to review the actual costs of these initiatives based upon actual experience.**

Federal legislation adopted in late 1986 enabled state's to further expand Medicaid coverage to pregnant women and children up to 100% of the federal poverty guidelines. Current Medicaid guidelines in Virginia are under 50% of the poverty guidelines, so a sizable number of additional women and children could be served by this option. Further discussion of this option is included in the next section of this report.

Physician Fee Increases in the Medicaid Program

The major infant mortality initiative of the 1986 General Assembly was the approval of a major increase in the Medicaid reimbursement rate for obstetrical services. This initiative required $1.1 million in general funds with matching federal support. The reimbursement rate for pre-natal care and delivery was increased from $262.50 to $625. Even with this increase, the rate is still far below the $1,232 which has been expressed by many obstetricians as a "reasonable rate," according to the recent survey of the Medical Society of Virginia.

Following up on the 1986 fee increase for obstetrical services, the 1987 General Assembly approved a fee increase for all office visits and other limited procedures. The expressed intent of this amendment was to address the concerns of many pediatricians over their low reimbursement level. Limited office visits were increased from $8.40 to $10.50. This initiative required $2.7 million in general funds with matching federal support (this represents only six months' cost as the fee increase will take effect on January 1, 1988).

Perinatal Centers and Grants

In fiscal 1985, the State Department of Health received funding to designate and fund regional perinatal centers. Currently, six regional centers each receive $150,000 per year. The six regional centers are located at the University of Virginia, Medical College of Virginia, Eastern Virginia Medical Authority, Fairfax Hospital, Roanoke Memorial Hospital, and Virginia Baptist Hospital in Lynchburg. The appropriation supports education, consultation and medical services to professionals and high risk patients. It is the intent of the Department that these centers not be viewed as the only treatment facilities for high risk deliveries, but rather serve as training and consultation centers for all service providers.

In addition to providing funds to the perinatal centers, the health department has also initiated a perinatal grant fund for regional and local health initiatives in areas of the state where the infant mortality rate is high and local resources are low. These grants have been provided directly to local health departments in addition to funding provided under the State/Local Cooperative Budget. In fiscal 1987 perinatal grants total $4.9 million.

Local Maternal and Child Health Pilot Programs

During the 1985 General Assembly, the City of Virginia Beach requested $100,000 to compensate obstetricians for pre-natal and delivery care for indigent women. The city made a commitment to provide an equivalent local match. This request was granted as an interim solution. Since that time funding for Virginia Beach continues (though at a reduced level) and direct funding for the cities of Chesapeake and Hampton for similar programs has been initiated.

At the same time, the Department of Health has established similar local programs in the Cities of Danville, Lynchburg, and Winchester, and in Prince William County. These efforts are supported through the Infant Mortality Preventive Action (IMPACT) program initiated under the Robb administration. A total of $250,000 per year is included in the appropriations act for fiscal 1987 and 1988. These programs are administered through the local health departments. In contrast, the programs in Virginia Beach, Chesapeake, and Hampton (which receive direct appropriations) are administered through the city governments.

V. OPTIONAL EXPANSION OF MEDICAID

As noted above, Virginia has already expanded Medicaid coverage to pregnant women and children who meet current Medicaid criteria. An important question to be resolved by the joint subcommittee is whether or not to recommend that the Governor include additional funding in the 1988-90 budget to expand Medicaid eligibility. The proposed expansion would cover those pregnant women and children whose incomes are below the poverty level, but above the eligibility limits for Medicaid.

1986 Congressional Action.

In late 1986 Congress adopted and the President approved legislation expanding Medicaid eligibility for lower income pregnant women and children. This legislation was one part of the Omnibus Budget Reconciliation Act (OBRA) of 1986.

Specifically, the new provisions will enable States to offer Medicaid coverage to four populations of people who have previously been ineligible for Medicaid even though their family incomes fall below the federal poverty threshold. (The federal poverty level for a family of four in February, 1986, was $11,000.) These newly eligible populations include pregnant women, very young children, the elderly, and the blind and disabled. To qualify for Medicaid, their incomes must be above the level which qualifies them for public assistance, but below the poverty level.

Congress also expressed a priority order for those States wishing to expand their Medicaid programs. States are not permitted to expand their coverage of elderly, blind or disabled clients until they have opted to expand coverage for pregnant women and children.

1987 General Assembly Actions

Senator Robert C. Scott and Delegate Walter H. Maxwell each introduced budget amendments during the 1987 General Assembly to implement the new option for expansion of Medicaid as of July 1, 1987. In addition, Senator Scott introduced Senate Bill 433 for the same purpose. These proposals would have provided for Medicaid coverage for pregnant women and children whose income exceeded current Medicaid limits but fell below 100 percent of the poverty level.

The General Assembly determined that further study of these proposals was warranted. Delegate Maxwell's budget amendment was considered and not approved by the House Appropriations Committee. Senate Bill 433 was unanimously reported out of the Senate Committee on Education and Health and re-referred to the Committee on Finance for consideration of its fiscal impact. Along with the companion

budget amendment, the bill was not reported from the Finance Committee, to permit further study of the fiscal impact.

Legislative Interest in Further Study. The SJR 172 study resolution was developed in response to the desire of the General Assembly to review this option in the context of Virginia's overall initiatives in maternal and child health. These initiatives have included increased funding for the Department of Health as well as for the Department of Medical Assistance Services, as described in the previous section of this report.

The General Assembly was concerned with the volume and magnitude of budget amendments for Medicaid during the 1987 session. The General Assembly also felt that actions to raise physicians fees should take priority in order to ensure that the current Medicaid population retains access to care.

Taking into account the 1987 legislative budget actions to increase physician reimbursement, total expenditures for Medicaid will increase by about 20 percent over the two years from fiscal 1986 to 1988, or from about $500 million in 1986 to over $600 million in 1988. Even with this major increase in expenditures for Medicaid, the level of services will not increase significantly. For these reasons, the decision was made to study the Commonwealth's overall system for financing maternal and child health. **The joint subcommittee may wish to request the Department of Medical Assistance Services to review its recent expenditure history and current projections for 1988-90.**

Fiscal Impact of Expanded Medicaid Option

The fiscal impact statement prepared by the Department of Planning and Budget (DPB) for SB 433 concluded the net cost of implementing the proposed Medicaid option would be about $3.3 million in general funds during fiscal 1988 and $4.0 million in 1989. This estimate is based on providing full coverage to pregnant women and limiting coverage of children to infants under age one. (The federal option permits states to cover children up to age five.)

However, if coverage were provided to the fullest extent permitted under the OBRA legislation, the cost to the state would increase to $4.7 million in 1988 and $7.2 million in 1989. The additional cost would represent the expenses incurred on behalf of children between the ages of one and five. These general fund cost estimates assume no change in the 51 percent federal matching rate which will go into effect on October 1, 1987. A task force chaired by the Deputy Secretary of Human Resources is currently reviewing in detail the estimated costs of inititating this option.

Total Program Cost Less Offsets. Assuming the program would initially be limited to pregnant women and infants under age one, the total program cost was projected by DPB to be $19 million in fiscal 1988. The federal share of the total cost would be $9.8 million while the general fund share would be $9.2 million.

This general fund cost would be offset by several existing state programs which currently pay for services for persons who would come under the Medicaid umbrella. These offsetting appropriations would be transferred to the Department of Medical Assistance Services as state match to obtain the federal Medicaid dollars. The offsets are estimated at about $6.4 million in 1988.

The offsets represent general funds which are currently appropriated for indigent health programs in the Departments of Health and Social Services, as well as for indigent care at the two state teaching hospitals. **The joint subcommittee may wish to request the Deputy Secretary of Human Resources to present the results of his task force study of this option at a later date.**

VI. ACTIONS IN OTHER STATES

Many states are taking steps to improve their health care delivery system for pregnant women and children. According to the Children's Defense Fund, fifteen states have already expanded Medicaid eligibility for pregnant women and children pursuant to the COBRA provisions. With the exception of Arkansas, eligibility was expanded to 100 percent of the poverty level. In the South, Arkansas, the District of Columbia, Maryland, Mississippi, North Carolina, and West Virginia have expanded Medicaid coverage.

However, it is important to note that many states have not only adopted this option, but have also expanded the pre-natal and delivery services provided under Medicaid. According to the National Academy of Sciences, which has done extensive research on infant mortality, it is very important that any comprehensive approach to pre-natal and delivery services include risk and nurtritional assessments, health education, and other support services as needed. This may include case management services to assure continuity of care for each patient.

In comparison, Virginia's current definition of the types of pre-natal care covered under Medicaid is fairly limited. **In order to address this point, the joint subcommittee may wish to request the Department of Medical Assistance Services to identify one or more alternative reimbursement models for this population which would include a wider array of services.**

VII. CONCLUSION

Improving pregnancy outcomes and reducing the infant mortality rate in Virginia are not easy tasks. A great deal of progress has been made and a number of policy and program initiatives have been funded in recent years. In order to make continued progress, a carefully defined set of strategies will be required. First, we must develop appropriate actions to reduce the number of unwanted pregnancies and reduce the incidence of out-of-wedlock births to women at risk. Second, we must improve our service delivery systems by addressing the problems of fragmentation and coordination, liability and malpractice insurance costs, and uncompensated care. Third, we must take steps to assure continuity of care for indigent mothers, by reexamining the roles, responsibilities and resources available to our local health departments. The importance of good nutrition, health education, and transportation cannot be overlooked in this regard. The decision to expand Medicaid eligibility (or to expand the array of covered services) should be made in the context of addressing these overall strategies.

NEW MATERNAL AND CHILD HEALTH FUNDING BY LEGISLATIVE SESSION

1982 Session

A total of $3.6 million in general funds was appropriated to provide the following:

$200,000 in each year to provide genetic disease testing.

$750,000 in the FY 1983, and $1.0 million in FY 1984 to provide neo-natal hospitalization coverage for low-income infants which was previously supported through federal funds to replace federal funds.

$750,000 in each year to provide hospitalization coverage for low-income high risk maternity patients which was previously provided with federal funds.

1984 Session

Department of Health

A total of $4.7 million in nongeneral funds (Health Department fees) was included to expand Maternal and Child Health Services. These funds were used to implement several recommendations developed by the Perinatal Services Advisory Council in their report to the General Assembly pursuant to HJR 218. This amendment included the following:

$1.1 million each year for local health departments to enable them to develop contractual arrangements with local health care providers for routine newborn services and maternity care, including prenatal, labor and delivery services.

$300,000 each year to formalize a regional system of perinatal care by providing educational and consultation services to the State's seven regional perinatal centers.

$1.9 million to augment to the Maternal and Child Health Hospitalization program.

1985 Session

Department of Medical Assistance Services

A total of $3.6 million in general funds to be matched with federal funds was appropriated for the Medicaid Program to expand Medicaid coverage to pregnant women and children as mandated by the Deficit Reduction Act of 1984. Three new groups of women and children were granted Medicaid coverage under this amendment:

1) Pregnant women who would otherwise be eligible if the child had been born and was living with the mother.

2) Pregnant women in two-parent families where the principal wage earner is unemployed and the family meets ADC income and resource requirements.

3) Children under the age of five who were born after September 30, 1983 and whose family's income and resources meet ADC guidelines.

A total of $1.9 million in general funds to be matched with federal funds was appropriated to provide Medicaid prenatal care for mothers in intact families where the husband is employed, but the family meets Medicaid medically needy criteria. This was an optional DEFRA initiative.

Department of Health

A total of $100,000 in general funds was appropriated for the City of Virginia Beach to provide obstetrical services for low-income pregnant women.

1986 Session

Department of Health

A total of $3.8 million in nongeneral funds in FY 1986 and $4.7 million in nongeneral funds in FY 1987 was provided to maintain perinatal services and high-risk maternal and neo-natal services following a decrease in federal funding for these programs. In addition, these funds supported case reviews of infant deaths to produce information which can be used to design continuing education programs for practitioners.

A total of $250,000 was appropriated for FY 1986 to support innovative local projects to prevent infant mortality.

The Virginia Beach pilot program which was initiated in FY 1985 to provide obstetrical services for low-income pregnant women was continued in FY 1986 at a general fund cost of $100,000. In addition, the City of Chesapeake received $100,000 to initiate a similar program. Both cities were required to provide an equivalent local match.

Department of Medical Assistance Services

A total of $2.6 million in general funds in FY 1986 and $3.0 million in general funds in FY 1987 with matching federal funds was provided to cover additional costs associated with the initiative began in FY 1985 to serve poor children up to age 5 who were born after September 30, 1983.

A total of $7.1 million in general funds with matching federal funds was approved for the biennium to allow payments to hospitals to continue beyond the current 21-day cap for children who are patients in hospitals.

A total of $1.1 million in general funds was appropriated with matching federal funds to support a fee increase for obstetrical services under the Medicaid Program. The reimbursement for a delivery was increased from $152.50 to $450.00. This action was taken to improve access of obstetrical services for the Medicaid eligible population.

1987 Session

Department of Health

Provided $250,000 in general funds to continue IMPACT, a program which supports local efforts aimed at preventing infant mortality. This program was created in FY 1986.

The Virginia Beach and Chesapeake pilots to improve access of indigent women to obstetrical services were continued, but reduced from $100,000 per locality to $50,000 per locality. Also, the City of Hampton received $100,000 to initiate a similar program.

RECOMMENDED AVAILABLE MEDICAID OPTIONS AND ESTIMATED COSTS TO IMPROVE PREGNANCY OUTCOMES AND REDUCE INFANT MORTALITY/MORBIDITY, USING MEDICAID PAYMENT RATES

(Revised 11/6/87)

Option #1

Expanded Medicaid eligibility coverage to pregnant women and children to age 1. This option is available under the Omnibus Budget Reconciliation Act of 1986, §9401. It allows states to provide coverage for pregnant women and children who are above Medicaid's current income limits whose countable income is below 100% of federal poverty guidelines. We recommend coverage of pregnant women and children under age 1 up to 100% of poverty. This recommended option would provide Medicaid coverage to additional pregnant women through 60 days following delivery and children under age 1. Estimated fiscal impact:

FY 89 (75% Utilization)		FY 90 (100% Utilization)	
GF:	$ 6,564,780	GF:	$ 9,558,927
NGF:	$ 6,895,913	NGF:	$ 9,705,335
TOTAL:	$13,460,693	TOTAL:	$19,264,262
ACTUAL GF:	$ 4,311,891	ACTUAL GF:	$ 6,760,742

Option #2

Expanded prenatal care services to pregnant women. This option is available under the Consolidated Omnibus Budget Reconciliation Act of 1985, §9501(b). This option allows Medicaid to extend coverage for preventive and curative services not presently covered under the State Plan only to pregnant women. These recommended additional prenatal care services include health education, nutritional assessment/counseling, additional home health and homemaker services. Estimated fiscal impact (includes 3 additional MEL):

FY 89 (75% Utilization)		FY 90 (100% Utilization)	
GF:	$ 748,718	GF:	$ 899,949
NGF:	$ 778,604	NGF:	$ 912,462
TOTAL:	$1,527,322	TOTAL:	$1,812,411

Option #3

Provide optional targeted case management (care coordination). This option is available under the Consolidated Omnibus Budget Reconciliation Act of 1985, §9508. Care coordination services would be provided to high risk pregnant women and children to assist these eligibles in gaining access to needed medical, social and educational services. These care coordinated services include an initial risk screening by the primary care provider and a care coordinator who would provide an in-depth risk assessment, be in contact with the primary care provider, and coordinate the access and follow-up to necessary services to improve pregnancy outcome. Estimated fiscal impact (includes 4 additional MEL):

FY 89 (75% Utilization)		FY 90 (100% Utilization)	
GF:	$1,489,754*	GF:	$1,528,034
NGF:	$1,541,759	NGF:	$1,549,794
TOTAL:	$3,031,513	TOTAL:	$3,077,828

*Actual GF is $1,800,583 for FY 89 and $1,887,928 for FY 90. These figures include Department of Health staffing costs for case management.

Outreach

Outreach is a service that includes case finding, marketing of services, education/materials, etc. It is recognized that outreach will compliment the three recommended options by providing awareness for providers and recipients. Based on our concern with Medicaid provider participation rates, it is recommended that three positions be made available to market these services to both providers and recipients. Further study is still needed to determine how best to utilize these positions in accomplishing the objectives. Results of further study will be made available to this subcommittee. Estimated fiscal impact:

	FY 89	FY 90
GF:	$240,000	$254,475

(The Department of Health has submitted a budget addendum to include outreach costs for staffing of one individual for the central office to administer this effort for the Health Department. This would include personnel costs to catalog and assess current approaches to outreach, dissemination of information to field workers, develop linkages with private and other local entities such as school systems to look at new outreach avenues, and resources for data system development to track outreach activities, development of appropriate media and educational materials and necessary travel to various outreach locations. These costs are estimated to be $80,000 in FY 89 and $84,825 in FY 90. Since it is recommended that 3 positions be available, this amount was multiplied to estimate total general fund costs necessary for this effort.)

Total GF Costs for Options #1, #2 and #3 and Outreach:

	FY 89	FY 90
ACTUAL GF (OPTION #1)	$4,311,891	$6,760,742
GF (OPTION #2)	$ 748,718	$ 899,949
ACTUAL GF (OPTION #3)	$1,800,583	$1,887,928
OUTREACH	$ 240,000	$ 254,475
TOTAL	$7,101,192	$9,803,094

TOTAL 88-90 BIENNIUM GF COST = $16,904,286

NOTE: Under Option 3, total costs for Medicaid include the federal share for providing care coordination services. Therefore, the federal share can not also be claimed for the cost of staffing the care coordination services.

11/06/87

OPTION #1

Medical Cost of New Pregnant Women &
Children Under Age 1 - 100% of Poverty

Medical Costs:	FY89 (51.23% NGF) (75% utilization)		FY90 (50.38% NGF) (100% utilization)	
Pregnant Women: [Number of pregnant women with incomes above Medicaid limit and below poverty level.]	(6,190)	$10,646,280	(8,389)	$15,235,612
Infants: [Number of infants under age 1 in families with incomes above Medicaid income limit and below poverty level.]	(3,026)	$2,814,413	(4,090)	$4,028,650
Total		$13,460,693		$19,264,262
GF		$6,564,780		$9,558,927
NGF		$6,895,913		$9,705,335
GF Cost Offsets: [Cost in state dollars of services currently provided to pregnant women and infants with incomes to 100% of poverty at MCV Hospitals, UVA Hospitals, the Dept. of Health and the Dept. of Social Services (state and local hospitalization program).]				
MCV		$1,088,870		$1,306,775
UVA		$556,911		$668,360
DOH		$691,609		$922,145
DSS		$229,552		$306,069
Total GF Cost Offsets		$2,566,942		$3,203,349

(next page)

GF Costs	$6,564,780	$9,558,927
GF Cost Offsets	-$2,566,942	-$3,203,349
GF Medical Costs	$3,997,838	$6,355,578
DSS Administrative Costs: [Cost for determining Medicaid eligiblity for this group of pregnant women and infants.]	$851,171	$1,210,151
GF	$283,440	$402,980
NGF	$567,731	$807,171
DMAS Administrative Costs: [Computer systems development of $58,000 in FY89 plus estimated one claim processed for each pregnant woman and infant in this group at cost of $0.35.]	$61,226	$4,368
GF	$30,613	$2,184
NGF	$30,613	$2,184
GF-Medical Costs	$3,997,838	$6,355,578
GF-DSS Administrative Costs	+$283,440	+$402,980
GF-DMAS Administrative Costs	+$30,613	+$2,184
Actual GF Costs	$4,311,891	$6,760,742

Total 88-90 Biennium GF Cost under Option #1 is $11,072,633.

11/6/87

OPTION #2

FISCAL 1989 (75% Utilization)
EXPANDED PRENATAL SERVICES COST AT 100% OF FEDERAL POVERTY LEVEL

SERVICE	% OF PATIENTS	# OF PATIENTS	UNITS PER PATIENT	MEDICAID PAYMENT*	SERVICE COST
TOTAL POPULATION OF PATIENTS		20,634			
(75% Utilization)		(15,476)			
PATIENT EDUCATION CLASS (PACKAGE OF SIX CLASSES)	75	11,607	6	$6	$417,852
NUTRITION ASSESSMENT	25	3,869	1	$20	77,380
NUTRITION FOLLOW-UP	25	3,869	2	$10	77,380
HOME HEALTH SERVICES (VISITS)					
HIGH-RISK ANTEPARTUM	3	464	8	$20	74,240
EARLY DISCHARGE POSTPARTUM	15	2,321	2	$30	139,260
HOMEMAKER SERVICES (DAYS OF HELP)	3	464	28	$33	428,736

TOTAL SERVICE COST: $1,214,848

* MEDICAID PAYMENTS ARE SET AT 50% OF THE RECOMMENDED UCR CHARGE WITH THE EXCEPTION OF PATIENT EDUCATION. THAT CHARGE IS SET AT 100% OF THE RECOMMENDED LEVEL.

ADMINISTRATIVE COSTS: $312,474

There are Medicaid administrative costs for systems development of $150,000 the first year, claims processing costs for additional claims at $.35 per claim, staffing for 3 positions to perform provider enrollment, claims resolution activities and policy development, implementation and monitoring.

TOTAL: $1,527,322

GF: $ 748,718

11/6/87

OPTION #2

FISCAL 1990 (100% Utilization)
EXPANDED PRENATAL SERVICES COST AT 100% OF FEDERAL POVERTY LEVEL

SERVICE	% OF PATIENTS	# OF PATIENTS	UNITS PER PATIENT	MEDICAID PAYMENT*	SERVICE COST
TOTAL POPULATION OF PATIENTS		20,973			
PATIENT EDUCATION CLASS (PACKAGE OF SIX CLASSES)	75	15,730	6	$6	$566,280
NUTRITION ASSESSMENT	25	5,243	1	$20	$104,860
NUTRITION FOLLOW-UP VISITS	25	5,243	2	$10	$104,860
HOME HEALTH SERVICES (VISITS)					
HIGH-RISK ANTEPARTUM	3	629	8	$20	$100,640
EARLY DISCHARGE POSTPARTUM	15	3,146	2	$30	$188,760
HOMEMAKER SERVICES (DAYS OF HELP)	3	629	28	$33	$581,196

TOTAL SERVICE COST: $1,646,596

* MEDICAID PAYMENTS ARE SET AT 50% OF THE RECOMMENDED UCR CHARGE WITH THE EXCEPTION OF PATIENT EDUCATION. THAT CHARGE IS SET AT 100% OF THE RECOMMENDED LEVEL.

ADMINISTRATIVE COSTS: $165,815

There are Medicaid administrative costs such as claims processing costs for additional claims at $.35 per claim, plus staffing of 3 positions to perform claims resolution activities, provider enrollment and policy development, implementation and monitoring. (Note: System development costs of $150,000 not necessary in second year.)

TOTAL: $1,812,411

GF: $ 899,949

TOTAL 88-90 BIENNIUM GF COST OPTION #2 is: $1,648,667

11/6/87

OPTION #3

FISCAL 1989 (75% Utilization)
CARE COORDINATION COSTS 100% OF FEDERAL POVERTY LEVEL

SERVICE	% OF POPULATION	# OF PATIENTS	UNITS PER PATIENT	MEDICAID PAYMENT*	SERVICE COST
PREGNANT WOMEN					
INITIAL RISK SCREENING (75% utilization)	100%	20,634 (15,476)	1	$10	$154,760
CARE COORDINATION					
a) INITIAL EVALUATION	40%	6,190	1	$25	$154,750
b) MONTHLY FOLLOW-UP (1)	40%	6,190	5.3	$40	$1,312,280
SUBTOTAL (For Women)					$1,621,790
CHILDREN AGE 0 TO 1					
INITIAL RISK SCREENING (75% Utilization)	100%	15,001 (11,251)	1	$10	$112,510
CARE COORDINATION (0 TO 1)					
a) INITIAL EVALUATION	25%	2,813	1	$25	$70,325
b) MONTHLY FOLLOW-UP	25%	2,813	11	$10	$309,430
SUBTOTAL (For Children)					$492,265
CARE COORDINATION COSTS (MOTHERS AND CHILDREN)					$2,114,055

* Medicaid payments are set at 50% of the recommended UCR charge, with the exception of Initial Risk Screening. That charge is set at 100% of the recommended level.

DMAS ADMINISTRATIVE COSTS: $917,458

Includes costs for additional staffing of 4 persons to provide care coordination, utilization review oversight and tracking cost effectiveness, a new invoice type, and additional claims processing costs of $.35 per claim.

TOTAL	$3,031,513
GF	$1,489,754

DEPARTMENT OF HEALTH ADMINISTRATIVE COSTS: $ 310,829

Department of Health budget addendum GF costs of $1,748,211 in FY 89 to provide staffing for 46 positions to perform care coordination services.

ACTUAL GF $1,800,583

11/6/87

OPTION #3

FISCAL 1990 (100% Utilization)
CARE COORDINATION COSTS WORKSHEET AT 100% OF FEDERAL POVERTY LEVEL

SERVICE	% OF POPULATION	# OF PATIENTS	UNITS PER PATIENT	MEDICAID PAYMENT *	SERVICE COST
PREGNANT WOMEN					
INITIAL RISK SCREENING	100%	20,973	1	$10	$209,730
CARE COORDINATION					
a) INITIAL EVALUATION	40%	8,389	1	$25	$209,725
b) MONTHLY FOLLOW-UP (1)	40%	8,389	5.3	$40	$1,778,468
SUBTOTAL (For Women)					$2,197,923
CHILDREN AGE 0 TO 1					
INITIAL RISK SCREENING	100%	15,205	1	$10	$152,050
CARE COORDINATION (0 to 1)					
a) INITIAL EVALUATION	25%	3,801	1	$25	$95,025
b) MONTHLY FOLLOW-UP	25%	3,801	11	$10	$418,110
SUBTOTAL (For Children)					$665,185
CARE COORDINATION SERVICE COSTS (MOTHERS AND CHILDREN)					$2,863,108

* Medicaid payments are set at 50% of the recommended UCR charge with the exception of Initial Risk Screening. That charge is set at 100% of the recommended level.

DMAS ADMINISTRATIVE COSTS: $214,720

Includes costs for additional staff of 4 persons to provide care coordination, utilization review oversight and tracking cost effectiveness, plus additional claims processing costs at $.35 per claim. (Note: System development costs of $700,000 not necessary in second year).

TOTAL	$3,077,828
GF	$1,528,034

DEPARTMENT OF HEALTH ADMINISTRATIVE COSTS: $ 359,894

Department of Health Budget Addendum GF costs of $2,294,536 in FY 90 to provide staffing of 58 positions (46 from 1989 plus 12 in FY 90) to perform care coordination services. ACTUAL GF $1,887,928

TOTAL 88-90 BIENNIUM GF COST OPTION #3 is: $3,688,511

11/6/87

APPENDIX D

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VIRGINIA HOSPITAL ASSOCIATION

December 9, 1987

Mr. Richard Hickman
Senate Finance Committee
General Assembly Building
Richmond, Virginia 23219

Dear Dick:

On behalf of the Virginia Hospital Association, I am pleased to forward the most recent version of our study of pregnancy coverage in Virginia.

The final phase of the Medicaid pregnancy coverage expansion project is in the process. This final phase involves refinement of the cost projections contained in this report. It is our intention to make a final report on pregnancy coverage in Virginia available to you and members of the General Assembly in early January.

Thank you again for allowing us the opportunity to research this most important issue.

Sincerely,

Katharine M. Webb
Vice President/Planning
and Government Relations

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Enclosure

PREGNANCY COVERAGE IN VIRGINIA

ACCESS, OUTCOMES, AND COSTS

OCTOBER 1, 1987

Stephen C. Pace
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PREGNANCY COVERAGE IN VIRGINIA

ACCESS, OUTCOMES, AND COSTS

I. SAMPLING METHODOLOGY

II. CLAIM DEMOGRAPHICS

III. ACCESS TO PRENATAL CARE

IV. BIRTH OUTCOMES

V. HOSPITAL RESOURCES CONSUMED

VI. MEDICAID EXPANSION IMPACT MODEL

VII. CONCLUSIONS/RECOMMENDATIONS

INTRODUCTION

With the passage of the Omnibus Budget Reconciliation Act (SOBRA) in 1986, the U.S. Congress made it easier and less expensive for states to expand their Medicaid programs to provide health services to pregnant women and children not previously covered. The Virginia Assembly considered, but did not pass, a SOBRA expansion in its 1987 session. Instead, the Assembly formed a Joint Study Committee charged with collecting and evaluating data relative to care for uninsured and indigent pregnant women and newborns in the Commonwealth and with making recommendations. The study committee in turn contacted the Virginia Hospital Association (VHA) and requested its input. Recognizing that inadequate pregnancy coverage is an issue that raises major social and economic issues, both for the Commonwealth and for all health care providers, the VHA agreed and began the study whose results are reported below.

This report should be seen as an "interim" document in the sense that its cost projections will be subject to further refinement later in the year. It is focussed on six major areas. After a brief review of sampling and data collection approaches, it provides information on:

- Basic demographics of the uninsured population as contrasted to those of publicly paid (Medicaid) mothers and to Virginians in general.
- Prenatal care access differentials among the same groups.
- Birth outcome variations, expressed in terms of frequencies of low birthweight infants, C-sections, complications, etc.
- Hospital resources consumed in serving the inpatient needs of these patients.
- A Medicaid expansion impact model projecting the cost consequences of expanding Medicaid eligibility under the "SOBRA" concept to cover pregnant women with incomes up to the federal poverty line.
- Conclusions/recommendations.

I. SAMPLING METHODOLOGY.

To assist the Assembly in conducting its Joint Resolution Study of the possibility of expanding pregnancy coverage under the Virginia Medical Assistance Program, the Virginia Hospital Association collected data in the summer of 1987 on uninsured and publicly paid (primarily Medicaid) births. Six hospitals were targeted for study: Virginia Baptist, Lynchburg; Norfolk General/Children's Hospital of the King's Daughters, Norfolk; Roanoke Memorial; the Medical College of Virginia, Richmond; the University of Virginia Hospital, Charlottesville; and Fairfax Hospital. These hospitals were chosen because each acts as a substantial deliverer of publicly-paid obstetric services in its service area and because each contains a designated Newborn Intensive Care Unit (NBICU) in charge of serving a large geographic area. This assures that obstetric-related activities at each hospital encompass a broad range of services, deal with both normal and complicated patients, etc.

Because our main intention in the study was to assess similarities and contrasts between the Medicaid-insured population and mothers lacking coverage at delivery but potentially eligible under SOBRA, our sample omitted extensive direct study of privately-insured patients. For comparison purposes, however, we have made use of Vital Statistics data on all Virginian births as computed by the Department of Health.

A survey form (included as Appendix A) was developed, a coordinator at each hospital was assigned, and hospital staff were asked to complete the survey form on a 100% sample of both public and self-pay patients for at least 30 days of delivery and NBICU activity.

It was left up to the hospital to determine whether the individual patient had Medicaid coverage or was likely in a self-pay/non-covered situation. In coding the completed survey forms, some "massaging" of data was necessary, primarily involving interpretations about family size (e.g., for Medicaid eligibility determination, the unborn child counts as a family member so the minimum family size in the sample is two), and for family income (e.g., if a woman reported employment and personal income and did not indicate job loss during pregnancy, then personal income was counted as family income, if none was indicated on the survey form).

In addition to survey forms, which were obtained at some level of completion for just over 500 deliveries, the hospitals also provided UB82 or equivalent financial summaries to reflect charges, length of stay, diagnostic information, etc., for all public and self-pay patients, including those who did not complete or refused the survey. The NBICU sample includes both NBICU admitted infants who were born at the sampled hospital and infants who were born elsewhere and transferred into one of the sampled hospital's NBICU units. A synopsis of the sample is included below:

	VA BAPTIST	NORFOLK/ CHKD	ROAN MEM'L	MCV	UVA	FAIRFAX	TOTAL
DAYS SAMPLED:	35	30/37	38	32	35	30	33(av)
TOTAL DELIVERIES:	221	404	296	483	178	661(e)	2243
PUBLIC/SELF PAY DEL:	59	77	40	366	129	26	697

On average, the six hospitals collected data for 33 days, during this interval there were 2243 total deliveries in the hospitals of which 697 were determined by the hospital to be either Medicaid-covered or to be self-pay or otherwise not to have adequate coverage arrangements made at the time of the birth. The largest and most complete data set was obtained at MCV, which is also the largest Medicaid provider in the Commonwealth.

The six hospitals deliver about 25% of the approximate 90,000 children who are born each year in Virginia. They accounted for about 40% of birth-related inpatient claims activity paid under the Virginia Medicaid program in 1986. Because the true financial status of these claims will not be finally known for several months (e.g., patients who listed as self-pays may eventually become Medicaid eligible, some self-pays may settle all or part of their hospital bill out of their own resources, some patients who were thought eligible for Medicaid coverage may have payment denied, etc.), further financial review of collections activity on these accounts will be needed to refine the results. The VHA intends to conduct such a follow-up later this fall. This report should, therefore, be seen at present as an illustrative case study of access and pregnancy financing issues (as opposed to a being a finalized, statistically rigorous financial analysis).

II. CLAIM DEMOGRAPHICS.

Tables 1, 2, and 3 compare characteristics of the two subsets of the surveyed population ("sample public" consists primarily those who appear Medicaid-eligible at the time of delivery; "sample self" consists of all others whose coverage the hospital deemed to be suspect). Table 1 indicates that the frequency of teenage mothers is about double in both the public and self-pay samples in comparison to deliveries for the Commonwealth as a whole. Table 2 is a racial distribution of deliveries. Whereas about one quarter of all Virginia births are to non-white mothers, almost 80% of publicly-paid births are to non-whites. Self-pays are more frequently white than publicly-paid births, although once again the preponderance of mothers in this category were non-white.

TABLE 1
AGE DISTRIBUTION (DELIVERIES)

	VIRGINIA TOTAL	SAMPLE PUBLIC	SAMPLE SELF
TEENAGE PERCENT	12.2%	23.3%	25.1%
AGE 20 OR ABOVE PERCENT	87.8%	76.7%	74.9%

Virginia totals drawn from Virginia Vital Statistics (1985).

TABLE 2
RACE DISTRIBUTION (DELIVERIES)

	VIRGINIA TOTAL	SAMPLE PUBLIC	SAMPLE SELF
WHITE PERCENT	74.5%	22.1%	36.0%
NON-WHITE PERCENT	25.5%	77.9%	64.0%

Table 3 contrasts the personal/household income situations of the public and self-pay samples. In both samples, the fraction of survey respondents who report personal income greater than zero (we interpret this to mean individuals who typically work) were about the same at 27.4% and 26.2%, respectively. Average personal income for individuals reporting income is low in both cases (approximately $500-600 per month). A much greater fraction of the self-pays (almost double at 58%) report being in households with income greater than zero. Self-pay average household income was reported at slightly more than $800 per month. These data are consistent with anecdotes that typically describe Medicaid deliveries as occurring in single, female-headed families and self-pay deliveries as being a phenomenon of the working poor and near-poor with multiple earners in the household.

TABLE 3
DELIVERIES REPORTING PERSONAL/HOUSEHOLD INCOME
(PERCENT OF TOTAL RESPONDENTS)

	SAMPLE PUBLIC	SAMPLE SELF
RESPONDENTS WITH PERSONAL INCOME = 0	72.6%	73.8%
RESPONDENTS WITH PERSONAL INCOME) 0	27.4%	26.2%
AVERAGE INCOME FOR PERSONS WITH INCOME (6 MOS)	$ 2,893	$ 3,703
HOUSEHOLDS WITH INCOME = 0	69.3%	42.0%
HOUSEHOLDS WITH INCOME) 0	30.7%	58.0%
AVE INCOME FOR HOUSEHOLDS WITH INCOME (6 MOS)	$ 3,112	$ 5,095

III. ACCESS TO PRENATAL CARE.

Table 4 estimates the trimester of the first prenatal visit to a physician or clinic. Public pay patients at 71% with first trimester visit and self-pay patients at 64% with first trimester visit both appear to have reduced access to care in comparison to Virginians in general.

This observation is reinforced by Table 5 which reports total prenatal visits. Only about 26% of all Virginia mothers get less than ten visits in the course of their pregnancy. These compare to more than 50% of both the

public and self-pay samples. It is also interesting to note that both the public and self-pay samples show similar visit patterns -- apparently being on Medicaid does not necessarily mean a woman will get much more prenatal care than if she was entirely uninsured.

TABLE 4
TRIMESTER OF FIRST PRENATAL VISIT
(FOR THOSE WITH VISITS)

TRIMESTER	VIRGINIA	SAMPLE PUBLIC	SAMPLE SELF
FIRST	80.5%	71.0%	64.0%
SECOND	16.3%	25.9%	31.0%
THIRD	3.0%	3.2%	5.1%

(Estimated preliminary value.)

TABLE 5
TOTAL PRENATAL VISITS

PRENATAL VISITS (RESPONDENTS ONLY)	VIRGINIA	SAMPLE PUBLIC	SAMPLE SELF
NONE	0.9%	0.8%	3.1%
1-5	3.9%	13.4%	15.0%
5-9	21.0%	36.2%	35.0%
10-14	61.3%	33.5%	33.1%
15+	13.0%	16.1%	13.8%

IV. BIRTH OUTCOMES

Table 6 through 9 describe birth outcomes. A commonly used surrogate measure of the health of newborns is the frequency of low birthweight babies. A common low birthweight cut-off is 5 pounds, 8 ounces (2500 grams). Evaluated along this dimension, the publicly-paid births appear to closely follow the overall state statistics, i.e., both the white and the non-white publicly-paid low birthweight frequencies are somewhat better than corresponding statistics for the state as a whole. (The overall adverse comparison for total deliveries, 7.1% vs. 9.3% appears to be the result of a higher frequency of non-whites in the public-pay population.) Self-pay low birthweight outcomes, however, appear substantially more adverse. Low birthweights for self-pay whites occur 47% more frequently than for all Virginia whites, and the non-white frequency of low birthweight is 55% greater than for the state as a whole. Almost one in five self-pay non-white Virginians delivers a low-weight infant.

TABLE 6
LOW BIRTHWEIGHT

	VIRGINIA	SAMPLE PUBLIC	SAMPLE SELF
TOTAL DELIVERIES (5LBS 8OZ	7.1%	9.3%	13.1%
WHITES ONLY	5.7%	4.0%	8.4%
NON-WHITES ONLY	11.8%	11.5%	18.3%

Table 7 shows C-section frequencies in the various cohorts. These results appear unremarkable.

TABLE 7
C-SECTION

	VIRGINIA	SAMPLE PUBLIC	SAMPLE SELF
DELIVERIES REPORTING C-SECTION	18.3%	17.5%	21.2%

Consistent with the higher frequency of low birth weight rates included in the self-pay population, Table 8 shows a similar increased likelihood that self-pay deliveries will result in an NBICU encounter. Table 9, Diagnostic Complications, is unremarkable.

TABLE 8
NBICU ENCOUNTER

	VIRGINIA	SAMPLE PUBLIC	SAMPLE SELF
DELIVERIES REPORTING NBICU ENCOUNTER	N/A	5.4%	8.1%

TABLE 9
DIAGNOSTIC COMPLICATIONS
(DX PRINCIPLE)

	VIRGINIA	SAMPLE PUBLIC	SAMPLE SELF
COMPLICATIONS MAINLY RELATED TO PREGNANCY (640-648)	N/A	8.3%	12.0%
NORMAL DELIVERY & OTHER INDICATIONS (650-659)	N/A	71.3%	69.0%
COMPLICATIONS IN LABOR AND DELIVERY (660-669)	N/A	20.4%	19.0%

EXCLUDES FAIRFAX (NO DATA) AND MCV (INCOMPLETE DATA).

V. HOSPITAL RESOURCES CONSUMED.

Hospital resource consumption for deliveries and for newborn intensive care children is reported in Table 10 and 11. Highlights include:

- There is apparently little systematic difference in public vs. self-pay lengths of stay for mothers observed in the sample (the high self-pay LOS observed at Roanoke Memorial is caused by a single case with a 30-day LOS who was air-lifted in from another hospital).

- Newborn intensive care LOS not surprisingly is substantially longer than mothers' LOS. Publicly-paid children stayed longer than self-pays. (It should be noted that this is a small sample of a patient population that can be expected to have highly variable needs for care. Conclusions should therefore be drawn with caution.

TABLE 10
RESOURCE CONSUMPTION PATTERNS (DELIVERIES)

	VA BAPTIST	NORFOLK/ CHKD	UVA	MCV	FAIR-FAX	ROAN MEML	SAMPLE TOTAL
DELIVERIES (MOMS ONLY):							
PUBLIC CLAIMS:	30	56	48	160	15	30	339
SELF CLAIMS:	29	21	81	206	11	10	358
PUBLIC LOS:	2.8	3.9	3.3	3.7	2.9	2.5	3.4
SELF LOS:	2.9	2.6	3.4	3.7	3.5	5.5	3.6
PUBLIC DAYS:	85	216	159	586	44	76	1,166
SELF DAYS:	83	55	272	770	39	55	1,274

TABLE 11
RESOURCE CONSUMPTION PATTERNS (NBICU)

	VA BAPTIST	NORFOLK/ CHKD	UVA	MCV	FAIR-FAX	ROAN MEML	SAMPLE TOTAL
NBICU (BABIES ONLY):							
PUBLIC CLAIMS:	1	8	3	9	1	1	23
SELF CLAIMS:	2	10	10	21	1	0	45
PUBLIC LOS:	52.0	26.9	23.7	13.7	5.0	21.0	21.2
SELF LOS:	3.0	6.3	27.6	12.1	2.0	0.0	13.4
PUBLIC DAYS:	52	215	71	123	5	21	487
SELF DAYS:	6	63	276	254	2	0	601
MEMO:							
TOTAL PUBLIC DAYS:	137	431	230	709	49	97	1,653
TOTAL SELF DAYS:	89	118	548	1,024	41	55	1,875

VI. MEDICAID EXPANSION FINANCIAL IMPACT MODEL.

Historically, states were substantially restricted in their ability to provide Medicaid coverage without also providing income maintenance payments to beneficiaries. The link between welfare and Medicaid was partially severed in 1986 with the passage of "SOBRA". Under this new law, states can extend federally matched Medicaid coverage to pregnant women and young children with household incomes up to the federal poverty line without having to go to the extra expense of providing income support payments. The 1987 Assembly requested information on the costs and potential offsets to existing state-funded clinical programs that could result from a SOBRA-type expansion of Medicaid. DMAS is responding by creating a "top-down" forecast of expenses based on overall demographics and expenditure patterns. To supplement this effort, the VHA claims sample can be used to create a "bottoms-up" forecast of potential SOBRA hospital expenditures. In doing so, the following assumptions are made:

- o Valid income and household data were surveyed.
- o Non-respondents to the VHA survey fit the same income and household patterns as respondents.
- o Income and household characteristics of the public and SOBRA-eligible patients in the sampled hospitals are the same as those for public and SOBRA-eligible patients for the state in general, and can therefore be used to predict state-wide results (i.e., hospitals like those sampled may have <u>more</u> Medicaid and self-pay patients than others, but these patients are not necessarily richer or poorer than others and do not live in different kinds of families than the patients who go elsewhere to deliver).

A. Forecast Methodology.

1. Separate claims sample into "public" and "self-pay" patients (as of the date of the hospital claim).
2. Separate the self-pay sample into "determinable" and "non-determinable" patients (determinables are those who report both income and household size and a judgement on their potential Medicaid eligibility is therefore possible).
3. Separate "self-pay determinables" into three classes based on income, household size, and a "blended" Virginia Medicaid qualifying standard:
   - <u>Potential current Medicaid eligibles</u>; i.e., individuals who were self-pays at delivery but who look like they could eventually be covered under current Medicaid standards.
   - <u>"SOBRA" eligibles</u>; i.e., patients not currently Medicaid covered but potentially covered under a "SOBRA" expansion to 100% of poverty.

- Not coverable, even under a SOBRA expansion.

4. Pro-rate the "self-pay non-determinable" statistics using the fractions developed for the "self-pay determinable" population.

5. Annualize the sampled data. Calculate the expected additional Medicaid per diem payments associated with the SOBRA population.

B. SOBRA Impact on Sample Hospitals.

1. Total sample: 784 claims (includes NBICU).

	SAMPLE PUBLIC	SAMPLE SELF
Claims	370	414
Days	1,653	1,875
Charges	$ 1,554,902	$ 1,903,518
Est. Medicaid Payment	$ 882,276	N/A

2. Self-pays only: 414 claims.

	NON-DETERMINABLES	DETERMINABLES
Claims	149	265
Days	776	1,099

3. Self-pay determinables only: 265 claims.

	POTENTIAL CURRENT MEDICAID ELIGIBLE	SOBRA @ 100% ELIGIBLE	NOT COVERABLE
Claims	128	86	51
Days	695	340	163

SOBRA eligibles represent 32.5% of claims, 30.9% of days for determinable self-pays.

4. Assuming that the "non-determinables" follow the same ratios, the estimated total SOBRA portion of the sample is:

COMPUTED SOBRA DAYS:	340
NON-DETERMINABLE DAYS X 30.9%:	240
TOTAL SOBRA	580 DAYS

(NOTE: Total SOBRA claims = 134)

5. On an annual basis (i.e., the sample period was approximately 1/11th of a year), using an estimated 1988 Medicaid average payment rate (including pass-throughs) if $496/day for the six hospitals, the payment by Medicaid for 100% SOBRA coverage of

deliveries and neonates at these hospitals in 1988 would be $3.153 million on 1,473 claims.

This also assumes that everyone potentially eligible for SOBRA would take advantage of the coverage, and ignores potential impacts on medically needy spend-downs and possibly third party liability for these patients.

C. State-wide Implications.

At the VHA's request, DMAS determined that its 1986 payments were made on 15,441 inpatient obstetric/newborn claims. 6,218 (40.3%) of these occurred at the sampled hospitals. Assume that a SOBRA expansion will cause the same percentage increase in Medicaid-covered claims in the rest of the hospitals in Virginia as was observed in the sample hospitals. This implies that a SOBRA expansion that covers 1,473 new claims in sampled hospitals (as computed above) should also cover about 2,182 new claims in other hospitals.

Based on a separate, less formal survey of 28 VHA member hospitals, it was determined that Medicaid average length of obstetric stay is 3.2 days. We estimate that average total Medicaid 1988 per diem payment to all hospitals in Virginia (excluding the six target hospitals that were intensively sampled) is $517. Using these parameters we conclude:

Estimated SOBRA-related Payments (six sampled institutions)	1,473 claims	$3.153 million
Estimated SOBRA Payments (all other hospitals)	2,182 claims	$3.610 million
TOTAL SOBRA HOSPITAL IMPACT (If SOBRA in effect in F88)	3,655 claims	$6.763 million

These should be viewed as preliminary estimates and are subject to the same qualifications/caveats as listed above. Estimating the total cost to DMAS of a SOBRA initiative would also require estimates of associated costs for prenatal and delivery of professional services, charges, outpatient care, etc., and for any offsets in existing state programs.

The VHA estimates that out of almost 90,000 births each year in the Commonwealth, between 15,000 and 20,000 are uninsured and lack Medicaid. The SOBRA expansion could resolve up to 20% of these.

VII. CONCLUSIONS/RECOMMENDATIONS.

A. The data clearly indicate that the lack of coverage is accompanied by reduced access to prenatal care and to increased probability of adverse birth outcomes.

B. The VHA believes that there are clear social imperatives to expand coverage in this area and that the availability of federal matching

funds and the possibility of offsets in other, 100% state funded programs makes it economically advantageous for the Commonwealth to do so.

C. The Association remains committed to supporting the exploration and analysis of these issues. A more refined version of this study reflecting the payments actually received associated with these claims will be submitted to the Assembly later in the year.

APPENDIX E

MINUTES

Joint Subcommittee Studying Financing of Maternal and Child Health Care (SJR 172)

Monday, June 29, 1987
General Assembly Building, 6th Floor

Attending: Senators DuVal, Holland, C.A., Truban
Delegates Bloxom, Creekmore, Heilig, Munford, and Thomas
Also Bob Doutt, Dick Hickman and Jane Kusiak

The joint subcommittee was called to order at 10:30 a.m. by Bob Doutt, Deputy Clerk of the Senate. The first order of business was the election of a Chairman and Vice-Chairman. Senator Clarence A. Holland was elected Chairman and Delegate Joan H. Munford was elected Vice-President of the joint subcommittee.

A presentation of background materials on maternal and child health was made by Dick Hickman and Jane Kusiak of the Senate Finance and House Appropriations Committee staffs. Copies of the background presentation were distributed to each member and to all attendees.

Dick Hickman presented background information concerning the relationship between poor pregnancy outcomes in Virginia (including infant mortality and low birth weight) and several risk factors, including the rate of births out of wedlock. Mr. Hickman identified several obstacles to improving the delivery of care for pregnant, indigent women, including a fragmented and uncoordinated delivery system, the climate of tort liability and rising malpractice insurance premiums for obstetricians and related professionals, and the financial burden on hospitals of uncompensated care.

Senator DuVal requested additional information regarding the comparison between Virginia's infant mortality rate and the rates of other Southern States.

Delegate Munford described the work of the joint subcommittee she chairs on preventing teen-age pregnancy (HJR 280). She indicated the trend today is that the rate of births out-of-wedlock is increasing in rural areas and among younger girls. She emphasized the importance of prevention in her subcommittee's work.

There was much discussion concerning the impact of rising malpractice insurance premiums, which is the subject of the joint subcommittee on tort reform (SJR 109/HJR 221). Senator Holland reported a 47 percent increase in premiums charged by St. Paul's Fire and Marine Insurance Company, one of the largest malpractice liability insurers for doctors. Senator DuVal reported a recent increase in insurance rates for obstetrical nurses from $48 to $1,500 per year. Senator DuVal expressed concern that nurses employed by hospitals can now be sued when their hospital is sued.

Jane Kusiak described a variety of recent funding initiatives, noting the Commonwealth's total investment in this area exceeds $40 million per year. Ms. Kusiak described the 1985 expansion of Medicaid eligibility for women and children, the 1986 increase in obstetricians fees under Medicaid, the designation of regional perinatal centers and development of perinatal grants, and recent pilot programs in local health departments.

Interest was expressed by several members in receiving more information concerning current expenditures for maternal and child health. Delegate Creekmore requested information on expenditures by Eastern Virginia Medical Authority (Medical College of Hampton Road as of July 1, 1987). Delegate Bloxom requested information concerning this issue as it relates to the Eastern Shore. Delegate Munford suggested the joint subcommittee review the experience across the Commonwealth. For example, in Petersburg the teen-age pregnancy rate is twice the national rate.

Ms. Kusiak described the 1986 amendment adopted by Congress to the Omnibus Budget Reconciliation Act which gives states authority to expand Medicaid for indigent women and children. Expansion of eligibility to include all indigent women under the poverty level (which was $11,000 for a family of four in 1986) and their infants up to the age of one, would cost about $4.0 million in general funds per year, plus federal matching funds. The Department of Medical Assistance Services is now refining these estimates.

Following the presentation and discussion of background information, the joint subcommittee adopted the following meeting schedule:

- Monday, July 29 (full day)
  Virginia Beach Convention Center

- Monday, September 21 (full day)
  Lynchburg

- Monday, October 19 (half day)
  Richmond

- November (half day, date to be determined)
  Richmond

As there was no further business, the meeting was adjourned at noon.

MINUTES

Joint Subcommittee Studying Financing of
Maternal and Child Health Care (SJR 172)

Monday, July 27, 1987
Pavilion Convention Center
Virginia Beach

Attending: Senators Holland, C.A., and Delegates Bloxum, Creekmore, Heilig, Munford, and Thomas. Also Bob Doutt, Dick Hickman and Jane Kusiak

The joint subcommittee was called to order at 9:30 a.m. by Chairman Holland.

Report of the State Health Commissioner

Dr. C. M. G. Buttery, State Health Commissioner, presented an overview of problems caused by poor pregnancy outcome. Copies of the presentation were provided. Dr. Buttery compared infant mortality rates in the U.S., in Virginia, in the Southern States, and by locality within Virginia. Dr. Buttery illustrated the extent to which women receive no prenatal care in the first trimester of pregnancy, by health district. Statewide, 2,619 women did not receive care until the third trimester in 1985. Statewide, 13, 873 women received no care until the second trimester, according to Department of Health records.

Dr. Buttery also reviewed the extent of teen-age pregnancy in Virginia. The numbers of live births in 1985 per 1,000 females under age 18 in the more populous health districts were:

Health District	Teen-age Pregnancy Rate
Norfolk	330
Richmond	278
Fairfax	179
Portsmouth	156
Virginia Beach	154
Newport News	136
Prince William	114
Roanoke	100
Petersburg	89

In fact, the Cities of Norfolk, Portsmouth, Chesapeake and Virginia Beach accounted for about one fifth (767) of the 3,841 births to teen-agers age 17 and under in 1985.

Dr. Buttery emphasized that the critical elements of quality prenatal care include:

- Start care in first trimester
- Comprehensive, risk appropriate care
- Ready access to delivery
- Available high risk neonatal nursery
- Funds to obtain access to care

Care should include related support services, according to Dr. Buttery. These would include case management, social work, homemaker, transportation, nutrition, education, and home health services, as well as primary and high risk medical care. Dr. Buttery suggested more resources are needed in urban areas where the largest numbers of infant deaths are seen.

Dr. Buttery emphasized that every child born should be a well, wanted child born into a loving family. He stressed the importance of bonding of the child to two parents.

Delegate Munford spoke in favor of counseling on family planning to prevent additional unwanted pregnancies.

Reports of Local Health Departments

Dr. William H. Cope, Director of the Peninsula Health District, introduced the directors of public health for the following districts: Norfolk, Chesapeake, Virginia Beach, Hampton, and Western Tidewater. In addition, the director of nursing for the Peninsula Health District spoke for the City of Newport News. Copies of their presentations were distributed.

Norfolk. Dr. H. McDonald Rimple, Director, Norfolk Health District, stated that Norfolk had 40 percent of the Eastern Region's poor in 1985. In 1984 in Norfolk, 254 women delivered without any prenatal care. This was reduced to 96 in 1985.

Dr. Rimple noted the infant mortality rate in Norfolk was 17.5 deaths of infatns up to age one per 1,000 live births. The rate was 12.3 for whites and 25.1 for blacks. The City of Norfolk has taken actions to reduce this rate. For example, Dr. Rimple described a school based health center which will open this fall at Lake Taylor High School. This is part of the City's efforts to reduce the number of teen-age pregnancies.

Dr. Rimple also described the extension of prenatal care within the Norfolk Department of Public Health. Recently there have been waiting periods of 6-8 weeks for women to be served at local hospitals. Case management has been promoted through the field nursing component of the prenatal program. Outreach is provided through cooperation with resource mothers.

In the City of Chesapeake the poverty rate has increased from 11.2 percent in 1980 to 15.1 percent in 1986, according to Dr. Nancy Welch, District Health Director. From 1981 to 1985 the number of pregnant women requiring prenatal care through the health department increased 147 percent, from 171 to 674 women.

Chesapeake. The City of Chesapeake also received a special grant in 1983 from the Department of Health to expand clinic services. As a result, clinic utilization increased substantially from 1980 to 1985:

CLINIC UTILIZATION, CITY OF CHESAPEAKE
(1980-1985)

	Type of Clinic	
	Family Planning (# Visits)	Maternity (# Persons)
1980	450	181
1985	1,827	600
% Increase	306%	232%

Source: Chesapeake Health District

As a result of expanded efforts at the local level, the five-year aggregate infant mortality rate in Chesapeake dropped from 18.1 in 1976-1980 to 12.4 in 1981-1985. Dr. Welch illustrated this improvement by explaining that 44 infants survived to age one in Chesapeake last year, who would not have survived had the rate been 18.1 instead of 12.4.

In 1986 the General Assembly appropriated $100,000 to the City of Chesapeake for a pilot maternal and child health project. The city entered into a formal arrangement with local physicians and the hospital authority to provide delivery and newborn services to indigent women. As of this date, 550 Chesapeake residents had been served.

Virginia Beach. Dr. George Sjolund, District Health Director for Virginia Beach, indicated that high quality, comprehensive prenatal and delivery services are available in Virginia Beach. The city's effort combines the prenatal care program with a city contract with a group of local obstetricians to provide comprehensive delivery care. A delivery care component was funded with a $100,000 grant from the General Assembly in 1986. However, current funding of the health department's prenatal clinic component is still not adequate, according to Dr. Sjolund. Less than 25 percent of poor, pregnant women begin care in the first trimester.

Hampton. Dr. Carol Hogg, District Health Director for Hampton, reported that prenatal care is provided through the Hampton Health Department. The department also provides post partum care and family planning services for the mother and pediatric care for the infant.

Previously, the only delivery care was provided through the emergency room at Hampton General Hospital. With an increasing number of indigent deliveries, the rising cost of malpractice insurance, and the problems often associated with high risk maternity patients, the obstetricians at Hampton General Hospital took the position that after July 1, 1987 they would no longer deliver indigent patients from Hampton without compensation.

The 1987 General Assembly provided a $100,000 grant matched with $82,000 in local funds to contract for delivery services. The city has hired one person to (1) determine eligibility, (2) bill patients and/or third party payers for the physician's delivery charge, and (3) pay the physicians who render services in the program. The 14 obstetricians have formed a corporation and are paid monthly.

The infant mortality rate in Hampton has dropped from 18.5 in 1980 to 13.4 in 1985. For whites the rate dropped form 13.0 to 8.4, while for non-whites the rate dropped from 18.2 to 22.6.

Report on Tort Reform

Mary Devine of the Division of Legislative Services presented an overview of tort reform efforts in the General Assembly, and distributed a handout which described legislation adopted in the 1987 session. Anthony Troy of Mays & Valentine, representing the American Insurance Association, concluded there was no single solution to the medical malpractice crisis, but that a combination of actions was required. Mr. Troy referred the joint subcommittee to the recent General Accounting Office report entitled "Medical Malpractice: A Framework for Action" (May 1987). Copies of that report are available from staff.

A summary of the GAO report prepared by the American Insurance Association and the GAO executive summary are attached.

Report of the Medical Society of Virginia

Dr. Bill LeHew spoke on behalf of the Virginia Medical Society. Dr. LeHew has been a practicing obstetrician in Tidewater for over 20 years, is an Associate Professor at the Medical College of Hampton Roads, and is a member of the Governor's Perinatal Advisory Committee.

Dr. LeHew suggested this problem is multifaceted and cannot be solved by any one single action. He referred to a survey of the 630 practicing obstetricians in Virginia, conducted by the Medical Society. Only 170 (27 percent) responded but the results indicated serious problems. Of those who responded, 51 percent have limited their practice due to the availability or affordability of insurance. There is a reluctance to accept Medicaid patients.

According to Dr. LeHew, Virginia's number of low birth weight babies is relatively high. This number needs to be reduced to achieve the goal of reducing the infant mortality rate to 9 by 1990. Dr. LeHew recognized this will require greater coordination between local health departments and hospitals to provide continuity of care. Dr. LeHew reported that a committee of obstetricians has met to discuss these problems and hopes to implement its recommendations by January 1988.

Report of the Virginia Hospital Association

Katherine Webb spoke briefly for the Virginia Hospital Association. She described the survey of indigent patients now being conducted for the association. One purpose of this survey is to determine the proportion of indigent mothers who are below the poverty line. Results of this survey should be available for presentation to the next joint subcommittee meeting.

Report of the Medical College of Hampton Roads

Joe Greathouse described the obstetrical and pediatric programs at the Medical College of Hampton Roads. The College receives $4.0 million per year in state funds for indigent care. Half of this amount is allocated for graduate medical education. The other half is allocated on a formula basis to most of the hospitals in Eastern Virginia.

The formula reflects the total volume of indigent care rendered. The 25 hospitals submit audited data on their indigent care expenditures, which total $65 million per year. The $2.0 million in state funds is then allocated on the basis of each hospital's share of the $65.0 million total. Most at risk patients, however, are cared for at Norfolk General Hospital, with some at DePaul Hospital, according to Greathouse.

The number of obstetricians in medical school classes has decreased slightly, and according to Greathouse, will decrease even more over the next several years. Greathouse indicated he does not believe there is an oversupply of general practitioners, obstetricians or pediatricians in this urban area.

Delegate Munford stated there is a real shortage of physicians in rural areas. Mrs. Munford asked staff to review the feasibility of providing tax incentives for obstetricians to deliver indigent women.

As there was no further business the joint subcommittee adjourned at 1:45 p.m.

WSFHR/76

MINUTES
JOINT SUBCOMMITTEE STUDYING FINANCING OF
MATERNAL AND CHILD HEALTH CARE
(SJR 172)

Monday, September 21, 1987
Radisson Hotel, Lynchburg

Attending: Senator Holland, C.A. and Delegates Bloxum, Creekmore, Heilig, Munford, and Thomas. Also: Bob Doutt, Dick Hickman and Jane Kusiak.

The joint subcommittee was called to order at 9:30 a.m. by Chairman Holland.

Virginia Primary Care Association

Bruce Berringer, Executive Director of the Virginia Primary Care Association explained the purpose of his organization was to increase the availability of health care resources in medically underserved areas and to improve access to services. It is a non-profit organization formed in 1983 to represent the community and migrant health centers in Virginia.

There are currently 27 such centers, serving a total of 52 medically underserved areas. The centers employ 42 full-time physicians, including four obstetricians and 3 pediatricians. The centers served over 45,000 patients in 1986 and expect to serve 55-60,000 this year.

The centers received a total of $4 million in federal funds under Section 330 of the Public Health Service Act, and collected another $4 million in patient fees. Another $2.5 million was written off according to a sliding scale for subsidized or free services.

In 1985 the association began a Perinatal Initiative to develop closer links with local health departments. This involved cooperative agreements between the State Department of Health, the U.S. Public Health Service, and the association.

This initiative resulted in the establishment in August 1985 of a unique perinatal system by the Central Virginia Community Health Center and the Southside Community Hospital. This consortium recruited an obstetrician to set up the Women's Health Center in Farmville. Compensation for the obstetrician included malpractice coverage.

Since January 1986, approximately 150 deliveries have taken place under a sliding fee system. About five percent of the patients have been referred to the University of Virginia Hospital for specialized care. The remainder were delivered at Southside Community Hospital. This has provided an option for uninsured women to stay in the Farmville area to deliver their babies.

Delegate Bloxum mentioned that the Delmarva Rural Ministries also receives federal funding under the Public Health Service Act to operate the Eastern Shore Rural Health System.

Senator Holland asked about the definition of "medically-underserved areas." As designated by the Public Health Service, such areas are determined according to an index which includes percentage of population below poverty, percentage of population above age 65, the infant mortality rate, and the number of primary care physicians per 1,000 population. Below a certain index level, localities are eligible to apply for federal funds.

Virginia Hospital Association

Katherine M. Webb, Vice President/Planning and Government Relations, Virginia Hospital Association introduced Stephen C. Pace. Mr. Pace is a consultant who has completed a survey on uncompensated delivery care for VHA.

Mr. Pace collected information on about one month's Medicaid or uncompensated deliveries in six hospitals: MCV, UVA, Fairfax General, Norfolk General, Roanoke Memorial, and Virginia Baptist of Lynchburg. These six hospitals account for one fourth of all deliveries and 40 percent of all Medicaid claims in Virginia.

Mr. Pace's sample contained 2,243 deliveries, of which 697 (31 percent) were either public pay (Medicaid) or self-pay (uninsured). A follow-up will be conducted to determine what proportion of the self-pay patients' bills are eventually written off as uncompensated care.

Within the sample, the frequency of teenage mothers is about double in both the public or self-pay categories in comparison to deliveries for the Commonwealth as a whole. While 12 percent of all births in Virginia in 1985 were to mothers under age 20, 23 percent of public and 25 percent of self-pay deliveries were to mothers under age 20.

Non-white mothers account for a disproportionate share of births in the sample. While 25.5 percent of all births in Virginia in 1985 were to non-whites, 78 percent of public and 64 percent of self-pay deliveries were to non-whites.

About three-fourths of the public pay and self-pay groups reported no personal income. Average personal income for those reporting some income was about $500-$600 per month. However,

self-pay patients were twice as likely to reside in households with income (58 percent for self-pay vs. 31 percent for public pay). Average household income was about $850 per month for self-pay compared to $518 per month for public pay.

Both public and self-pay patients in the sample appear to have reduced access to prenatal care compared to Virginians in general. Only about 26 percent of all Virginia mothers have fewer than ten visits in the course of their pregnancy. However, over 50 percent of the public and self-pay mothers in the sample have fewer than ten visits.

Both the public and self-pay samples show similar visit patterns. This suggests that being on Medicaid does not necessarily mean a woman will get much more prenatal care than if she is entirely uninsured.

However, the survey found that self-pay or uninsured mothers were substantially more likely to have adverse pregnancy outcomes. For example, for non-whites only, 11.5 percent of public pay deliveries and 11.8 percent of all deliveries statewide were low birth weight deliveries. Yet, 18.3 percent of self-pay deliveries for non-whites were low birth weight. This suggests that Medicaid coverage has reduced the risk of low birth weight deliveries to non-white mothers.

Mr. Pace estimated that expanded Medicaid coverage under the proposed option (up to the poverty level) would cover about 20 percent of current uncompensated expenditures for delivery care statewide.

Secretary's Task Force

In response to the legislative intent that the issue of expanded Medicaid coverage be studied, the Secretary of Human Resources convened a task force to analyze the costs of various options. Deputy Secretary Maston T. Jacks reported on the task force findings.

Deputy Secretary Jacks recommended:

- Expand Medicaid eligibility to pregnant women and children only up to age one;
- Expand the income standard up to 100 percent of the federal poverty level;
- Extend eligibility to 60 days after delivery;
- Do not incorporate a resource standard; and
- Do not adopt the presumptive eligibility process, but develop a simplified eligibility determination process with 10-day turnaround.

The Deputy Secretary recommended expansion of prenatal services targeted on high-risk patients. These services would include nutrition counseling and patient education. For a small number of clients the services might include home health and homemaker services.

The Deputy Secretary recommended expansion of case management targeted on high risk patients and special outreach efforts. The Administration will apply to the Robert Wood Johnson Foundation for grant support.

State Teaching and Other Hospitals

Carl Fisher, Executive Director of MCV Hospitals and Peter Munger, Director of Finance for UVA Hospitals, supported the expansion of Medicaid eligibility as a means of substituting federal for state dollars for indigent care. Carl Fisher indicated that 81 percent of all deliveries are to indigent women (39 percent Medicaid plus 41 percent self-pay).

Dr. Paul Underwood, Chairman of t he Department of Obstetrics and Gynecology at UVA Hospital, also spoke. He indicated the problems facing UVA and MCV Hospitals are the same. At UVA, 85 percent of all deliveries are to indigent women. Dr. Underwood also stressed the need for a contractual relationship between the hospital and the health department.

The joint subcommittee also heard testimony from George Dawson, President, Century Health Corporation, which operates Virginia Baptist and Lynchburg General Hospitals. Dr. Dawson described the extent of neonatal services in his nine-county region (Perinatal Region 3) and the extent of his bad debts. His firm's bad debt write-off last year was $ .5 million, or $300-$350 per paying patient. He is developing a more structured relationship between his hospitals, local health departments, and private physicians to improve continuity of care. Three midwives have been hired under a contractual relationship with the local health department and the hospital has funded an obstetrician.

Dr. Harry Jarrett of Lynchburg described recent changes which have made the delivery of indigent patients a more complex issue:

- Increasing number of clinic patients;
- Increased liability insurance costs;
- Higher standards of care;
- Greater number of tests;
- Referral of high-risk patients to UVA; and,
- Increased costs.

Cooperative solutions are needed between the hospital and its obstetrical staff and the local health department. Health department clinics should provide complete prenatal coverage of patients, then hospitals can contract with physicians for delivery services.

Virginia Perinatal Advisory Council

Dr. John Kattwinkle of UVA Hospital spoke on behalf of the Virginia Perinatal Advisory Council. He described the progress made over the past ten years through regionalization of perinatal services. The number of newborn intensive care units has increased from three to seven and the number of neonatologists has increased from three to twenty-eight. Virginia's neonatal infant mortality rate has been reduced 50 percent, and Virginia's record is among the best in the country -- given the infants we have to work with.

Virginia's rate of low birth weight deliveries has decreased in the general population, but not as much among unmarried, low-income younger mothers.

In other words, Virginia has a good birthweight-specific infant mortality rate, but there are just too many low birth weight infants delivered. Addressing this problem will require altering lifestyles.

Local Health Departments

Dr. Joanna Harris spoke for the Central Virginia Health District (Lynchburg and Bedford cities; Amherst, Appomatox, Bedford, and Campbell counties). Her district received a grant of $100,000 per year under the IMPACT program. She has contracted with Virginia Baptist Hospital to provide physicians for high-risk maternity clinics, and nurse midwives. As a result, the quality of prenatal care has improved and the infant mortality rate has reached a low of 8.8 deaths (per 1,000 live births in 1986).

Dr. Harris indicated the only obstetrician in Bedford has announced he will no longer see patients who have no Medicaid or other coverage.

Dr. Harris described Lynchburg's teenage family planning clinic -- the first in Virginia, with over 400 active patients. She spoke of the need for additional funds for family planning to prevent unwanted pregnancies in the first place. Also, funds for voluntary sterilization of adults were exhausted in the first two months of this fiscal year.

Dr. Edwin Brown, Deputy Commissioner, noted the Department of Health has requested a budget addendum of $1.6 million in general funds for sterilization.

Dr. Mollie Hagan, Director, Alleghany Highlands Health District, also stressed that prevention is the key. As of September 17, 1987, a total of 547 eligible persons had applied for voluntary sterilization, of which 340 were considered high-risk. Only 151 were funded.

In Botetourt County, three-fourths of all maternal and child health clinic visits would be funded under the proposed Medicaid expansion. Almost seven percent of MCH clinic visits are currently Medicaid-eligible and another 68 percent represent clients whose income is above current Medicaid standards but below the poverty level.

Dr. Donald Stern, formerly Director of the Danville/ Pittsylvania County Health Department and as of May 1987, Regional Medical Director for the Southwest Region, addressed the joint subcommittee. While at Danville, Dr. Stern increased nursing visits from 28,000 in FY 1983 to 42,000 in FY 1986, a 50 percent increase. During this period, infant mortality dropped to an historic low of 8.5 deaths per 1,000 live births in 1985. Teen pregnancies dropped 16 percent.

Dr. Stern highlighted several actions which helped achieve these results:

- Allocated federal Maternal and Child Health (MCH) block grant funds ($16,000) to hire a social worker, nutritionist, outreach worker, nurse coordinator and clerical support. State positions were not available so the agency developed local positions through Pittsylvania County.

- Allocated federal MCH block grant funds for diagnostic tests for patients with income below the poverty level but above the Medicaid eligibility level. The agency increased the level of testing for these patients.

- Employed an OB/Gyn nurse practitioner. The agency stratified maternity care based on patient risk assessment and level of service needed.

- Reorganized patient records and follow-up to assure patients' needs were met. The agency used a case management/team approach.

- Developed cooperative efforts with local physicians and hospitals.

- Allocated a $75,000 IMPACT grant (from state general funds) each year for FY 1986 and 1987.

The Danville/Pittsylvania Health Department used the IMPACT grant to recruit obstetricians through cooperative efforts between the health department and Danville Memorial Hospital. Two obstetricians have been hired and a third is being recruited. This initiative is serving virtually all indigent women in the two localities. About 500-550 women will attend the clinics this year. Between 30-40 percent of the deliveries will be at Danville Memorial.

The program has been successful, according to Dr. Stern, by assuring access to quality perinatal care and by following up on each patient's needs.

Dr. Stern addressed efforts in Danville and Pittsylvania County to reduce teenage pregnancy.

Next Meeting Date

The joint subcommittee agreed to cancel the meeting scheduled for Monday, October 19, and to reschedule that meeting for Monday, November 9.

As there was no further business, the meeting was adjourned at 1:00 p.m.

WSFHR/101

MINUTES
JOINT SUBCOMMITTEE ON FINANCING
MATERNAL AND CHILD HEALTH
(SJR 172)
November 9, 1987
Richmond

Attending: Senators Holland, C.A. and DuVal; Delegates Bloxum, Creekmore, Heilig, Munford, and Thomas. Also: Bob Doutt, Dick Hickman and Jane Kusiak

Vice Chairman Munford called the meeting to order at 9:30 a.m.

Preventing Teenage Pregnancy

Delegate Munford described the activities and findings of her joint subcommittee on preventing teenage pregnancy. She expressed concern that this is becoming more of a rural problem and that one half of ADC payments statewide went to unmarried teenagers.

According to Delegate Munford, there are three major reasons for the increasing rate of teenage pregnancy:

1. Families in turmoil. The increasing number of one parent households is a major problem.

2. Sexual messages in the media. Sex is presented in the media as recreation without responsibility for raising children.

3. Ignorance and misinformation. Many teenagers lack basic information about reproduction, contraception and family responsibilities.

Delegate Munford viewed education as the key to solving this problem. In particular, children need to know about families. Children also need positive messages which stress abstinence and saying no to sexual activity. Children also need accurate information about reproduction and sexually transmitted diseases.

House Bill 1413 directed the Department of Education to develop a model program for family life education. This has been inaccurately labeled as sex education. For grades K-3 the model program emphasizes learning about families and what it means to be committed to a family.

House Joint Resolution 281 directed the Department of Education to work with business and industry to provide increased work/study opportunities.

During the second year of the study, Delegate Munford's joint subcommittee has worked closely with the State Board of Education on the proposed Standards of Learning for Family Life Education. The cost associated with this program is primarily due to the need for teacher training.

The joint subcommittee has also:

- Asked the Health Department to provide better family planning services to teenagers at times which are more accessible. However, the joint subcommittee concluded that health clinics for purposes of family planning in the schools were not appropriate.

- Asked the Social Services Department to increase efforts to collect child support from teen fathers.

- Encouraged the development of toll-free hot lines.

- Recommended continuation of the study and evaluation of results by an advisory group under the Governor.

Delegate Munford distributed charts to each member indicating the extent of teenage pregnancy in each locality.

Draft Report

Dick Hickman and Jane Kusiak presented a draft report which was considered and amended by the joint subcommittee.

Delegate Heilig moved, and Delegate Thomas seconded the motion that the proposed Medicaid options and increased reimbursement for obstetricians, from the 25th to the 35th percentile, be approved. The total general fund cost of these options in 1988-90 was estimated at $20.3 million. The motion passed unanimously.

Delegate Munford moved and Senator DuVal seconded the motion that the joint subcommittee affirm its support for the following budget addendum requests by the Department of Health:

1. Voluntary sterilization for adults;

2. Family planning services; and

3. Increased staffing for local health departments.

The motion passed, with Delegates Creekmore and Thomas voting against.

Staff indicated the final report would be prepared and circulated to the Members prior to the December 18 meeting of the joint money committees. A signature page would then be prepared for individual members to sign the report on December 18. Members not planning to be in Richmond on that date could make other arrangements to sign the report.

As there was no further business, the meeting was adjourned at 11:00 a.m.

WSFHR/100