JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

THE VIRGINIA GENERAL ASSEMBLY

MEDICAL ASSISTANCE PROGRAMS IN VIRGINIA: AN OVERVIEW

A report in a series focusing on medical assistance programs in the Commonwealth of Virginia

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Medical Assistance Programs in Virginia: An Overview

June 13, 1978

Joint Legislative Audit and Review Commission

Preface

This report is the first in a series of reports focusing on medical assistance programs in the Commonwealth of Virginia. It is being done as part of a pilot study under the 1978 Legislative Program Review and Evaluation Act.

The Act is intended to provide for an orderly and systematic legislative oversight process in Virginia. The review and evaluation studies are made with the cooperation of the standing committees of the General Assembly.

This Overview differs from other reports in the pilot series in that it focuses on the State's medical assistance system and the individual programs of which the system is composed. The other reports tend to focus on one of three types of service delivery--long term, inpatient, and outpatient health care.

The descriptive nature of the Overview is also unique, in that it does not attempt to evaluate programs except in a very broad sense. Its primary purposes, indeed, are to serve as a legislative reference tool, to provide some perspective on this very complex public program area, and to assist in providing a common base of information to the General Assembly.

Ray D. Pethtel

Ray D. Pethtel
Director

June 13, 1978

TABLE OF CONTENTS

Medical Assistance Programs in Virginia: An Overview

Few people realize that medical care for the poor now makes up the third largest block of expenditures in the biennial budget. Only education and transportation consume larger shares.

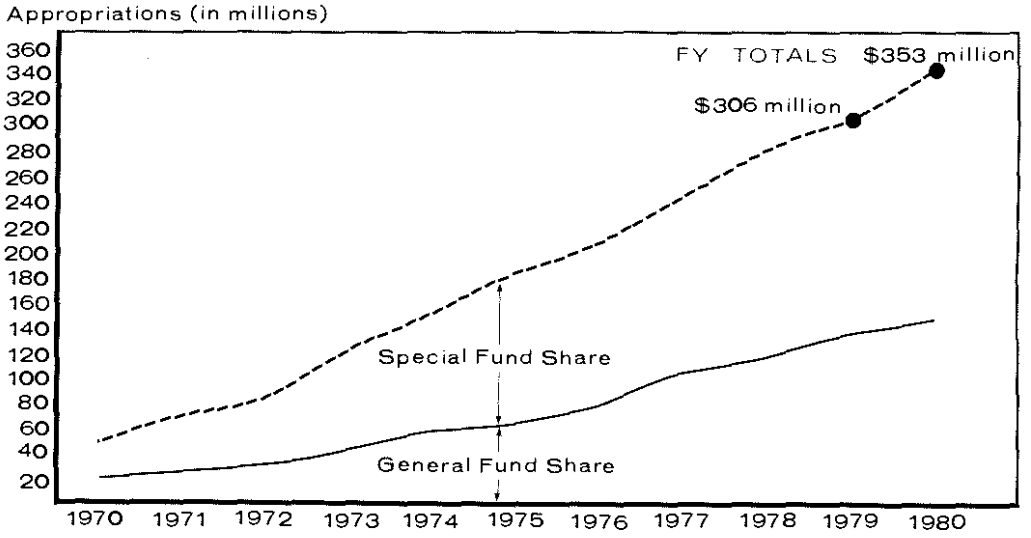
Total expenditures for all public health activities in Virginia have increased twelvefold during the past ten years, compared to a threefold increase in the State budget as a whole. Total general and special fund expenditures for indigent health care in the 1976-78 biennium will exceed $700 million. Of this total, $230 million in general fund appropriations was used to support medicaid, a federal-State program of health care assistance for the poor. During the 1978-80 biennium, general fund appropriations for medicaid increased to $286 million. (Figure 1 shows medicaid appropriation trends.)

The rapid increase in public health care costs and the massive expenditure of State funds for medicaid were primary factors in the JLARC decision to select this area for review and evaluation. The spiraling costs of health care in general have alarmed the public and focused its attention on costly health programs.

Frequent news reports of fraud and abuse associated with the medicaid program have also undermined public confidence and demonstrated a need for stringent legislative oversight.

Figure 1

VIRGINIA MEDICAID APPROPRIATIONS



Source: Commonwealth of Virginia Budgets.

Need for a Broad Scope

The rapid increase in health care costs can only be understood as part of an intricate relationship involving health care providers, insurers, government programs, and many other factors. There is no simple explanation of the problems which have resulted from spiralling health care costs.

While concern over the rising cost of medicaid was an initial impetus for this study, it was also apparent that an evaluation of medicaid by itself would be insufficient. The inter-relationships between the many health care programs and problems makes it difficult to isolate even this one predominant program. In addition, many of the reasons for the increasing costs of medicaid also account for rising costs throughout the health care field.

Therefore, JLARC found it necessary to view indigent health care in total. Medicaid, although very important, is just one of many publicly funded programs that serve the poor. These programs have evolved over the years in response to the issues and needs of their day. As a result, they vary widely in what they offer and whom they serve. Some programs, like medicaid, offer a broad range of services but only to a portion of the poor. Other programs offer specialized services to practically everyone.

In addition, the poor and many of the public programs which serve the poor are dependent on the private health care industry for the actual delivery of care. In fact, the providers of medical care to the poor are largely part of the private sector, even if reimbursed from public funds as in the case of medicaid. It is the whole health care system which provides medical services to the poor and public programs within this system cannot be adequately assessed in isolation from it.

Focus On Service Delivery

Because there is no single source of health care for the poor, and because of the many distinct and dissimilar programs which contribute in one way or another to the State's effort to provide health care to the indigent, JLARC chose to evaluate indigent care from a service delivery perspective. Health care involves three basic types of services: outpatient, inpatient, and long term care.

- *Outpatient care* is medical treatment given to persons who do not require hospitalization.

- *Inpatient care* is medical treatment given to persons required to stay overnight in a hospital.

- *Long term care* is extended treatment in nursing homes and similar institutions for patients who need daily assistance in routine activities such as eating and dressing.

Evaluating health care for the poor from this service delivery perspective allows an assessment not only of the programs involved but also of the quality and availability of patient care, issues essential to an evaluation of program effectiveness. A series of medical assistance reports is being developed to evaluate selected aspects of each service delivery area individually. This report presents a general overview of medical assistance programs available to the poor.

One additional report is being prepared on the State's Certificate of Public Need program, a regulatory program designed to hold down health care costs by controlling the proliferation of medical facilities and certain types of equipment and services. This study is being undertaken in response to a statute passed by the 1977 General Assembly mandating that an assessment of this program be carried out by JLARC.

Legislative Mandate for Comprehensive Evaluation

The entire JLARC study effort will be coordinated with legislative standing committees as directed by the Legislative Program Review and Evaluation Act of 1978. This act provides for the orderly and comprehensive legislative review of the functional areas of State government by the standing committees of the House and Senate and the JLARC.

The act provides that a pilot review and evaluation be carried out from the functional area of "Individual and Family Services" and incorporate the work already underway on health care programs. The committees participating in this pilot study will be the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health.

Organization of This Overview

The series of medical assistance reports uses as a starting point this overview of health care in Virginia, especially as it relates to the poor.

The first section of the overview consists of a survey of the indigent in Virginia, a historical summary of the evolution of health care programs for the poor and a look at general gaps in the existing system and planning efforts to close them.

The second section of the overview contains a detailed inventory of the specific health care programs which currently exist

in Virginia. The inventory is intended to serve as an information base for succeeding reports in the series. As a comprehensive catalogue of public health programs in Virginia, this inventory will itself serve as a valuable tool in understanding the diversity of available indigent care.

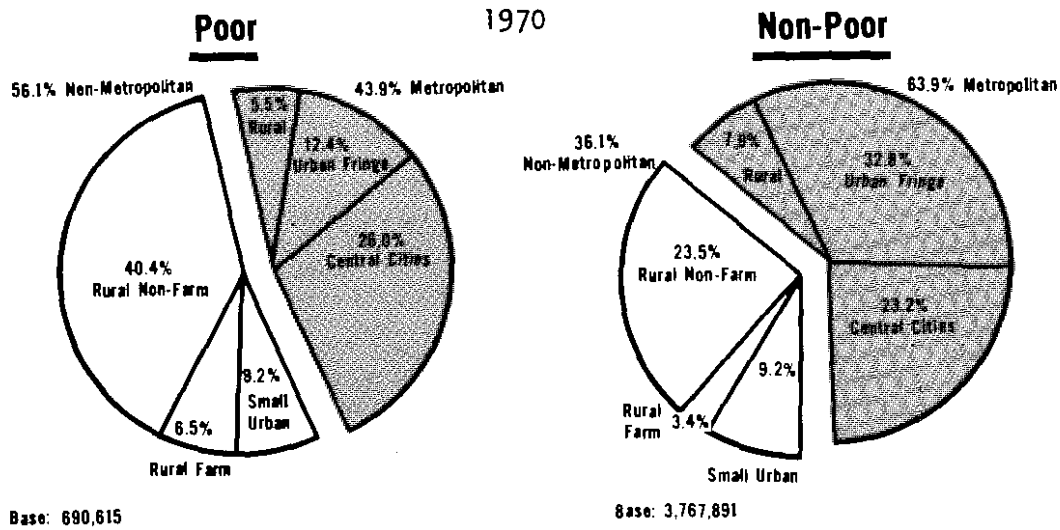
As a final note regarding the review, one point needs to be made about the scope of what is being covered in the series. A broad definition of medical care could include both physical and mental components of health. For the most part, the JLARC review has been limited to the physical, and not the mental, component of medical care. Mental health care programs are currently the subject of other legislative studies.

THE INDIGENT IN VIRGINIA

According to the 1970 census, Virginia's poor* were almost evenly divided between the rural and metropolitan areas of the State (Figure 2). Unlike many states, Virginia did not have a majority

Figure 2

DISTRIBUTION OF POOR INSIDE AND OUTSIDE MAJOR METROPOLITAN AREAS 1970



Source: U. S. Census 1970.

*These figures are based on federal guidelines to define poverty using the cost of a minimal diet as a base. Separate income levels are then calculated depending on family size, number of children, and farm-nonfarm residence. For 1977, the poverty level for a nonfarm family of four was $5,500.

of its poor concentrated in one or two major metropolitan areas. Instead, concentrations of the poor were found in many areas throughout the State as deplcted on the map in Figure 3.

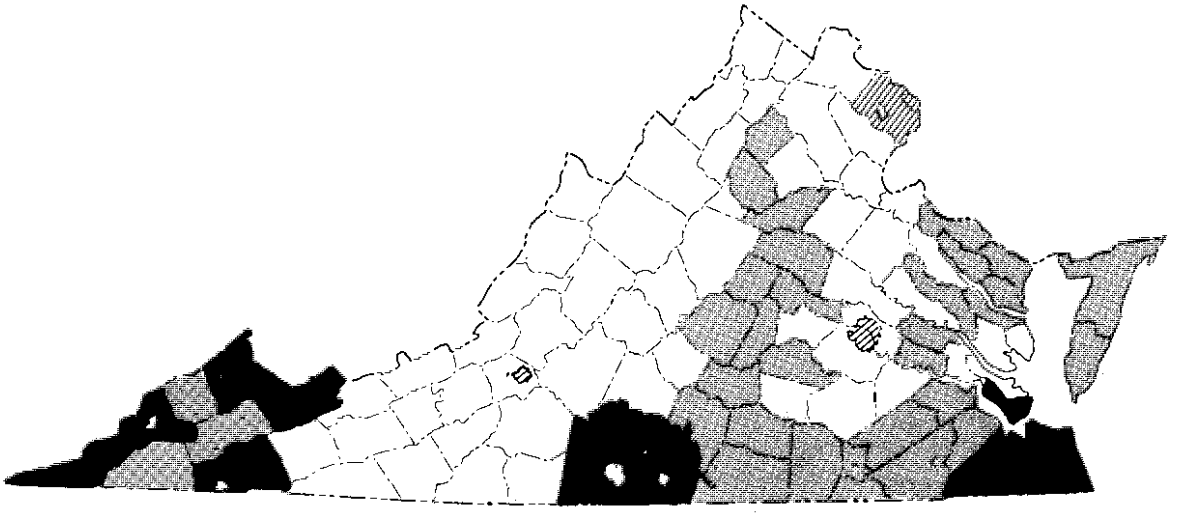
Current information on the distribution of the poor within the State is not available. However, the Bureau of the Census estimates that the percent of poor nationwide is declining. Whereas the 1970 census showed Virginia with about 700,000 poor (the 16th largest indigent population in the nation), a 1977 Bureau estimate places the number of poor in Virginia at about 500,000, dropping Virginia's current ranking to 18th.

Virginia's improved ranking reflects significant gains in per capita income relative to the national average. Per capita income in Virginia has risen from 84 percent of the national average in 1960, to 94 percent in 1970 and 99 percent today.

Detailed information concerning the impact of these income changes on poverty in Virginia's localities will not be known until 1980 census data is available. However, the greatest impact is likely to be found in Virginia's coal producing counties in the southwest which have experienced the largest per capita income gains.

Figure 3

CONCENTRATIONS OF POOR IN VIRGINIA
1970



Source: JLARC.

The implications of this decline in poverty are unclear. However, in the case of medicaid, enrollment appears to have leveled off in Virginia after experiencing a dramatic increase in the early seventies. The earlier enrollment increase accounted for much of the past increases in medicaid costs.

Despite the stabilization of the number of Virginia medicaid recipients, costs have continued to increase, partially because the mix of recipients is changing. The numbers of aged, blind, and disabled, generally the costliest groups to serve, have been increasing at a faster than average rate. This trend is expected to continue over the next biennium resulting in still higher program costs.

Health Gap Between the Poor and Nonpoor

By most available measures of health status, the poor are less healthy than the nonpoor. For instance, life expectancy for black males, the majority of whom are poor, is six years less than for white males. A similar discrepancy exists between black and white females. The difference is even more striking in terms of infant mortality rates, another indicator of health status. Infant mortality for blacks occurs at about 23 per 1,000 live births compared with a rate of only 14 among whites. It is generally recognized that this gap makes the United States rank behind many other industrialized nations when measured against these traditional health indicators.

Whether poor health is a result of poverty or poverty is a result of poor health is open to dispute. The fact remains that the poor are consistently shown to be less healthy both in short term (Figure 4) and long term conditions (Figure 5). The cause and effect relationships have not been clearly established; but such factors as inadequate housing, unsanitary living conditions, and malnutrition are most often associated with both poverty and poor health.

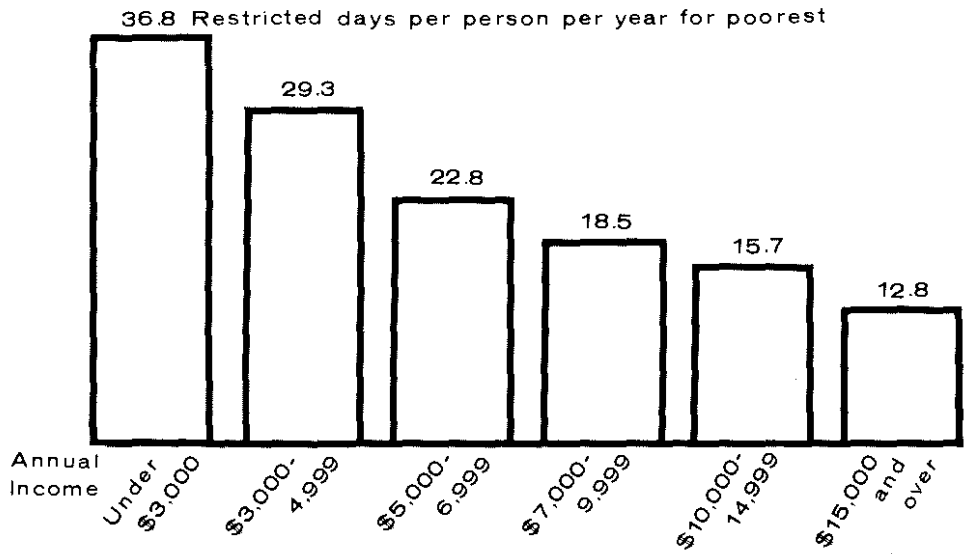
Significant efforts, both public and private, have been directed at providing adequate health care for the poor and thereby narrowing the health gap between the poor and nonpoor. The next section deals with the development of health care programs for the poor and focuses on efforts in Virginia.

MILESTONES IN THE DEVELOPMENT OF HEALTH PROGRAMS FOR THE POOR

As stated earlier, health care programs for the indigent have evolved over a long period of time in response to the needs and concerns of their day. Programs and directions established years ago continue to shape public policy today. In general, a trend of offering more services to more people can be seen.

Figure 4

MORE SICK AND INJURED DAYS FOR THE POOR

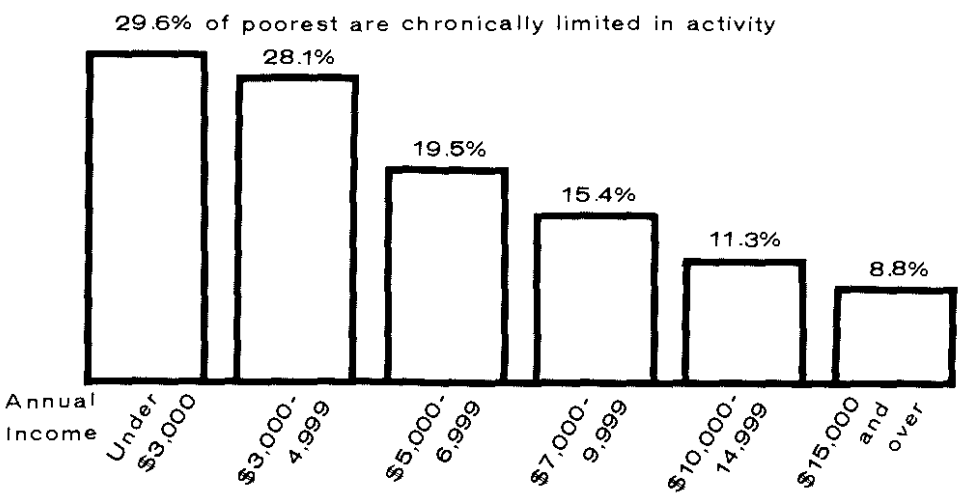


A restricted day is a day in which a person reduces his usual activities for the whole day because he is sick or injured.

Source: Health Interview Survey (Unpublished data, 1976), National Center for Health Statistics.

Figure 5

MORE POOR HAVE CHRONIC HEALTH PROBLEMS



Chronic limitation is any condition existing three months or more which prevents a person from engaging in his normal activity, school, work, or housekeeping.

Source: Same as Figure 4.

The earliest public health programs were not directed specifically at the indigent. In 1872, Virginia became the third state to establish a State Board of Health. Some cities acted even earlier. In fact, Petersburg in 1780 became the first city in the United States to create a board of health.

Virginia's State Board of Health had an uncertain beginning and went without funds for the first six years. The board members resigned, and it was not until the threat of a cholera epidemic in 1893 that funds were finally appropriated and the board reestablished. When the epidemic did not materialize, funding was suspended until 1896 when the board succeeded in securing a small appropriation. Funding has since continued uninterrupted.

In 1908, the position of health commissioner was established. The commissioner was given the statutory authority to appoint, with the approval of the board, such assistants as necessary for the performance of his duties. The Virginia Department of Health evolved from this authority. No specific statute has ever been passed establishing the State Department of Health, but the commissioner's assistants currently number in the thousands and the operating arm of the board is now a major State agency. In addition, while the statute does provide for establishing the State Board of Health and assigns it specific responsibilities in several functional areas, the Virginia *Code* does not delineate the basic purposes of the Board or its full range of responsibilities.

Virginia Medical Schools

State-supported medical schools have traditionally been an important source of medical care for the indigent. Virginia has two State-supported medical schools--the Medical College of Virginia (MCV) in Richmond and the School of Medicine of the University of Virginia in Charlottesville.

Both schools were founded in the mid-1800's and operate major teaching hospitals that provide comprehensive health care services. These services are designed to meet the instructional requirements of the medical schools as well as to provide a source of medical care for citizens of the Commonwealth, including the poor. In appropriating funds, the General Assembly recognizes the role of these schools in providing indigent care.

A third medical school, the Eastern Virginia Medical School at Norfolk, was founded just a few years ago. It is a private institution but is subsidized, in part, by State appropriations. Beginning in 1977-78, a portion of these funds were specifically identified for indigent care.

Key Dates in the Development of Public Health in Virginia

1780	*First Board of Health in the U. S. established in Petersburg, Virginia.*
1819	*School of Medicine at University of Virginia founded.*
1854	*Medical College of Virginia founded.*
1870	*Medical Society of Virginia founded.*
1872	*Act creating the State Board of Health passed.*
1908	*Position of Commissioner established.*
1932	*Bureau of Rural Health established, forerunner of Local Health Services.*
1933	*Federal Emergency Relief Act passed making funds available for the first time for medical expenses of persons on relief.*
1935	*Social Security Act passed providing public assistance funds that cover medical expenses.* *Act establishes Maternal and Child Health and Crippled Children's programs.*
1946	*State establishes State and Local Hospitalization Fund.*
1947	*Hill-Burton program started in Virginia.*
1954	*Law passed allowing local health departments to affiliate with State.*
1960	*Kerr-Mills Act passed, forerunner of Medicaid.*
1965	*Congress passes law creating Medicaid and Medicare programs.*
1966	*Congress passes Comprehensive Health Planning Act.*
1960-68	*Maternal and Child Health programs expanded to include Child Development and Family Planning.*
1968	*Congress passes Partnership for Health Act.*
1969	*Medicaid program started in Virginia.*
1971	*Last local health department joins State-Local cooperative system.*
1972	*Law passed requiring a physical exam of all children entering public schools in the State. Health Department directed to conduct free exams for the indigent.* *Congress amends Medicaid-Medicare programs. Sets up PSROs to review appropriateness of care.*
1973	*General Assembly passage of Certificate of Public Need Law.* *Eastern Virginia Medical School opens.*
1974	*Comprehensive Health Planning Act replaced by National Health Planning and Resource Development Act.*
1978	*Law passed giving Statewide Health Coordinating Council and State Department of Health responsibility for health planning.*

The New Deal--A Watershed in Subsidized Health Care

A wide variety of social programs now in effect came about as a result of the Great Depression. Provisions were made in some of the New Deal welfare programs to subsidize limited medical assistance for the poor. The Federal Emergency Relief Act of 1933 was the first such program to make federal funds available to the states to help those on relief pay for certain medical expenses.

In 1935 the Social Security Act was passed, establishing federal grants-in-aid to the states for public assistance to several categories of the needy: dependent children, the blind, and the aged. The act partially subsidized health care in that it allowed medical expenses to be used in determining the amount of financial assistance available to the needy.

The Social Security Act also established specific health programs for dependent children, expectant mothers, and crippled children. Passage of the act led to the creation that same year of the Maternal and Child Health Bureau and Crippled Children's Bureau in the Virginia Department of Health.

Post War Efforts in Virginia

Efforts were also underway at the State level to provide increased medical assistance to the poor. Significant State steps were undertaken to build hospitals and provide hospital care and specialized medical services for the poor. Some of these efforts were independent and others were spurred by federal initiatives.

SLH Funding. In 1946 the State and Local Hospitalization Fund (SLH) was established to assist localities in providing hospital care for the indigent.

Hill-Burton Participation. Additional financial assistance for hospitals came in 1947 when the Hill-Burton program was adopted by the State. The Hill-Burton program had been passed by Congress to provide funds for hospital construction. Hospitals receiving this funding were in turn required to provide an unspecified portion of their medical services to the poor. Although Congress has not appropriated funds for this program in recent years, the requirement to serve the indigent still applies for hospitals which received Hill-Burton money. Sixty-eight of Virginia's 109 licensed general hospitals were built with some assistance from this program.

Local Involvement. The advent of the Maternal and Child Health Program and Crippled Children Program in the 1930's created a growing need for a closer cooperative arrangement between the State and the various localities. Up until the 1950's, the State Department of Health worked with localities primarily through its Bureau of Rural Sanitation. As local health departments began to expand

throughout the State, this arrangement proved less and less satisfactory.

To encourage State-local cooperation, the General Assembly in 1954 passed a law that allowed most local health departments to affiliate with the State Department of Health. At that time, the department established a formula for cost sharing between the State and participating localities. By 1966 all but seven localities had joined the cooperative system. The law was amended and additional monies appropriated before these last seven localities, some of the largest in the State, affiliated. By 1971, all localities had joined the State-Local Cooperative System. In the meantime, major legislation had been passed at the federal level that dramatically expanded government funding of indigent medical care.

Social Security Amendments Expand Funding

In 1960, the Kerr-Mills Act amended the Social Security program to greatly expand the concept of subsidized medical assistance. For the first time, funds for indigent medical care were separately identified from general welfare assistance. Furthermore, benefits were extended to the aged who were not on welfare but whose incomes were insufficient to meet their medical expenses. The Kerr-Mills Act provided for open-ended federal matching payments to the provider (e.g., the hospital, doctor, etc.), instead of to the recipient as had been done in the past.

Medicare and Medicaid. The Social Security Amendments of 1965 (PL 89-97) created the medicare and medicaid programs (Title XVIII and Title XIX respectively). Medicare was designed to provide subsidized health insurance to persons 65 or older, regardless of income, who were eligible for Social Security benefits. It was seen as an extension of Social Security Insurance and was intended to remove the welfare "stigma" for elderly users that had existed under the Kerr-Mills program.

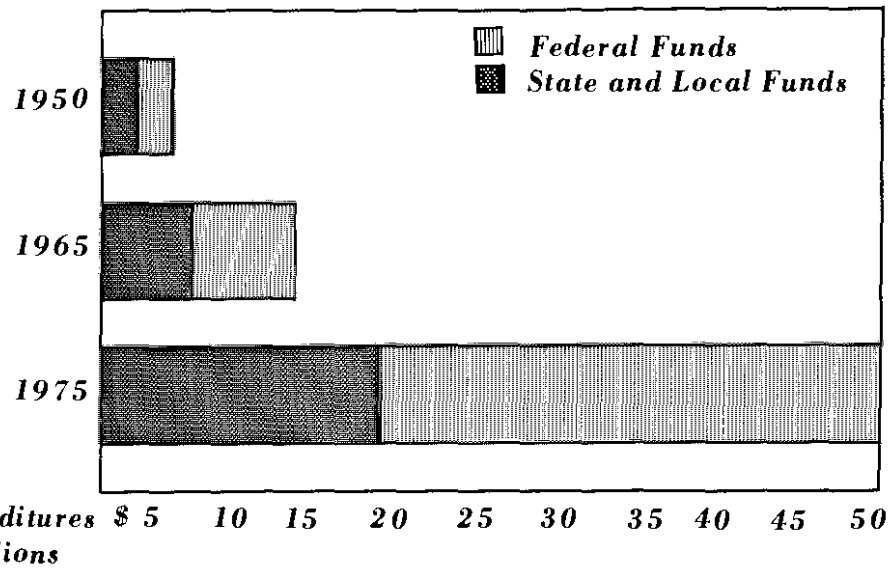
Medicaid was intended to be a simple extension of the Kerr-Mills program since it continued the concept of welfare-related payments to providers. The original goal was to provide comprehensive care to all indigents and to open the door to "mainstream" care for them. It soon became apparent that the cost of meeting this goal was going to be far greater than expected and that basic revisions to the original goal and objectives would be required.

Medicaid Revisions. By the time Virginia began to participate in medicaid in 1969, some of the program's difficulties were beginning to be understood. Problems in determining eligibility, reimbursing providers, and containing costs had already been experienced by other states. As a result, Congress had amended the act in 1967 to limit eligibility and strengthen program controls.

Congress made a further effort in 1972 to contain medicaid costs. New steps were taken to more tightly regulate the program. Provisions were made to require copayments from select eligibility groups for certain services. In addition, the federal role in oversight of State activities was increased, in part, because of the increasingly large federal role in the financing of public health programs (Figure 6). For example, a new type of regulatory agency, Professional Standards Review Organizations (PSRO), was created. These are federally funded physician organizations charged with determining if services provided under medicaid and medicare are "medically necessary" and in accordance with professional standards. Meanwhile, other legislation was being enacted that had important implications for providing health care to the indigent as well as the health care system in general.

Figure 6

NATIONAL EXPENDITURES FOR HEALTH
UNDER PUBLIC PROGRAMS



Source: "Social Welfare Expenditures, 1950-1975", Social Security Bulletin, January 1976.

The Development of Specialized Programs

In addition to medicare and medicaid, the 1960's witnessed a basic expansion of specialized programs such as the Maternal and Child Health program. Under the Kennedy administration, emphasis was placed on helping the retarded. In Virginia, this resulted in

what is now the Child Development Program which provides basic diagnostic services to children experiencing developmental problems such as retardation.

In 1966, as a result of provisions in the medicare legislation, Virginia established a Home Health program. Select provisions of the medicare legislation permit services such as physical therapy and routine injections to be administered in the home by someone other than a physician. Virginia elected to certify its local health departments to provide this type of care. The service has since been extended to include medicaid recipients.

Family planning services were added to the basic Maternal and Child Health program during the early sixties. In 1969, under the Nixon administration, family planning was extended to all who wanted it.

In 1972, the Commonwealth established the requirement that all children entering public schools be given a physical examination. The Health Department was empowered to conduct these examinations without charge to the medically indigent.

Initiatives Involving Underserved Areas

Among recent health care initiatives have been steps by the federal government to augment health care delivery to underserved areas. Although federal funds are not specifically targeted at the indigent, underserved areas generally contain a large number of poor.

Three programs have been created targeting underserved areas: Rural Health Initiatives (RHI), Urban Health Initiatives (UHI), and Health Underserved Rural Areas (HURA). Unlike most programs which provide only specific services or reimburse physicians for specific visits, these programs provide primary care. Patients are diagnosed, treated, or referred, just as the nonpoor are when they visit a general practitioner. Care is usually provided in community health centers which are open to all. Payment is based upon the ability of the patient to pay.

As of March, 1978, twelve RHI's have been funded in Virginia. HURA programs have been funded in Roanoke and Charlottesville. No UHI's have yet been funded in Virginia.

GAPS IN AVAILABILITY OF CARE

Fifty years of health legislation at both the State and federal levels have resulted in a wide assortment of publicly funded programs that offer services to the poor. Despite sharply rising expenditures for these programs, many gaps remain in the types of services available to large segments of the poor.

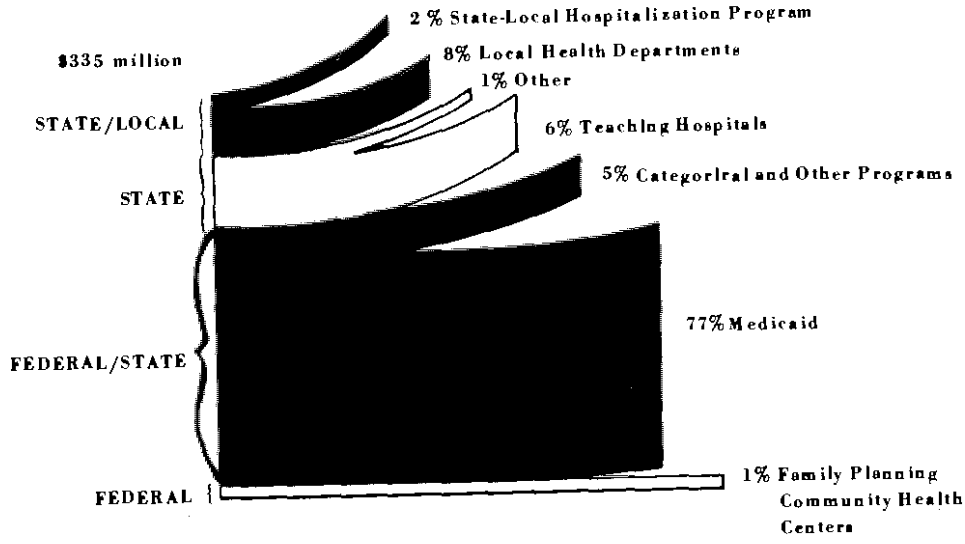
Programs vary tremendously in the types of services offered and in eligibility requirements. Some are exclusively for the poor while others serve the nonpoor as well. Many are aimed at people with only a particular type of condition or disease. Moreover, some programs are service providers while others serve as a funding source by reimbursing providers for the cost of indigent medical care. A few do both. These factors contribute to the complexity of describing medical care available to the indigent and must cause as much confusion to the indigent in seeking care as to the provider in seeking reimbursement for services.

Not everyone is eligible for the services offered through the various medical assistance programs. Income is the criterion most often used to restrict eligibility but income requirements too, differ by program. For some programs, the level of income determines if the person is eligible to receive services. In other cases, services are provided to everyone, but the patient may be required to pay all or part of the cost based on his ability to pay.

For many services, availability may be limited by other factors such as age, marital status, work status, and place of residence. Some programs require that an individual live in the locality where the service is offered. In other cases, residency is only a factor because the services are available in certain locations and distance limits participation. While most programs limit services to specifically defined eligibles, a few services are available to all without charge. These services normally involve children or are preventive in nature.

Figure 7

TOTAL EXPENDITURES FOR INDIGENT HEALTH CARE
Fiscal Year 1977



Base: $335 million excluding $2.9 million in misc. Funds

Source: JLARC.

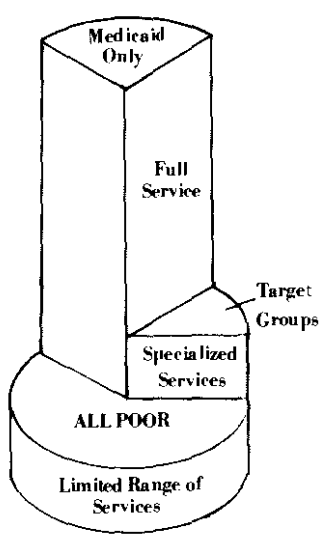
As is evident in many cases, the poor are only eligible for health care when they have a medical need covered by one of the special programs. For instance, the maternal health program will cover the hospitalization cost of a complicated delivery but not a normal delivery. The crippled children program will pay the cost of open heart surgery for a child with a congenital heart defect but will not pay the cost of treating a child with cancer. A poor person with tuberculosis can receive treatment indefinitely at Blue Ridge Sanatorium while a similar person with emphysema (a lung condition) cannot. A farm laborer suffering the loss of a leg might be fitted with an artificial limb through vocational rehabilitation, while a typist would not. These programs nonetheless represent an important, if limited health care resource to the poor.

Limited Coverage for Two Parent Families

Medicaid is the largest single indigent health care program in the State (Figure 7). In spite of this, the medicaid program only covers a limited portion of the State's poor, mainly because two parent families are not normally eligible under Virginia's program. Fewer services are available to the State's poor who do not qualify for medicaid (Figure 8).

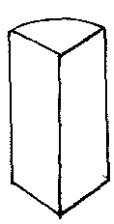
Figure 8

PORTION OF THE POOR ELIGIBLE
FOR BASIC TYPES OF MEDICAL ASSISTANCE



Full Services

Full medical services are available to only a small portion of the poor, medicaid recipients--the blind, disabled and aged, poor, and ADC (one-parent families).

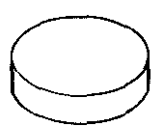


Specialized Services

Specialized medical services are available to select target groups, i.e. prenatal care for pregnant women.

Limited Services

A very limited number of services, usually preventive in nature, are available to all the poor.



Source: JLARC.

The State and Local Hospitalization Fund, the teaching hospitals, and the general medical clinics offered through local health departments represent the best alternatives for the nonmedicaid eligible to obtain basic types of general medical care. Each of these programs, however, has various limitations that prevent them from being generally available to all of the poor. Those not living near one of the two teaching hospitals or in one of the few localities having a general medical clinic are particularly hard pressed, especially those who live in areas that also lack private sector health resources.

In spite of the existing gaps, there is nevertheless a significant State commitment to medical care for the poor. The biennial expenditure of almost $700 million extends medical care to many thousands of people in the State who could not otherwise afford it.

MOVEMENT TOWARD COMPREHENSIVE HEALTH PLANNING

While the problems of rising costs, proliferating programs, and gaps in the delivery of care have long been known, planning efforts to reconcile them have generally failed. Congress recognized the ineffectiveness of existing planning efforts when in 1974 it passed the National Health Planning and Resources Act (PL 93-641) replacing the Comprehensive Health Planning Act of 1966.

The 1966 act was originally intended to help ensure that the money from the growing number of categorical programs was well spent. The act set up planning agencies at both the State and local levels. An umbrella "A" agency, as it was called, was responsible for Statewide planning. At the local level, "B" agencies were established to conduct planning within designated regions.

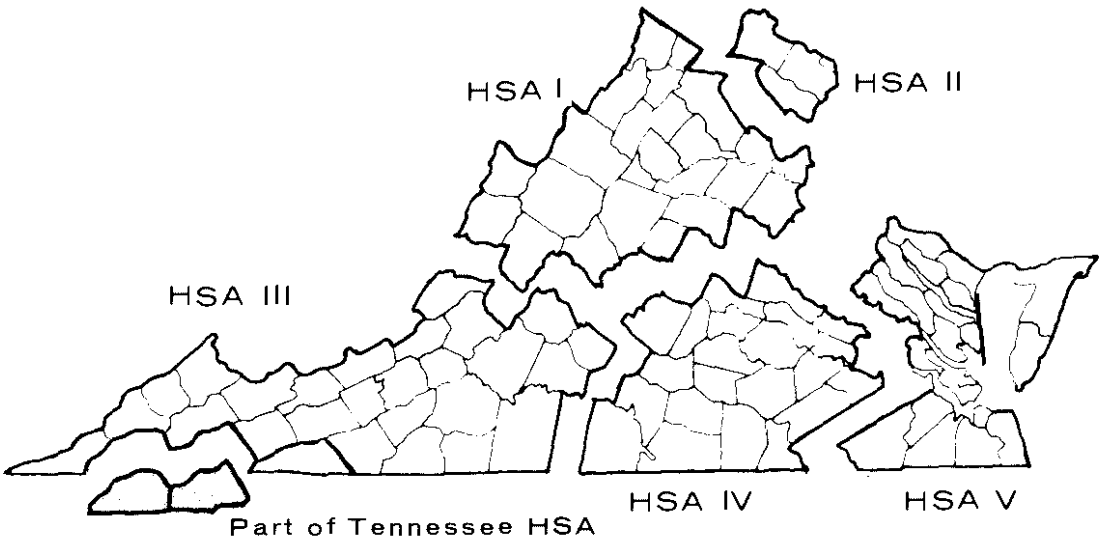
Soon after the act was passed, however, many began to view comprehensive health planning as something much more. Though unintended by Congress, many looked at the "A" agencies as a means of tying all the disparate sources of health care into a more coherent, unified, and efficient system. Unfortunately, the planning process suffered from two basic flaws that prevented it from doing either.

First, since "B" agencies were voluntary, not all regions in a state established one. In fact, Congress never appropriated enough money to fund all the "B" agencies needed to cover the country. Second, no authority was given to either the local agencies or the umbrella agency to implement the plans they were to develop. In Virginia, few plans were ever developed, let alone implemented.

The National Health Planning and Resources Act of 1974 attempted to address these deficiencies. Under the act, regional Health Systems Agencies (HSA's) were set up in every state. Unlike

Figure 9

HEALTH SERVICE AREAS IN VIRGINIA



*Washington and Scott County and the City of Bristol are part of a Tennessee Health Service Area.

Source: JLARC.

the old "B" agencies, the new HSA's covered all areas within a state (designated as Health Service Areas) and, in some cases, even cut across state boundaries to keep related areas intact. In Virginia, the city of Bristol and the adjoining counties of Washington and Scott were included in a Tennessee HSA. The rest of Virginia has been divided into five HSA's (see Figure 9).

In addition to ensuring that all regions would be covered, the new act also provided more funds for staffing the individual HSA agencies, another weakness of the old system.

Emphasis on Regional Control Under P.L. 93-641

The goal of Congress in setting up these HSA's as expressed in the act was to contain costs, increase accessibility, prevent duplication, and generally to improve the health of the people in the region. To meet these goals, the HSA's were given the responsibility of developing plans that would set priorities for their regions. To encourage the implementation of these plans, the HSA's were given funding authority over any of a limited number of programs

carried out solely within their region. HSA authority was restricted to programs funded under the Public Health Service Act, the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act or the Drug Abuse Office and Treatment Act of 1972. In the future, more programs are expected to be brought under HSA control.

As further help in implementing the plans, Congress set aside a limited amount of funds for use by the HSA's in initiating projects on their own for the benefit of their particular region.

The 1974 act does provide for a Statewide Health Coordinating Council (SHCC). The SHCC has responsibility for approving or disapproving a comprehensive State Health Plan and also has funding authority over the same federally funded programs as the HSA's in cases where the program is carried out in more than one Health Service Area. However, emphasis on regional authority is retained on the SHCC through a provision of the act which requires 60% of the SHCC members to be appointed from nominations by the individual HSA's.

By law, the SHCC is to be staffed by the State Health Planning and Development Agency. An act passed by the General Assembly in 1978 places the responsibility for conducting health planning in the State with the Department of Health and names the Department as the official State Health Planning and Development Agency for Virginia. In its capacity as the official health planning agency for the State, the Department serves as staff to the SHCC and prepares the initial draft of the State Health Plan which the SHCC must later approve or disapprove. However, the initial draft developed by the Department must be based on the individual regional plans first developed by the HSA's. The effect of this and of many of the other provisions of the law is to place heavy emphasis on regional control while deemphasizing the role of the states. Despite this regional emphasis one important area has been left to the responsibility of the State health planning agency (i.e., the State Department of Health).

In addition to drafting the State Plan, the State Health Planning agency also has responsibility for developing a separate Medical Facilities Plan as well as for administering the State's Certificate of Need program, a review program required under the 1974 act to regulate construction of new health facilities and certain types of new services and equipment. Final authority for approving or disapproving a project under this program rests with the Commissioner. Even with this authority, decisions under Certificate of Need that are contrary to the priorities set forth in the State Plan or the individual HSA plans cannot be made without justification.

Virginia's five HSA's are now fully operational. Regional plans have recently been completed and approved. All but one HSA, HSA V in Tidewater, have received full designation from HEW and can begin exercising their full authority under P.L. 93-641.

Although the National Health Planning and Resources Act addresses many of the weaknesses of prior planning efforts, it too puts little emphasis on planning and controlling the resources made available to meet the health care needs of the indigent. The act is new, however, and more attention may be focused on the poor when a better understanding of all health resources is achieved.

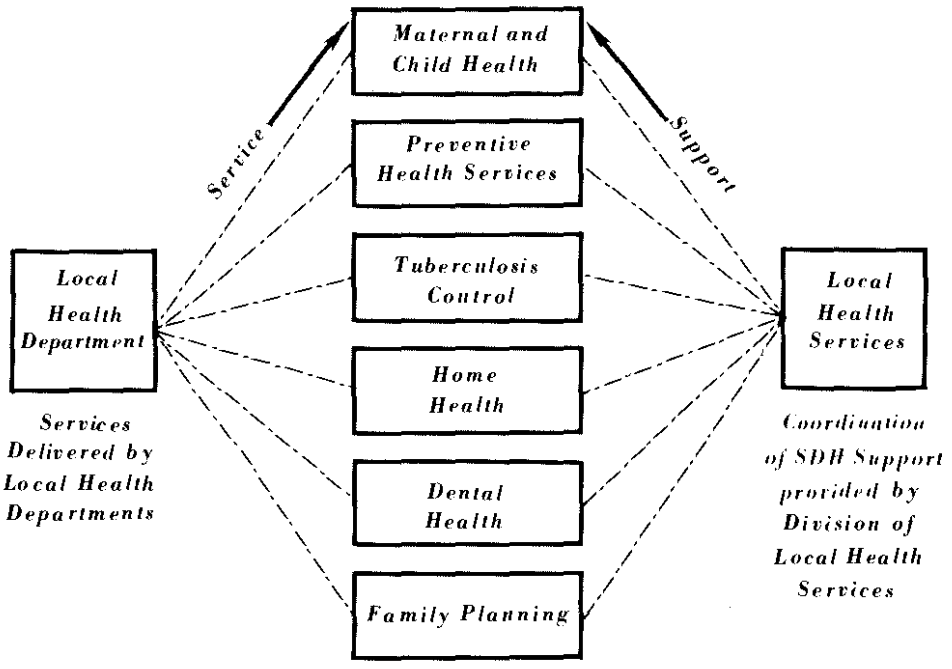
One of the first steps taken by the HSA's was to initiate a health survey of Virginians patterned after one done nationally for a number of years. Results from this survey will provide for the first time detailed information on the health status and needs of those living in the State. While the survey will not focus on the indigent *per se*, it should provide information at a sufficient level of detail to identify the needs of the poor in Virginia--both as a separate group and relative to the rest of the State. When this data becomes available later this year, the State should be in a better position to define the needs of the poor and plan for an allocation of resources to meet those needs.

Inventory of State and Federal Programs Providing Medical Assistance To The Indigent

The first section of this overview highlighted what has been done in the area of public health to address the medical needs of the indigent. This section provides a detailed description of each of the various publicly funded programs which serve as a source of health care to the State's poor. This inventory of indigent care programs is intended to serve as a comprehensive reference source on what medical care is currently available to the State's poor.

The program descriptions are arranged according to the agency principally involved in managing the program. The inventory begins with those programs under the responsibility of the State Department of Health. Within this group of programs, a distinction is made between those centrally or regionally controlled by the State Department of Health and those carried out in conjunction with local departments of health. In the case of the latter, management is shared by the department and these local offices. This arrangement is explained in greater detail under the category Local Health Services, a division within the Department of Health which serves as a focus for coordinating the management of local health department activities. The programs which are jointly managed by the State and the local health departments are illustrated below.

LOCAL HEALTH DEPARTMENT SERVICES



Text continued on page 24

STATE DEPARTMENT OF HEALTH PROGRAMS PROVIDING MEDICAL ASSISTANCE TO THE INDIGENT

PRINCIPAL MANAGEMENT AGENCY

	PROGRAM	Page Reference	SERVICES: Inpatient	Outpatient	Long-Term Care	Comprehensive	Specialized	Preventive	ELIGIBILITY: Free	Only Poor Free	By Income	Other	TARGET GROUP	EXPENDITURES Fiscal 1977: % Federal	% State	% Local	% Third Party	Total
STATE DEPARTMENT OF HEALTH	MEDICAID	25	●	●	●	●					●		Single parent families with dependent children eligible for ADC; blind, aged, and disabled individuals eligible for federal assistance under SSI	58	42	-	-	$258,258,354
	CRIPPLED CHILDREN	35	●	●			●	●		●			Children afflicted with particular types of physical diseases, defects, or conditions which "hinder normal growth and development"	52	48	-	-	$3,787,922
	CHILD DEVELOPMENT	40		●			●	●	●				Children experiencing problems in development; suspected mental retardation	60	40	-	-	$1,267,145
	LOCAL HEALTH SERVICES	42		●		●	●	●		●			Services available to all, primary emphasis on indigent and medically indigent	4	49	38	9	$28,800,000
SDH WITH LOCAL HEALTH DEPARTMENTS	MATERNAL AND CHILD HEALTH	48	●	●			●	●		●			Expectant mothers and children; primarily infants in the first year of life	81	19	-	-	$4,749,665
	FAMILY PLANNING	52		●			●	●		●			Women of child bearing age	92	8	-	-	$2,050,380
	PREVENTIVE MEDICAL SERVICES	55		●				●	●				Immunization, preschoolers; venereal disease, adults; cervical cancer, adult women	100	-	-	-	$658,661
	TUBERCULOSIS CONTROL	59		●			●	●	●				Anyone, especially the poor who, as a group, have the highest incidence of tuberculosis	-	100	-	-	$790,427
	DENTAL HEALTH	64		●			●	●		●			Anyone not under the care of private dentist, priority placed on children	-	100	-	-	$191,949
	HOME HEALTH	67		●			●			●			Anyone, with emphasis on those 65 and over on medicaid	-	6	-	94	$2,000,000

Funding From Cooperative Budgets

Eligibility Definitions

Free/ Only Poor Free – Services open to all, either without charge or free only to the poor

By Income/ Other – Eligibility for services restricted, either by income or some other basis. Services provided without charge for those eligible.

OTHER STATE AND FEDERAL PROGRAMS PROVIDING MEDICAL ASSISTANCE TO THE INDIGENT

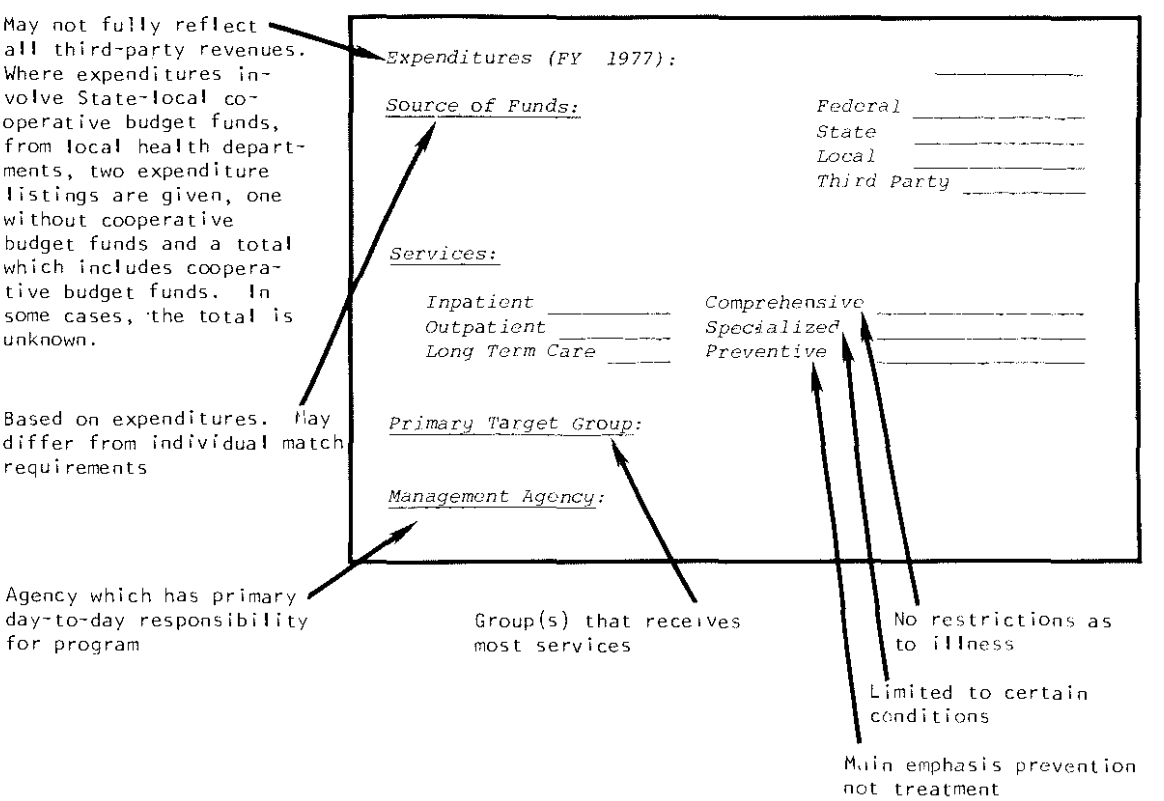
PRINCIPAL MANAGEMENT AGENCY	PROGRAM	Page Reference	SERVICES: Inpatient	SERVICES: Outpatient	SERVICES: Long-Term Care	SERVICES: Comprehensive	SERVICES: Specialized	SERVICES: Preventive	ELIGIBILITY: Free	ELIGIBILITY: Only Poor	ELIGIBILITY: By Income	ELIGIBILITY: Other	TARGET GROUP	EXPENDITURES Fiscal 1977: % Federal	% State	% Local	% Third Party	Total
REGIONAL GRANT PROGRAMS (SOH)	APPALACHIAN HEALTH PROJECT	70		●				●				●	Children living in any of seven Appalachian counties of Sourhwest Virginia	85	15	-	-	$310,829
	MIGRANT LABOR HEALTH PROJECT	73	●	●		●						●	Migrant workers and their families on Virginia's Eastern Shore	100	-	-	-	$120,000
STATE DEPARTMENT OF WELFARE	TITLE XX	75		●			●				●		Individuals receiving some form of public assistance	75	9	16	-	$3,400,000
	STATE AND LOCAL HOSPITALIZATION	79	●	●		●					●		Indigents nor eligible for medicaid or other indigent care programs	-	43	57	-	$5,622,823
	GENERAL RELIEF	83		●		●					●		Unemployable persons nor eligible for aid under a federal program	-	63	37	-	$300,938
OTHER WITHIN STATE	VOCATIONAL REHABILITATION	85	●	●			●					●	The physically and mentally disabled who are capable of productive activity	80	20	-	-	$2,317,000
	TEACHING HOSPITALS	88	●	●		●				●			Indigents nor eligible for medical assistance from other indigent care programs	-	100	-	-	$21,400,000
	BLUE RIDGE SANATORIUM	59	●				●			●			Anyone, especially the poor who, as a group, have highest incidence of tuberculosis	-	100	-	-	$3,164,370
U. S. PUBLIC HEALTH SERVICE	RURAL HEALTH INITIATIVES	91		●		●				●			Residents of medically underserved rural areas	100	-	-	-	$500,000
	HEALTH UNDERSERVED RURAL AREAS	94		●		●				●			Residents of medically underserved rural areas, parricularly those eligible for medicaid	100	-	-	-	$470,0000

The remaining programs are managed by the State Department of Welfare or other State agencies and institutions. A few, the last ones covered, are under the direction of U. S. Public Health Service and have little or no State involvement.

Key information contained in the descriptions is summarized in the chart on the preceding pages. This information is also contained at the beginning of each description in a standardized format as shown in Figure 10. Each description contains information on the administration of the program, relevant legislation, the source and level of funding, requirements for eligibility and a discussion of the types of services provided.

Figure 10

KEY TO PROGRAM SUMMARIES



Medicaid

Medicaid is the largest single indigent care program in the State. It differs from most other programs in that it provides a comprehensive range of services to those who qualify. The program functions the same as private health insurance does for the nonpoor--it reimburses providers for services rendered to anyone certified as medicaid eligible.

Expenditures (FY 1977): $258,258,354

Source of Funds:

Federal	58%
State	42%
Local	*
Third Party	

*less than 1%

Services:

Inpatient	X	Comprehensive	X
Outpatient	X	Specialized	
Long Term Care	X	Preventive	

Primary Target Group: Single-parent families with dependent children eligible for ADC; blind, aged, and disabled eligible for federal assistance under SSI.

Management Agency: State Department of Health

Virginia's medicaid program is administered centrally through the State Department of Health under rules and regulations promulgated and enforced by the Health Care Financing Administration of the U. S. Department of Health, Education and Welfare (HEW). While the State Department of Health has overall responsibility for the program, the authority for determining eligibility has been delegated to the State Department of Welfare. Actual eligibility determination is carried out through the 123 local Departments of Welfare located throughout the State. Claims processing, a major function of the program, is handled under contract with a private computer company. All other functions, such as policy formation, utilization reviews, cost control measures, and certification of providers are the sole responsibility of the Department of Health.

Legislative Base

Medicaid was created by Congress in 1965 as Title XIX of the Social Security Act (PL 89-97). Medicaid is often confused with medicare (Title XVIII, PL 89-97), a federally subsidized health insurance program for those 65 and over on Social Security. Essentially, medicaid is a health insurance program for the poor paid for

out of State and federal tax dollars; medicare is a health insurance program for the aged paid for out of Social Security employee/employer payroll contributions.

In 1966, the General Assembly authorized the State Commissioner of Health to prepare and administer a state medicaid plan for Virginia subject to the approval of HEW, the Governor, and the State Board of Health (Section 32-30.1 *Code of Virginia*). The plan was subsequently approved in June, 1969, and the program became operational on July 1 of the same year.

Source and Level of Funding

Medicaid is by far the most expensive of all the publicly-supported health programs for the poor. Expenditures for this program alone amounted to roughly $250 million in fiscal 1977 or nearly 66% of the total spent for indigent care in the State. Most of the funds for the program are used for the reimbursement of medical services used by recipients. Less than 5% are used in administrative costs. Most of the administrative costs of the program are funded 50% federal, 50% State.

The federal share of program services is determined by formula based on the state's average per capita income. The formula is designed to provide the largest federal match for those states with the lowest average per capita income. Under the formula, the highest the federal share can be is 83% with a lower limit set at 50%.

In Virginia, the federal share has been declining gradually due to a continuing rise in the State's per capita income. In 1970, the federal share for Virginia was 65.04%. For the current fiscal year 1977-78, the share was 57.01%. By October 1, 1979, the date the next adjustment will be made, the federal share may drop to 55%. Until the lower limit is met, the State can expect to pay for a larger and larger share of the medicaid program over the next few years. At the current rate of expenditures, each 1% drop in the formula represents an additional $2.5 million in State funds.

Federal law allows localities to participate in the program up to 60% of the total nonfederal share. Several states, including New York, have elected to do this and have encountered problems as a result. Virginia has elected to keep the program centrally controlled at the State level. In Virginia, only the administrative costs of eligibility determinations are shared by localities. The local share of these administrative costs is 20%; the State share is 30%; and the federal share is 50%.

Total expenditures, including the costs for eligibility determination for FY 1977, are shown in Table 1. Appropriations for FY 1979 and 1980 are $305.8 million and $353.3 million, respectively--a substantial increase from the past biennium. This excludes the costs of eligibility determination which are made by the Department of

Table 1

MEDICAID EXPENDITURES FY 1977

	Medical Services	Administration[1]	Total
Federal	$143,928,683	$ 4,865,548	$148,794,231
State	104,232,372	4,073,715	108,306,087
Local		1,158,036	1,158,036
Total	$248,161,055	$10,097,299	$258,258,354

[1]Includes cost of eligibility determination.

Source: Department of Health, Department of Welfare.

Welfare. Funds for eligibility determination are explicitly authorized but not separately identified in the budget. In FY 1977, an estimated $4.6 million was spent for this function.

Eligibility

Eligibility for medicaid is linked directly to eligibility for other federal programs. Anyone eligible for either the Aid to Families of Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program is automatically eligible for medicaid. Coverage of both the AFDC and SSI eligible is federally mandated. In addition, Virginia, like most other states, has elected to provide optional coverage for the "medically needy."

AFDC Category. Virginia is one of 24 states that elects to cover only single-parent families under AFDC. This is the Aid to Dependent Children (ADC) option. As a result, only those in single-parent families are eligible for medicaid. Excluded are all two-parent families with dependent children even though federal regulations would allow coverage of that group if covered under a state's AFDC program. A special provision in the law does allow needy children under the age of 21 to be served by medicaid even if not included under the state's AFDC program. While Virginia has not elected to cover this optional group, the State has taken advantage of a related provision which allows coverage of all foster care children.

Supplemental Security Income Category. The SSI program provides federal cash assistance (welfare) to the indigent aged, blind, and disabled. The SSI program began in 1974 when it consolidated and federalized welfare payments that had been made by State and federal-State categorical programs to these groups.

Medically Needy Category. In addition to covering ADC and SSI recipients, the states are allowed the option of providing coverage for "medically needy" individuals whose incomes are no more

than 133% of the levels set to qualify for ADC and who otherwise meet the requirements for eligibility in either of these programs. Virginia is one of 36 states that have chosen this option.

Individuals with incomes above the level set for the "medically needy" may also qualify (if categorically related) if the excess income is spent for medical expenses.

Income Criteria. The income levels set for eligibility are shown in Table 2. Allowance is made for both family size and the cost of living in the area of the State the recipient lives. Income levels for the "medically needy" are somewhat above those set for ADC; but for the most part, do not take advantage of the 133% maximum allowed.

Table 2

INCOME LIMITS FOR ELIGIBILITY UNDER MEDICAID AND AID TO DEPENDENT CHILDREN PROGRAMS[1]
(Effective July 1, 1978)

Family Size	Cost of Living Differential[2]					
	Low		Medium		High	
	ADC	Medicaid	ADC	Medicaid	ADC	Medicaid
1	$1,428	*$2,300*	$1,704	*$2,500*	$2,388	*$2,900*
2	2,244	*2,700*	2,520	*3,100*	3,204	*3,500*
3	2,892	*3,100*	3,156	*3,400*	3,804	*3,900*
4	3,504	*3,500*	3,780	*3,800*	4,464	*4,300*
5	4,128	*3,900*	4,464	*4,200*	5,304	*4,800*
6	4,632	*4,300*	4,980	*4,600*	5,808	*5,300*
7	5,232	*4,800*	5,568	*5,100*	6,408	*5,800*
8	5,880	*5,300*	6,216	*5,600*	7,056	*6,400*
9	6,432	*5,800*	6,768	*6,100*	7,608	*6,900*
10	7,020	*6,400*	7,368	*6,700*	8,196	*7,400*
each additional	588	*600*	588	*600*	588	*600*

[1]Eligibility for medicaid is based on set of figures in italics. Adjacent set of figures represents income limits for qualifying for ADC cash assistance payments. Persons above the ADC levels but still eligible for medicaid are considered to be in the "medically needy" group.

[2]Differences reflect allowance for cost of living variations in different areas of the State.

Source: State Departments of Health and Welfare.

Persons Served

The Virginia medicaid program became operational for ADC and SSI recipients on July 1, 1969, and for medically needy on January 1, 1970. From 1970 to 1976, the total number of medicaid eligibles increased by 100%, growing from 196,700 to 395,000 (Figure 11). The rate of growth stabilized during 1974 as a result of a tightening of the ADC eligibility determination process.

Since 1974, the number of SSI (aged, blind, and disabled) and SSI-related medically needy eligibles has increased more rapidly than ADC. This trend will probably continue and accelerate since ADC levels have been decreasing both nationally and in Virginia over the last two years. Between August 1975 and August 1976, the State Department of Welfare reported an ADC decrease of almost 8,000 people. This decline may be partially explained by the fact that, until this year, income eligibility levels have not been adjusted for inflation since 1973. While the total impact of this change in recipients has not yet been assessed, SSI recipients, as a group, are more expensive to serve than ADC recipients.

Recipient Categories. A total of 392,106 recipients were enrolled during FY 1976. The majority (82%) were in the federally mandated cash assistance categories, and the medically needy accounted for the remaining 18% (Table 3). A greater percentage of the medically needy were in the aged, blind, and disabled category than in the ADC-related category.

Table 3

MEDICAID ENROLLMENT, FY 1976 BY CATEGORY OF RECIPIENT

		Categorically Needy		Medically Needy	
	Total	ADC[1] &FC	Aged, Blind, Disabled	ADC[1] &FC	Aged, Blind, Disabled
Number	392,106	252,210	69,309	28,421	42,166
Percent	100	64	18	7	11

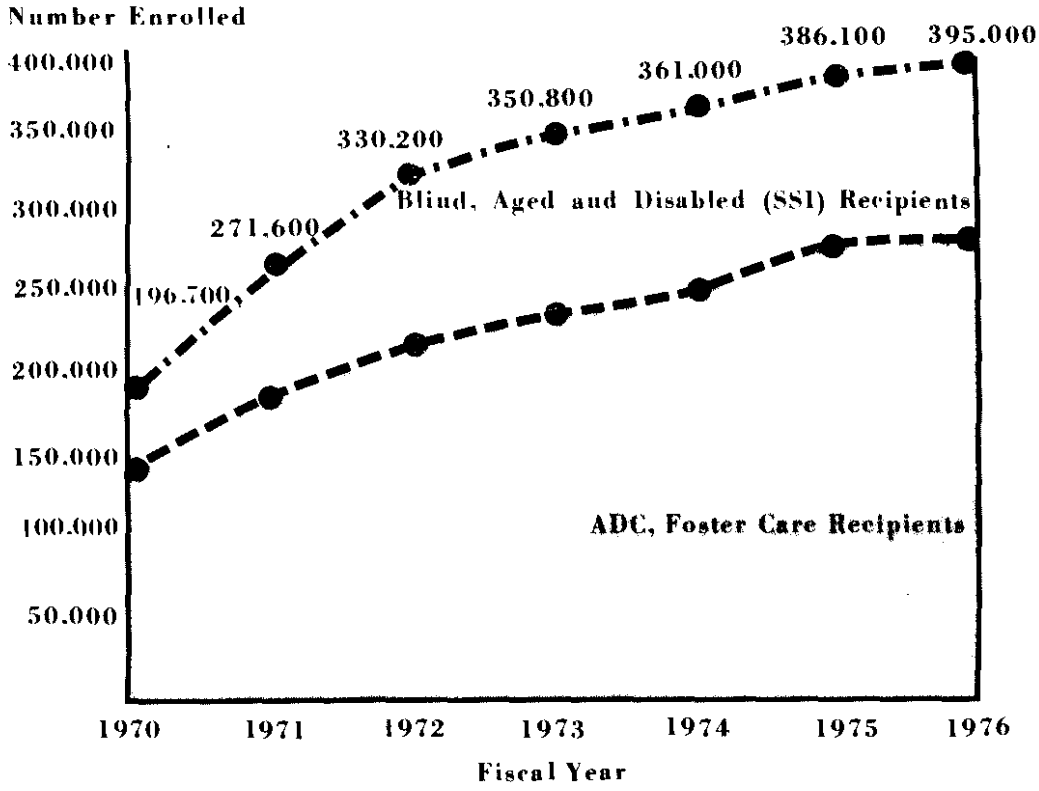
[1] Includes foster children.

Source: State Department of Health Presentation to House Appropriations Committee, December 1976.

As seen in Figure 12, SSI recipients are the most expensive category of medicaid recipients served. This is attributable primarily to the elderly in this category, many of whom require costly nursing home care. However, blind and disabled SSI recipients are also costly to serve since they often require many more services than the average ADC recipient.

Figure 11

MEDICAID ENROLLMENT FROM FY 1970 to FY 1976



Source: State Department of Health.

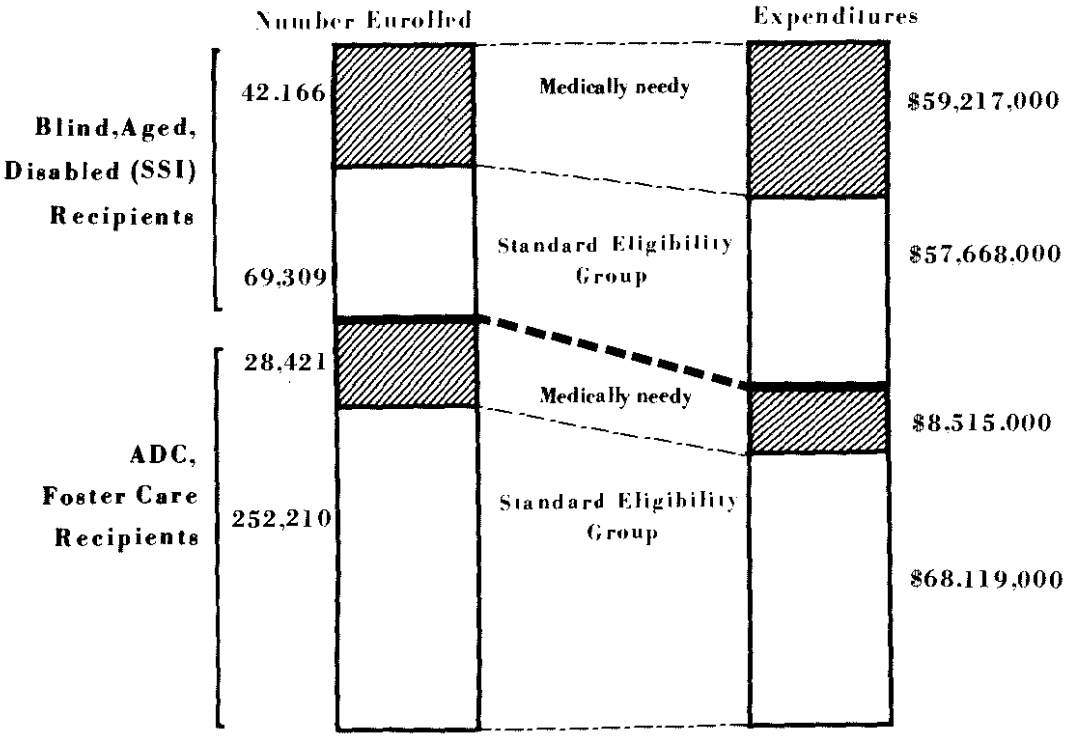
Services Provided

One of the main goals envisioned by Congress for medicaid was to open for the poor the door to mainstream care--the same type of care enjoyed by the nonpoor. To ensure that the states provided comprehensive services, the law required eight basic services to be offered. In addition, states could choose to provide a number of optional services. As shown in Figure 13, Virginia elected to provide most of the services allowable with the exception of the following:

- private duty nursing;
- adult dental services;
- chiropractor;
- prosthetic devices;
- psychiatric care for noninstitutionalized patients
- under 21 years of age.

Figure 12

MEDICAID EXPENDITURES BY CATEGORY OF RECIPIENT
FY 1976



Source: State Department of Health.

One of the mandated services that differs from all the others is Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Under the EPSDT program, all medicaid children under the age of 21 must be seen once a year and provided treatment for any condition found. This is the only service that is largely preventive rather than curative in nature. In Virginia, responsibility for this screening lies primarily with the local departments of health.

Limits on Services. According to federal law, the states determine the scope and duration of all services, including the required services. States may require preauthorization for services and nominal cost sharing by recipients. However, cost sharing may be imposed only on optional services for welfare cash recipients and on

Figure 13

MEDICAID SERVICES OFFERED IN VIRGINIA

Required by Federal Government	Additional Options Elected by Virginia
Inpatient	Intermediate Care Nursing Home
Laboratory and X-ray	Clinic Services
Physicians	Prescribed Drugs
Transportation	TB Hospitals - 65 or older
Home Health Services	Medical Supplies
Outpatient Hospital	Optometrist
Skilled Nursing Home	Intermediate and skilled care of all mentally retarded
Medical Screening Diagnosis and Treatment - under age 21 (includes dental services)	Hospital care of the medically ill 65 or older
	Mentally ill in hospitals - 65 or older

any service provided to the medically needy. In FY 1975, Virginia, like many states, found that rapid rises in costs necessitated cutbacks in services and imposed the following restrictions:

- Hospital stays limited to 14 days--extension to maximum of 21 days if medically justified.
- Required recipient copayment of $.50 for each prescription or refill. Eliminated nonprescription drugs.
- Limited medical supplies and equipment to oxygen, renal dialysis, and ostomy equipment except for patients of Home Health Agencies.
- Limited dental services to recipients under 21; fluoride, x-ray, and prophylaxis treatment (cleaning) limited to once each six months. Preauthorization required for some treatments.
- Preauthorization at local health department for
  - nonemergency medical transportation
  - optometrist services; required recipients to pay $2.00 for each pair of glasses and $.50 for repairs over $5.00. Exception is glasses prescribed for recipients under 21 as part of Early Prevention, Diagnosis, and Treatment.

Provider Reimbursement

All medicaid payments are made to providers, not to recipients. Within federal guidelines, the State establishes reimbursement methods and payment levels for each type of provider. In order to be eligible for reimbursement, providers must enroll in the program and agree to accept medicaid reimbursement as payment in full. Each broad class of provider--physicians, hospitals, etc.--is reimbursed according to different criteria.

Practitioner Reimbursement. Over 70% of all physicians in Virginia and over 60% of the dentists are enrolled in medicaid. Physicians and dentists are reimbursed on the basis of the lesser of three charges: (1) his charge for the service rendered, (2) his usual and customary fee for the service, or (3) his geographic maximum. Essentially, the fees cannot exceed those set by similar providers for equivalent services in the same community.

Pharmacy and Other Types of Providers. Reimbursement on the basis of usual and customary fees is also made to pharmacies and providers of laboratory and x-ray services, prosthetic devices and eye glasses, transportation, and medical supplies and equipment. In the case of pharmacies, the reimbursement may be less if the cost of the drug (as State or federally established) plus the State-allowed dispensing fee is lower than the usual and customary amount charged. In Virginia, the dispensing fee is set at $2.25. This fee includes $.50 the pharmacy must collect from the recipients for each prescription filled.

Hospital Reimbursement. Practically all the hospitals in the State participate in medicaid. To be enrolled, a hospital must be licensed by the State and certified by the Department of Health.

Hospitals are reimbursed on the basis of their reasonable operating and construction costs. Reasonable cost is computed as the ratio of total number of medicaid charges over the total number of all patient charges multiplied by the total cost of running a hospital.

$$\frac{\text{Medicaid Patient Charges}}{\text{Total Patient Charges}} \times \text{hospital cost} = \text{medicaid payment}$$

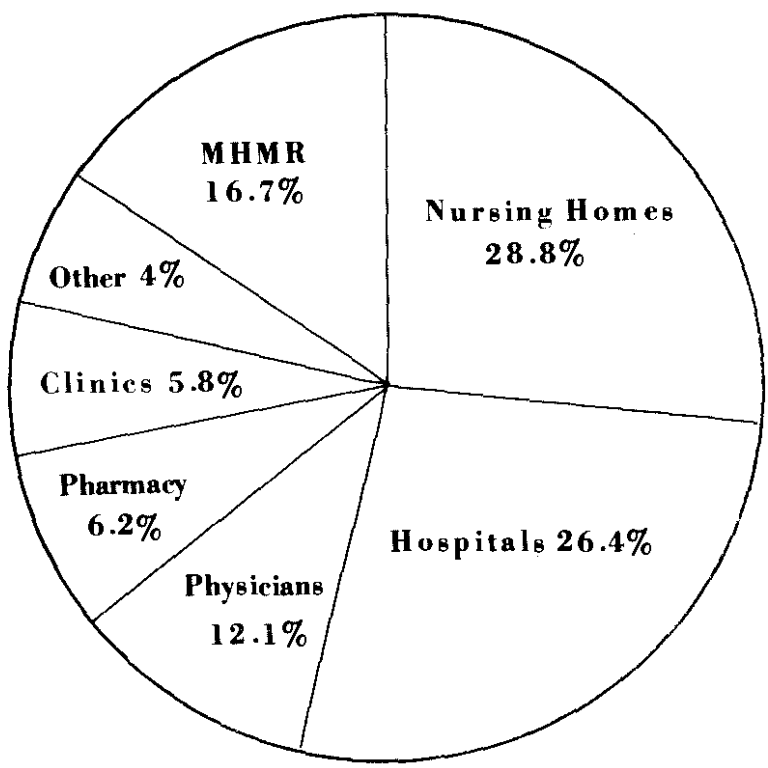
Some costs not directly related to patient care are disallowed. These include telephone, vending machines, contributions, fund raising, rental property, coffee shops, beauty and barber shops, and accelerated depreciation. The system is retrospective in that hospitals pass on allowable costs associated with patient care incurred in a given year. Based on this system, medicaid provides no incentive to hospitals for reducing costs. There is no differentiation between the reimbursement provided to an efficient hospital and that provided to an inefficient one. This problem and some possible alternative reimbursement methods will be more fully addressed in the JLARC inpatient service delivery report.

Nursing Home Reimbursement. All but 19 nursing homes in the State participate in medicaid. In Virginia, nursing homes are reimbursed on the same cost-related basis as hospitals. However, in the case of nursing homes, medicaid pays for the difference between what a patient can contribute on his own (e.g., social security if available) and the total cost of care. The State sets a ceiling on the per diem reimbursement based upon 150% of the Statewide average of all nursing home costs.

Service Expenditures. The largest single expenditure of medicaid funds is for long-term care, both nursing home care and care for those 65 and older in the State's mental institutions (see Figure 14). In the case of the latter, medicaid is actually subsidizing care the State would otherwise have to fund on its own. A full discussion of this is provided in the JLARC service delivery report on long-term care. Hospitals account for roughly one-fourth of all medicaid expenditures, physicians only 12%. The rest is used for clinic visits and various supportive services.

Figure 14

MEDICAID SERVICE EXPENDITURES FY 1977



Base: Total Expenditures $248,161,055

Source: State Department of Health.

Crippled Children

B

The crippled children's program provides a full range of diagnostic and treatment services to children afflicted with particular types of physical conditions which can hinder normal growth and development. Corrective surgery is often the main service provided by the program. Congenital heart problems, eye, and hearing defects and common types of orthopedic problems are among the types of conditions covered.

Expenditures (FY 1977): $3,787,922

Source of Funds:

Federal	52%
State	48%
Local	
Third Party	

Services:

Inpatient	X	Comprehensive	
Outpatient	X	Specialized	X
Long Term Care		Preventive	

Primary Target Group: Children afflicted with particular types of physical diseases, defects, or conditions which "hinder normal growth and development".

Management Agency: State Department of Health.

Unlike medicaid, the crippled children's program serves not just as a funding source but as a provider as well. The program is one of two centrally administered programs in the State that use regional centers to provide services. The program is administered by the Bureau of Crippled Children within the Department of Health. Services are provided at six hospital-based centers located around the State. The six centers are located in Norfolk, Richmond, Fairfax, Charlottesville, Roanoke, and Bristol. The Richmond center is unique in that it is divided among three hospitals which treat different types of conditions. In addition, there are six other hospitals located around the State that also serve as centers for certain types of cases.

In addition to the centers, clinics are held on a rotating basis at selected locations throughout the Commonwealth. For the most part, local health departments serve as sites for the clinics and for keeping in contact with the patient. Public health nurses from local health departments schedule patients for the clinics and, if necessary, follow-up on patients treated at the centers.

Legislative Base

The crippled children's program is one of the categorical programs created under Title V of the amended Social Security Act. The program dates back to the mid-1930's, and is one of the earliest federal grant-in-aid programs. Control and development of the program has been left mainly to the states; and in Virginia, the program evolved in close cooperation with the Orthopedic Society, a professional society of orthopedic specialists.

In the 1960's, the program expanded from a narrow emphasis on crippling conditions to include other conditions. The program today deals with far more than just "crippling" conditions, but takes in such conditions as burns, hemophilia, and congenital heart problems. Nonetheless, the emphasis remains on providing specialized services not readily available in a locality and covers disabilities that may be so complicated and extended in nature that the cost would be catastrophic even to families of moderate income.

Source and Level of Funding

The crippled children's program is funded jointly with federal and State funds. The State contributes $2.1 million of the total $3.9 million budget. The State is only required to match part of the federal monies on a one-to-one basis (A Fund). Once this is matched in full, B Funds become available with no further match required. There is an additional stipulation that the State must maintain the program at least at the same level it was funded in fiscal 1968. In that year, the State appropriated $568,560. Thus, in fiscal 1976, under federal guidelines, the State only needed to appropriate this amount or at most an amount equal to the A Fund or $709,700 to receive the maximum funds available. The State, however, has had a strong commitment to this program and has appropriated much more to support additional services (see Table 4).

Table 4

SOURCE OF FUNDS FY 1976

Federal Monies		$1,759,205
A Fund	$709,700	
B Fund	783,300	
RB Fund	266,205	
State General Fund		2,125,550
		$3,884,755

Source: Department of Health.

In addition to these monies, there is a special grant for a facial deformities program. In FY 1976, this grant amounted to $266,205. In FY 1977, this was reduced to $43,360. However, another

grant was awarded in this year for a special multiple handicap program at University of Virginia amounting to $169,600. Even with these additional funds, the State's contribution amounts to over half the funds available for this program.

Eligibility

Under federal law, children under the age of 21 afflicted with any physical "disease, defect, or condition which may hinder the achievement of normal growth and development" can be served by this program. In addition, in Virginia under a special provision of the 1976-78 Appropriations Act, this program can also provide services to adults suffering from cystic fibrosis or hemophilia. This was allowed since many such individuals who have been served by this program are now able to live beyond the age of 21. The bureau claims that the expertise to treat these conditions is not available outside this program, thus necessitating the care to be continued.

The program does not treat every possible disabling condition, but specializes in certain types of cases. The main target of the program centers on treating specialized cases that require hospitalization. Different centers treat different types of cases. There are 17 separate specialities in all. For instance, there is only one speciality unit for burns located at MCV to serve the entire State. On the other hand, all centers and most field offices treat orthopedic cases.

While program services are available to all without regard to economic status, charges to recipients are made based on the State income guidelines for local health department services. There are four income levels under these guidelines. The lowest level (A) was set at $5,754 for a family of four. Any family at or below this level would not be required to pay for services received through this program for an eligible child. Anyone qualified for medicaid is considered in this category. Income levels for B and C were set at $7,547 and $9,341 for a family of four respectively. Families at these incomes pay an annual clinic fee of $10 for a child in category B, $20 for a child in category C. Income above $9,341 is considered above scale (category D) and families must spend $2,000 or 20% of their income on medical expenses, whichever is greater. Once eligible, such families need only pay a $50 annual fee. It is estimated that approximately 60% of the cases served have incomes in category A, 20% in category B, 10% in category C, and 10% or less in category D.

Services Provided

A full range of diagnostic and treatment services are available to those who qualify. While most of the 20,527 cases served in FY 1977 were seen in clinics, about half were only seen once. Many of the clinic visits involve checkups for those who have received hospitalization before under the program.

About 10% (2,084) of the cases served in FY 1975 were hospitalized for an average of ten days (10.4). Furthermore, one out of every six (16.5%) of those hospitalized was subsequently readmitted. About half of all cases received other, supportive services as well, either in conjunction with a hospitalization or a clinic visit. Table 5 shows the number of cases that have received these different types of services. The table also shows the number covered by medicaid, about 20% of the total.

Table 5

SERVICES PROVIDED THROUGH CRIPPLED CHILDREN'S PROGRAM
FY 1977

	Total	BCC	Medicaid
Cases Actively Served[a]	20,527	11,924	8,603
In Clinics	20,103	11,500	8,603
In Hospitals	1,595	1,150	477
Inpatient	(1,550)	(1,104)	(477)
Outpatient	(45)	(45)	(--)
Auxiliary Services[b]	7,918	7,918	NA

NA: Not Available
[a]Out of 37,104 registered.
[b]Includes such items as braces, orthopedic shoes, x-rays, physical therapy, and drugs.

Source: Bureau of Vital Records and Health Statistics, Department of Health.

The bureau maintains a registry of the children served through the program. According to this registry, over 100,000 individuals have been served since the program first began. Of these cases, 37,104 were still considered active in fiscal 1977, though not all were necessarily served during the year. About half (20,527) the active cases received some form of services during the year. Table 6 shows the relative distribution of the different types of cases served.

Service Expenditures

A large part of the expenditures of this program are for hospitalization. In FY 1975, about $1.5 million was spent for this alone. Not all of this, however, came from money allocated to this program. A total of $548,690 of this amount represented additional funds generated from medicaid for the hospitalization costs of those eligible.

The largest category served by this program is orthopedic type cases. In fiscal 1977, $1.0 million was spent serving this group. Cost per case, however, was actually somewhat low at $108 per case. Other categories such as hemophilia or burn are more costly per case.

Table 6

DISTRIBUTION OF CHILDREN SERVED THROUGH CRIPPLED CHILDREN'S PROGRAM
(as of June 30, 1977)

Type of Case	Cases	Percent
Orthopedic[a]	7,484	36.4%
Child Neurology	3,088	15.1
Congenital Cardiac[b]	3,143	15.3
Defective Hearing	2,247	10.9
Eye Surgery	1,265	6.2
Pediatric Urology	958	4.7
Plastic Surgery	541	2.6
Facial Deformity	499	2.4
Pediatric Surgery	497	2.4
Pediatric Neurosurgery	419	2.1
Cystic Fibrosis	218	1.1
Hemophilia	67	.3
Burn Surgery	57	.3
Pediatric Endocrinology	44	.2
Total Served	20,527	100.0%

[a]Includes Cerebral Palsy, Amputee, Rheumatoid Arthritis.
[b]Includes Rheumatic Fever.

Source: Department of Health.

Child Development

The child development program is one of the few medical assistance programs that is designed to provide diagnoses and not treatment. Any child experiencing problems in development can be seen by a team of professionals consisting of a physician or nurse practitioner, a psychologist, a specialist in education, and a social worker. Once a diagnosis of the child's problem is made, suitable arrangements are made with schools or agencies in the community.

Expenditures (FY 1977): $1,267,145

Source of Funds:

Federal	60%
State	40%
Local	
Third Party	

Services:

Inpatient		Comprehensive	
Outpatient	X	Specialized	X
Long Term Care		Preventive	

Primary Target Group: Children experiencing learning difficulties; suspected mental retardation.

Management Agency: State Department of Health.

The child development program is centrally administered by a separate section under the Bureau of Child Health within the Department of Health. Services are provided through regional centers located in each of the following 12 localities:

Richmond	Danville	Fredericksburg	Charlottesville
Arlington	Lynchburg	Norfolk	Newport News
Roanoke	Petersburg	Winchester	Bristol

The Bureau of Child Health sets guidelines and acts as a technical consultant to the centers. Although some child development centers are located within local health departments, all centers have direct responsibility for the operation of their program.

Legislative Base

The child development program has evolved over the last 20 years as an outgrowth of the maternal and child health Title V legislation. The program began with four special demonstration research projects in Roanoke, Richmond, Arlington, and Norfolk. In the 1960's, others were started under the crippled children's program. In 1968-69,

maternal and child health was split into two bureaus. At that time, the various child development centers were consolidated under the Bureau of Child Health.

Source and Level of Funding

The program is funded jointly with federal and State funds under Part A of Title V of the maternal and child health program. Under this section, the State is required to match one-for-one the federal contribution.

Eligibility

Any child under the age of 21 experiencing developmental problems can be seen at any of the 12 regional centers. No restriction can be made in regard to family income. No fees may be charged for basic diagnosis; however, the cost of extra services such as x-rays, laboratory fees, and outside consultants may be charged according to the family's ability to pay.

Services Provided

The primary emphasis of the child development program is on diagnosis. In FY 1977, 3,082 children experiencing developmental problems were screened by teams of professionals through this program. Most of the children seen are from five to nine years of age. About a third of all children tested are found to be retarded. Others may have a learning disability, a language (speech) problem, and/or a behavior problem.

After diagnosing the problem, the center then recommends a suitable plan for helping the child overcome his difficulty. Occasionally, the staff may do limited, short term counseling; but if extensive treatment is called for, a referral is made elsewhere.

The program works in close cooperation with the public schools. In fact, these centers play an important part in helping the Department of Education satisfy the legislative mandate to provide for the education of all children, including those with learning problems. A full-time special education consultant from the Department of Education is assigned to each center and acts as a liaison between the schools and the center.

Local Health Services

Local health services are preventive, treatment and environmental services that are delivered through local health departments and paid for primarily by funds from State-Local cooperative budgets.

Expenditures (FY 1977): $28,800,000[1]

Source of Funds:

Federal	4%
State	49%
Local	38%
Third Party	9%

Services:

Inpatient		Comprehensive	X
Outpatient	X	Specialized	X
Long Term Care		Preventive	X

Primary Target Group: Available to all. Primary emphasis on indigent women and children and certain of the chronically ill.

Management Agency: State Department of Health in cooperation with participating localities.

[1]*Estimated cooperative budget funds only. Does not reflect an additional $16.3 million for environmental services. See funding section.*

Medicaid, crippled children, and child development are the only Statewide programs funded through the Department of Health that are centrally or regionally administered. All other medical services available to the indigent under the department's responsibility are carried out through local health departments.

The operation of local health departments in Virginia is a cooperative effort between the State Department of Health (SDH) and 136 cities and counties. The State provides nearly 60% of the operating funds for local health departments and also establishes policies and procedures to be followed in the provision of the various preventive, environmental, and treatment services. These services encompass more than just health care to the indigent. For instance, sanitation is one of the basic functions that has long been the responsibility of local health departments.

At the State level a division of the Department of Health, headed by an Assistant State Health Commissioner, has been given responsibility for local health services. The Division of Local Health Services is responsible for establishing policy and uniform practice among local health departments, particularly in regard to administrative procedures.

Oversight of such programs as maternal health or child health is the responsibility of separate bureaus in other divisions. A key function of LHS is the coordination of these bureaus and the semiautonomous local health departments. The relationship between the Division of Local Health Services and the various bureaus will be dealt with more fully in the forthcoming JLARC service delivery report on outpatient care.

At the local level, the basic operating unit of the State-local health services system is the local health district. There are 34 local health districts in all. Twenty-five local health districts are multijurisdictional. In addition, there are nine health departments that form their own districts. Multijurisdictional districts take in as few as two and as many as ten local health departments. There are 122 semiautonomous local health departments in all. All 136 localities in the State are served by either their own local health department or one of these districts.

Each district is headed by a local health director who must be a physician licensed to practice in the State. The director is appointed by the State Health Commissioner subject to the approval of the governing body of each jurisdiction in the district. All subordinate positions in the district are appointed by the health director. Supervisory positions within the district, however, are usually filled after consultation with SDH.

Local administration of the district is guided by a central management team composed of the health director, the administrative director, supervisors for public health nursing, sanitarians, and other appropriate supervisory personnel. In single jurisdictional districts, the management team is the local health department supervisory staff. It oversees a generally large program in a relatively limited geographical area. A multijurisdictional management team generally must supervise multiple staffs spread out over several counties.

The central management team and, in particular, the district director serve two basic functions. First, the team develops and oversees a program of health services for the district. Development of a program requires assessing local needs and negotiating with both local governments and SDH over funding for the program. The second function is program coordination with SDH on matters of policy and practice. SDH establishes many of the policies and procedures which local health districts must follow.

Legislative Base

The State-Local Cooperative System was established in 1954 (*Virginia Code* Section 32-40.1-.3). The program authorized most local health departments to affiliate with the State Department of Health. Central to this affiliation was an SDH-established formula for sharing the costs of operation between the State and participating localities.

By 1966, all but seven large localities had joined. The law was amended that year and additional monies appropriated before these last seven localities affiliated. Five years later, all cities and counties had joined the cooperative system. The system is unlike those in many states where local health departments remain completely autonomous.

Source and Level of Funding

Local health departments are funded to provide two basic types of services: environmental and medical. Environmental services provide protection for the entire community by ensuring that proper sanitary methods are observed by food handlers and in the disposal of human wastes. Environmental services are largely regulatory in nature.

Medical services, on the other hand, provide care to individuals through clinics, nursing visits, and consultations. Although some medical services can have benefit for the entire community (e.g., immunization and venereal disease treatment), the most recent trend has been toward medical care for the individual. Increasingly, a broader range of medical services has been directed at the indigent who do not have access to regular medical care.

The primary sources of funding for local health services are the State-local cooperative budgets. These budgets provide for the operating costs of the local health departments. Cooperative budgets thus pay for the personnel costs and overhead expenses of implementing locally such programs as maternal health, child health, home health and family planning.

The State and local shares of the cooperative budget are based on a formula devised by the State Department of Health. Under this formula, each locality must contribute its share of the budget based upon the estimated true value of real property in the community. The minimum local contribution under the present system is 18%, while the most any locality must contribute is 45%. Presently, the Statewide average is 60% State, 40% local. No ceiling technically exists on the overall amount the State must match. As a result, localities with a larger tax base are able to afford much larger budgets even though the amount they must contribute is higher on a dollar-for-dollar basis.

Historically, SDH policy has been to match all funds appropriated by localities, but budget constraints in recent years have severely reduced the availability of State funds for this purpose. As a result, SDH has been unable to fund all requested local services. In many instances, this inability to match local funding has resulted either in a reduction of service or 100% local financing of some activities.

Expenditures for local health departments and the sources of these funds are presented in Table 7. The data in this table

Table 7

SOURCE OF FUNDS FOR LOCAL HEALTH DEPARTMENT
EXPENDITURES, MEDICAL AND NONMEDICAL
Fiscal Year 1977
(Amounts in Millions)

	Funds From Cooperative Budget		Other Funds		Total	
Source	Amount	Percent	Amount	Percent	Amount	Percent
State	22.2	44%	0	0	22.2	44%
Local	17.1	34	2.1	4	19.2	38
Federal	1.6	3	3.6	7	5.2	9
LHD Revenue	4.2	8	0	0	4.2	8
Total	45.1[1]	89%	5.7	11%	50.8	100%

[1] Amount devoted to medical services estimated to be $28.8 million.

Source: Compiled by JLARC from SDH sources.

include expenditures for all services, not just medical services. The table shows the amount financed through State-local cooperative budgets as well as additional funds derived from federal grants and local supplements.

Table 7 shows that the cooperative budget is by far the major source of LHD support, amounting to $45.1 million. State funds account for slightly less than half of this sum (44%) and local monies comprise approximately one-third (34%). Federal health revenue sharing grants and revenues earned by LHD's account for the remainder of the cooperative funding.

An additional $5.7 million (11% of total) of LHD expenditures is not funded by the cooperative budgets. Federal project grants and local supplements provide these funds. Federal grants support maternal and child health projects at three LHDs and additional family planning personnel in many others. Local supplements are used to pay for additional personnel or cost of living salary differentials. For example, the Fairfax County health department fully funds 26 positions in addition to those supported by the cooperative budget and also appropriates money to cover salary differentials permitted in Northern Virginia. The Table 7 data do not include Statewide and regional services provided through LHD's such as crippled children programs or regional chest clinics. Local services provided through local positions and funds are likewise excluded. The City of Richmond Nursing Home is an example of this type of activity.

JLARC estimates that in FY 1977, $28.8 million of the $45.1 million in cooperative budget funds for local health departments were

spent for medical services. This estimate is based on a JLARC analysis of local health department cooperative budgets submitted for that year. The analysis separates the amount expended for environmental health activities from that spent for medical services. This estimate will be used as the basis for LHD medical expenditures throughout this overview and in the subsequent JLARC report on outpatient services. The estimate is being used because it better represents the amount devoted just to indigent care than would the $45.1 million total.

Eligibility

Most local health department medical services are available based on the family's ability to pay. The State has established income criteria based on family size and income. A family of four earning below $5,754 per year is not required to pay any charge for service; for those earning between $5,754 and $7,547, a payment of one-third charge is required; between $7,547 and $9,341 two-thirds of the charge is applicable; and above $9,341 full charges are assessed. Determination of ability to pay is made by the local health department when an individual first seeks services. Persons eligible for medicaid or medicare are served and the cost of the service is billed to medicaid and medicare. Some services of general public health significance, like tests for TB and venereal disease, are an exception to this and are offered free to all.

Services Provided

Much of the medical care delivered by local health departments is provided by public health nurses under the direction of a physician. In the past, the primary role of the public health nurse was to visit patients in their homes. Over the years, however, nursing time has been concentrated more in clinics.

Clinics. During fiscal year 1977, Virginians made more than 1 million visits to some 57,000 clinics held in local health departments across the State. The following are some of the basic types of clinics offered most frequently through local health departments:

Maternal and child health
Family planning
TB and respiratory
Preventive health
Dental health
General medical

Localities provide these and other types of specialized services depending on the needs of the community and the availability of qualified physicians. With the exception of general medical clinics, the services listed above are separate identifiable programs supported with State and/or federal funds. These programs and the

Table 8

PUBLIC HEALTH NURSE VISITS
FY 1977

Type	Number of Visits	Percent
Child Health	192,365	29%
Home Health	192,211	29
Crippled Children	64,445	10
Family Planning	58,838	9
Tuberculosis	48,782	7
Mental Aftercare	34,699	5
Maternal	33,625	5
Chronic Disease	28,203	4
Communicable Disease	7,038	1
Other	8,878	1
Total Visits	669,084	100%

Source: Department of Health.

services they offer will be the next described. Most of the cost of these clinics is absorbed under the cooperative budget. No estimate is available, however, on how much of this local health department money is devoted to each type of program.

Home Visits. In addition to clinics, public health nurse visits remain an important activity of local health departments. Many of these visits are follow-up visits made to people seen in clinics. Table 8 shows the relative frequency of the basic types of public health nurse visits made in fiscal 1977.

The only two identifiable programs exclusively associated with home visits by public health nurses (and not clinics) are those that come under the home health program and mental aftercare. Home health is described as a separate program in this inventory. Mental aftercare involves visits to former mental patients, many of whom have been discharged as a result of the State's policy of shifting toward more deinstitutionalized community based care. As a part of the mental rather than physical aspect of health, this program will not be described further in this inventory.

Maternal and Child Health

The maternal and child health programs provide prenatal care to expectant mothers and routine pediatric care to children, primarily infants in the first year of life. Special emphasis is placed on pregnancies that are likely to result in medical complications.

Expenditures (FY 1977) Without Cooperative Budget Funds			*Expenditures (FY 1977) With Cooperative Budget Funds*		
Total		*$4,749,665*	*Total*		*Unknown, see Funding section*
Source of Funds:	*Federal*	*81%*	*Source of Funds:*	*Federal*	
	State	*19%*		*State*	
	Local			*local*	
	Third Party			*Third Party*	
Services:	*Inpatient*	*X*		*Comprehensive*	
	Outpatient	*X*		*Specialized*	*X*
	Long Term Care			*Preventive*	*X*

Primary Target Group: Expectant mothers and children; primarily infants in the first year of life.

Management Agency: State Department of Health in conjunction with local health departments.

Maternal and infant care has long been available through most local health departments as a result of federal grant-in-aid. The program is administered through the Bureau of Child Health and the Bureau of Maternal Health. These bureaus set policy and provide technical assistance to local health departments.

Legislative Base

Maternal and child health services were offered by many local health departments even before there was a formal State and Local Cooperative System. Additional support for these services, particularly in rural areas, came in the 1930's as part of the New Deal legislation. When Title V of the amended Social Security Act was passed in 1935, maternal and child health became one of the first grant-in-aid programs. The purpose of the program as expressed in the act is "to extend and improve services for reducing infant mortality and otherwise promoting the health of mothers and children--especially in rural areas and economically distressed areas." Administrative responsibility for the program is left to the states. The Department of Health, Education, and Welfare sets policy and establishes regulations governing the use of the funds but does little to oversee the program.

The Virginia *Code* contains only one minor direct reference to the maternal and child health program. Section 32.167.1 gives the program the responsibility for certifying and licensing all midwives in the State. While additional responsibilities related to maternal and child health covered in the *Code* are assumed by the bureaus (such as the requirement that all newborns be screened for PKU, phenylketonuria, a preventable condition that leads to retardation), no specific reference exists to the original Title V legislation.

Source and Level of Funding

The basic funds for the maternal and child health program are largely federal. However, the cost of maternal and child health clinics held in local health departments is mostly absorbed under the cooperative budget. No estimate is available on how much of the $45 million in local health department funds is devoted just to this function, although this program probably consumes one of the largest blocks of LHD funds.

The availability of federal funds is made on a matching basis to the states. Funds are allocated under a formula on the basis of the proportion of live births in each state to the total births nationwide. States must match part of the federal funds (A funds) on a one-to-one basis. Once this amount is met, additional funds (B funds) become available for a number of related demonstration projects. These additional funds are made available without any added State funds required. Table 9 shows the amount of funds involved.

Table 9

SOURCE OF FUNDS FY 1977

A Fund	$1,600,395
Federal	(800,195)
State General Fund	(800,200)
B Fund-Demonstration Projects	$2,196,270[a]
Total	$3,796,665

[a]Includes $164,570 in expected third-party payments.

Source: 1976-1978 Governor's Budget Exhibit.

Eligibility

Medical care provided through the maternal and child health programs is available to any woman or infant in need of these services.

Emphasis is placed on providing free service to the indigent. Fees may be charged to the nonpoor based on income guidelines set by SDH.

Services Provided

Comprehensive prenatal care is provided to expectant mothers through clinics held in local health departments. Indigent patients not covered under medicaid and likely to encounter medical complications at the time of delivery can receive free hospitalization under this program.

Child health consists primarily of well-baby care for infants in the first year of life. For the most part, this involves routine preventive checkups and not treatment for illnesses. However, some local health departments have expanded their coverage to include treatment for illnesses of older children as well.

The Bureau of Child Health estimates that one-half (13,000) of the State's medically indigent infants receive services at local health department child health clinics in the first year of life. Approximately 150,000 child health clinic visits occur annually. Hospitalization, if required for infants from indigent families not covered by medicaid, can be paid for by this program. More recently, emphasis has been limited to newborns. Table 10 shows the number of patients for whom hospitalization was paid under the MCH program.

Table 10

FREE HOSPITALIZATION CASES

Type of Case	FY 1974	FY 1975
Obstetric	1,059	1,322
Pediatric	846	833
Premature	416	472

Source: Department of Health, Statistical Annual Report 1974, p. 203.

The federal funding arrangement for use of B funds requires that a series of related health projects be carried out by the states, including one of each of those listed in Table 11. These projects must provide comprehensive services and serve a specified geographic area. Initial projects are intended to serve as pilot projects and provide models for future projects of this nature throughout the State. (An additional requirement for family planning is met through the State's family planning program.)

Table 11

REQUIRED DEMONSTRATION PROJECTS

Project	Location	B Fund Appropriations (FY 1977)
Children and Youth	Norfolk	$ 743,825
	Charlottesville	720,000
Maternity and Infant Care	Richmond	563,745
Dental Health	Greene County	96,000
Intensive Infant	Eastern Shore	72,700
		$2,996,470

Source: State Department of Health.

Children and Youth. Although only one is required, Virginia has two children and youth projects--one in Norfolk and one at the University of Virginia at Charlottesville. These projects are similar to child health clinics except that services are more comprehensive, and a wider range of children are served. For instance, these projects include a nutrition and social worker component that normally are not provided by local health department child health services.

Maternity and Infant Care. A maternity and infant care project has been established to serve the Richmond area. The basic services provided are very similar to those available in maternal and child health clinics operated by local health departments. This special demonstration project, however, provides for additional staffing, more comprehensive care, and more emphasis on client follow-up.

Dental Health. Dental health projects provide basic dental care for preschool and school-age children. Virginia's sole dental project is operated under the auspices of the University of Virginia. Originally limited to Greene County, the project now covers Madison County as well.

Intensive Infant. Intensive infant care projects concentrate on providing improved medical and nursing supervision for infants born prematurely or with conditions detrimental to their normal growth and development. The State has one small intensive infant care project at King's Daughters Hospital in Norfolk to serve the Eastern Shore.

Family Planning

Basic forms of birth control and information on their use are available through the family planning program. These services are available through all 122 local health departments in the State.

Expenditures (FY 1977) WITHOUT Cooperative Budget Funds:			*Expenditures (FY 1977 Estimates) WITH Cooperative Budget Funds:*		
Total		*$2,050,380*[1]	*Total*		*Unknown, see Funding section*
Source of Funds:	*Federal*	*92%*	*Source of Funds:*	*Federal*	
	State			*State*	
	Local			*Local*	
	Third Party	*8%*		*Third Party*	
Services:	*Inpatient*			*Comprehensive*	
	Outpatient	*X*		*Specialized*	*X*
	Long Term Care			*Preventive*	

Primary Target Group: Women of child bearing age.

Management Agency: State Department of Health in conjunction with local health departments.

[1]*Excludes $2 million in Title XX federal funds.*

Until the end of World War II, birth control services were not freely available because Virginia, like many other states, had laws restricting their availability. In 1945, Virginia laws restricting the availability of contraceptives were abolished. Subsequently, the Commissioner of Health directed that family planning services be made available through local health departments and, in 1946, specific monies were set aside for this purpose. In 1966, the General Assembly appropriated funds specifically for family planning.

In 1970, federal support for family planning was added. It was at this time that the Department of Health created a separate Bureau of Family Planning.

Federal support began with two initial HEW grants in Virginia; one to expand family planning services in Richmond, and one shortly thereafter to Norfolk. In 1972, a third HEW grant was made for family planning services in northern Virginia. In 1973, these three grants were consolidated into one single categorical grant for Statewide use. Until then, the program was largely a federal-local program with limited State responsibilities.

After the grants were consolidated, the State assumed more responsibility. Currently, HEW sets policy and establishes regulations for implementing the program. Administrative responsibility for the program, however, now rests with the Bureau of Family Planning. The

bureau interprets HEW regulations, monitors, evaluates, and assists the local health departments with special problems encountered in the operation of the program.

Legislative Base

Current programs are based on the Family Planning Services and Population Research Act of 1970 (PL 91-572) which added Title X, "Population Research and Voluntary Planning Programs", to the Public Health Services Act. Section 1001 of the act authorizes grants to be made to assist in establishing and operating family planning projects. The purpose of these projects is to provide family planning services so individuals can have the freedom to determine the number and spacing of their children. This program is one of the few whose funding must be authorized under the new health planning act (PL 93-641).

F

Source and Level of Funding

The family planning program is mainly supported through Title X money. However, additional monies for family planning are also available from Title V of the Maternal and Child Health Section of the Social Security Act of 1935. A 1970 amendment to Title V requires that no less than 6% of the funds for maternal and child health be devoted to family planning. In the past family planning has also received significant Title XX welfare funds because family planning is one of six basic mandated services. From November 1, 1976 to July 1, 1977, the Department of Welfare elected to make family planning universally available with these monies. That meant that anyone, regardless of income, could receive family planning services free. This policy was subsequently changed.

Currently, Title XX funds are still available but on a more restricted basis. Table 12 shows the different amounts of funds supporting this program. Note that these figures do not include the costs covered by the local health departments through the cooperative budgets. In fiscal 1975, this was estimated to be 62% of the cost of the entire program. The figures shown also do not include the cost of family planning services received through a private physician's office and paid for through medicaid or Title XX.

Eligibility

No restriction is placed on who may be served through this program although priority is placed on serving individuals from low income families. Under federal guidelines, anyone with an income below 150% of the federal definition of poverty must be served free.

Table 12

SOURCE OF FUNDS
FY 1977

			Program Total
Title X	Federal	$1,650,000	$1,734,630
	Other	84,630	
Title V	Federal	229,245	458,495
	State General Fund	229,250	
Medicaid			43,000
Title XX			2,000,000
Total			$4,236,125

Source: 1976-78 Governor's Budget Exhibit and Bureau of Family Planning.

If the person is eligible for medicaid, medicaid will be billed. Many indigents not covered under medicaid in Virginia, such as two parent families, can receive free services under Title XX.

Services Provided

Family planning clinics are held periodically in every local health department. An individual attending one of these clinics is counseled and provided the appropriate form of contraceptive. The process involves a one-on-one counseling session, followed by a group lecture on family planning methods, and a physical exam by a doctor. The doctor will then prescribe the birth control method preferred. Sterilizations, including tubal ligations, hysterectomies, and vasectomies are available through this program. In addition to providing contraceptives, the program also will provide medical help or referral for patients with infertility problems.

In fiscal 1977, about 94,000 people were served through this program. The goal is to reach 75% of all the indigents in need of family planning by July 1, 1978--about 167,000 individuals.

Preventive Medical Services

Preventive medical services encompass a variety of programs, most of which are intended to benefit the community at large. Nonetheless, some, like immunizations, involve direct medical services that are of benefit to the poor.

Expenditures (FY 1977) WITHOUT Cooperative Budget Funds:		*Expenditures (FY 1977 Estimates) WITH Cooperative Budget Funds:*	
Total[1]	*$658,661*	*Total*	*$2.0 million*
VD Control	*429,664*	*Distribution of additional funds unknown.*	
Cervical Cancer Screening	*157,557*		
Immunization	*71,440*		
Source of Funds: *Federal*	*100%*	*Source of Funds:* *Federal*	
State		*State*	
Local		*Local*	
Third Party		*Third Party*	
Services: *Inpatient*		*Comprehensive*	
Outpatient	*X*	*Specialized*	
Long Term Care		*Preventive*	*X*

Primary Target Group: Immunization; preschoolers. Venereal disease; adults. Cervical cancer; adult women.

Management Agency: State Department of Health in conjunction with local health departments.

[1] *The allocation of $620,764 in State funds appropriated to the Bureau of PMS in FY 1977 among these three programs is unknown.*

The administration of these programs is the responsibility of the Bureau of Preventive Medical Services. Of the programs administered by the bureau, three are of direct significance to the poor in terms of the services provided: chronic disease control, venereal disease control, and immunizations. Each is carried out through local health departments. The bureau's other programs--disaster medical services, emergency medical services, epidemiology, and the control of hospital-acquired infections are of more general significance to the community as a whole.

Legislative Base

The control and reporting of communicable diseases has long been the responsibility of the states. Immunization programs are authorized by §32-36 of the *Code of Virginia*. This section provides general authority to localities to require vaccination for the purpose of preventing epidemics. Section 32-57.1 requires that children

be immunized against diptheria, tetnus, whooping cough, and polio by the age of one year, and against measles and German measles by age two. State health regulations promulgated pursuant to this section further require the prescribed vaccinations be administered before a child is admitted to a public school, and §22-220.1 also imposes this requirement.

Federal support of venereal disease control dates back to World War I. At the State level, venereal disease control is authorized by statutes on the control of communicable disease. Section 32-90 of the *Code* declares VD to be dangerous, and §32-91 requires physicians and medical personnel to report all positive laboratory tests for VD to the State Board of Health. Section 32-93 requires local health officers to investigate all suspected cases of VD and authorizes them to require physical examinations of infected persons. Local health officers may quarantine identified cases if necessary (§32-96).

Control of chronic diseases has largely been a federal, not a state, concern. Passage of the Heart Disease, Cancer and Stroke Amendments Act (PL 89-239) created additional support for such efforts as Virginia's screening program for diabetes and cervical cancer. However, no legislation exists at the State level specifically authorizing such activities.

Source and Level of Funding

Much of the funding for preventive health services comes from the federal government. In addition, the cost of services carried out through local health departments is largely through their cooperative budgets. Most of the cost of lab tests and some personnel costs are paid for in this way. While the bureau does receive $620,746 in State appropriations, the distribution of this money among the different programs is unknown. Bureau and federal funds, together with the costs absorbed through the cooperative budgets, could amount to as much as $2 million.

Eligibility

Preventive health services are available without charge to all segments of the population, poor and nonpoor alike. The rationale for this policy is that the community as a whole benefits from the detection and elimination of certain diseases and that charging for preventive health services would discourage individuals from seeking care and thus reduce protection to others living in the community.

Services Provided

Preventive medical service programs have two basic functions. The immunization and VD control programs attempt to control communicable diseases which can threaten the entire community. Screening programs, such as the cervical cancer program, are aimed principally at the individual. Early detection is aimed at minimizing the risk of preventable disabling and life threatening health conditions.

Immunization. The immunization program provides for the distribution of vaccines and for the Statewide assessment of immunization levels. Emphasis is placed on immunizations against childhood diseases.

Presently, immunization levels for these diseases are needlessly low both in the State and nation. In July, 1975, SDH conducted a survey of immunization levels of two-year old children in Virginia. Although the survey showed that levels for all categories had increased since 1974, and that Virginia immunization levels exceeded the national average, only 60% of Virginia's two-year olds were shown to be immunized against basic childhood diseases (Table 13).

Table 13

STATE AND NATIONAL IMMUNIZATION LEVELS

Vaccine	Virginia 1975	Virginia 1974	United States[1] 1974
Polio (3+doses)	80.5%	69.1%	63.1%
DPT (3+doses)	88.7	81.3	73.9
Measles	83.8	80.6	64.5
Rubella	80.9	71.0	59.8
Mumps	59.9	40.2	NA
Polio (3+),DPT (3+), Measles, & Rubella[2]	59.8	52.8	NA

[1]Data taken from 1974 U.S. Immunization Survey and includes children ages one to four years.

[2]Represents completion of basic series of immunizations.

NA: Not available.

Source: SDH, Statewide Immunization Survey of Two-Year Old Children, July 1975.

The long term objective of the immunization program is to raise immunization levels of preschool (0-4 years) and school enterers (5-6 years) to 90 and 95% respectively. Short term goals include assessing immunization levels of school enterers, maintaining existing levels, increasing surveillance, and reporting of communicable diseases and improving public information. Local health departments conducted 2,650 immunization clinics between January and June 1975, an average of 440 clinics per month. Total attendance at these clinics was 51,373 or 19 persons per clinic.

Venereal Disease Control. The venereal disease program provides diagnosis and treatment for VD. This service is open to all persons on a walk-in basis. Physicians in local health departments prescribe treatment. In addition, 34 field representatives are stationed throughout the State to test for VD and follow up on suspected carriers. In fiscal 1977, local health departments conducted 2,690 VD clinics with a total attendance of 58,502.

Cervical Cancer Screening. Uterine cancer is the second most common form of cancer in women. During 1974, an estimated 1,100 women in Virginia developed uterine cancer and 247 died. Detected early, the disease is largely preventable. Lower income women are known to have a higher rate of uterine cancer than women from more advantaged backgrounds but are less likely to obtain regular physical examinations which could detect uterine cancer in its early stages. The cervical cancer screening program encourages early detection by providing lab work for pap smears taken during clinics sponsored by volunteer groups. During FY 1975, 101,992 pap tests were performed of which 543 were suspicious and 134 positive. The screening program, however, provides no treatment services and no systematic follow-up is made of those whose results appear abnormal. In FY 1975 only seven biopsies were known to have been performed.

There are two cervical cancer screening programs. One is a State funded program which is directed at the indigent. A separate program, sponsored with a three-year federal grant from the National Cancer Institute, is open to all women.

Other Screening. PMS has dropped its screening program for diabetes because it turned up few new cases--only 345 of 1,763 positive samples found in FY 1975 were new cases (20%). While some diabetes screening continues through local health departments which sponsor the program through their cooperative budget, the bureau only absorbs the cost of the laboratory work. Beginning in 1977, PMS established a federally funded program to promote screening for hypertension (high blood pressure).

Tuberculosis Control and Treatment

Tuberculosis control in Virginia consists of two programs: community-based detection and care and the operation of the Blue Ridge Sanatorium. Community-based detection and care consists primarily of regional x-ray clinics and outpatient care in local health departments. Blue Ridge provides extended inpatient treatment.

Expenditures (FY 1977) WITHOUT Cooperative Budget Funds:		*Expenditures (FY 1977 Estimates) WITH Cooperative Budget Funds:*	
Total	*$3,954,797*	*Total*	*Unknown, see Funding section*
Blue Ridge	*$3,164,370*[1]	*Blue Ridge*	*NA*
TB Clinics	*790,427*	*TB Clinics*	*Unknown*
Source of Funds: *Federal*		*Source of Funds:* *Federal*	
State	*100%*	*State*	*100%*
Local		*Local*	
Third Party		*Third Party*	
Services: *Inpatient*	*X*	*Comprehensive*	
Outpatient	*X*	*Specialized*	*X*
Long Term Care		*Preventive*	*X*

Primary Target Group: Anyone, especially the poor, who as a group have the highest incidence of tuberculosis.

Management Agency: Blue Ridge; UVA. TB Clinics; SDH in conjunction with local health departments.

[1] *Excludes nearly $1 million in third-party reimbursements that are paid directly to the general fund.*

H

TB control has changed significantly since 1908 when half of the State's appropriation for public health was earmarked for this purpose. Four TB sanatoria were built between 1909 and 1920. Of these, only Blue Ridge remains today.

Until this year, Blue Ridge was administered as a separate institution linked to the Department of Health by the director who reported directly to the State Commissioner of Health. Effective July 1, 1978, the General Assembly transferred Blue Ridge to the University of Virginia, renaming it the Blue Ridge Hospital Division of the University of Virginia. TB patients will continue to be treated at the facility.

At the time the State's TB sanatoria were being built, regional x-ray clinics were set up for the purpose of diagnosing and detecting the disease. In 1947, the Division (later Bureau) of

Tuberculosis Control was established within the Department of Health. In 1951, the division started the development of local clinics in areas where local health departments did not have such clinics.

The advent and rapid improvement of drug therapy in the 1950's and 1960's, combined with the increased availability of TB clinics, dramatically changed the nature of TB control. By 1970, TB had been eliminated as a major cause of death. Today, TB can be detected early, before the infection reaches an advanced stage. As a result, the program has shifted away from institutionalization in favor of community-based detection and treatment.

Legislative Base

Explicit legislation authorizing the establishment of TB sanatoria is described in Sections 32-311 through 32-321 of the *Code of Virginia*. TB sanatoria are directed to provide treatment "by the most advanced methods...at minimum expense to the patients". Section 32-312.1, however, authorizes SDH to ascertain patient ability to pay and to charge patients and collect accordingly. This legislation remains unchanged despite the transfer of the last remaining sanatorium to the University of Virginia.

In transferring Blue Ridge to UVA, the General Assembly (Chapter 38, 1978 Acts) provided that "continuity of inpatient care of such (TB) patients is to be coordinated with outpatient care as provided by private and public health physicians at both the State and community levels".

While there is no specific legislation authorizing local TB clinics, authority can be implied from the communicable disease statutes. Sections 32-85.1 through 32-89 of the *Code* generally refer to detection and quarantine of suspected cases of TB. Section 32-85.1 authorizes local health officers to quarantine persons suspected of having TB, and other sections specify that tubercular patients be segregaged from others in hospitals and State institutions.

Source and Level of Funding

Both Blue Ridge and the TB control program are supported entirely with State funds, with some additional local support from cooperative budgets of local health departments for the cost of operating TB clinics.

FY 1976 appropriations for Blue Ridge amounted to $3,380,280. A large share of the cost of operating this facility, however, is recovered in third-party payments. In FY 1976, third-party reimbursements amounted to $1.2 million or roughly a third of the total expenditures at Blue Ridge. These reimbursements are not part of the budget for Blue Ridge but are paid directly to the general fund.

Current appropriations for Blue Ridge are shown in Table 14. The costs of patient care and the operation of the facility have been divided between the State Department of Health and the University of Virginia, respectively. Physical health services program funds have been appropriated to the State Department of Health which, in turn, will contract with UVA for the care of TB patients. Administrative and support service program funds have been transferred to UVA and may be expended only for operation of the Blue Ridge Hospital Division.

Table 14

APPROPRIATIONS FOR TB INPATIENT CARE AND BLUE RIDGE HOSPITAL DIVISION 1978-80

	FY 1978-79	FY 1979-80
Patient Physical Health Services (to SDH)	$1,675,610	$1,701,620
Blue Ridge Administrative and Support Services (transferred to UVA)	$1,874,125	$1,936,075
Total	$3,549,735	$3,637,695

Source: 1978-80 Appropriations Act.

Total appropriations for tuberculosis control amounted to $796,000 in FY 1976. Some additional revenues are earned through third-party payments from medicaid and medicare. In the case of medicaid, such services must be provided as part of a general medical clinic. Only a few local health departments, such as the one in Newport News, have incorporated TB clinics into their general medical clinics. Current appropriations for TB control for 1978-80 are $918,705 and $938,045 respectively.

Eligibility

TB services both at Blue Ridge and through local health departments are open to anyone regardless of income. The poor are served free. Fees are set for the nonpoor on the basis of their ability to pay. However, since the type of services offered through TB clinics is largely preventive, little effort is made to collect from anyone. In any case, since the highest incidence of TB is among the poor, the majority of those seen are served free.

At Blue Ridge, anyone over 65 in need of this type of care is covered under medicaid. Generally, the types of patients admitted to Blue Ridge are severe cases where the individual is either very debilitated or cannot be relied upon to follow a treatment regimen if left in his home community.

Services Provided

The Blue Ridge Sanatorium provides extended hospital care for those known to have or suspected of having tuberculosis or other mycobacterial diseases. This care can encompass diagnosis, drug therapy, general care, bed rest, and patient education.

In addition to its treatment services, Blue Ridge also provides medical education for doctors and nurses. Medical students from UVA are given four to six weeks of professional work in pulmonary medicine and tuberculosis. Thirty-seven medical students rotated through Blue Ridge for training during FY 1976. Blue Ridge also conducts a tuberculosis nursing program on its grounds.

Blue Ridge has a 262 bed capacity, but because of the decline in the need for institutional care, less than 100 beds are currently used for TB patients. Blue Ridge treated 702 patients in FY 1976. Average occupancy was only 52.7%. Patient loads have been significantly reduced from a high of 959 in FY 1972. Similarly, length of hospitalization has been reduced in recent years. Despite these reductions, costs have risen steadily over the same period (Table 15).

Table 15

TB ADMISSIONS DECLINE WHILE COSTS INCREASE
FY 1969 THRU FY 1976

FY	Adm.	Treated	Discharged	Average Hospital Days	Per Diem	Average Cost Per Patient Discharged	Total Expenditures
1969	510	793	525	205	$18.56	$3,804	$1,649,821
1970	633	901	644	159	21.33	3,391	2,076,727
1971	541	898	684	143	25.61	3,662	2,392,858
1972	745	959	707	120	27.10	3,252	2,248,194
1973	694	946	749	108	30.90	3,337	2,496,542
1974	716	913	718	102	37.71	3,846	2,656,191
1975	680	875	655	101	46.64	4,711	3,007,552
1976	562	702	570	89	57.57	5,124	2,897,912

Source: Blue Ridge Sanatorium, Annual Report FY 1976.

Blue Ridge Sanatorium also provides a limited number of outpatient services. Sanatorium staff members help operate the regional chest clinic at Charlottesville. In addition, Blue Ridge provides a Statewide consulting service to Virginia physicians. This service involves advice to physicians in the diagnosis and treatment of suspected TB cases. In some cases, the patient will be sent to the sanatorium for testing. During FY 1976, there were 694 outpatient visits.

A key function of the TB control program is the provision of chest x-rays. Regional chest clinics are scheduled on a regular basis at 48 locations throughout the State. During FY 1977, 6,466 clinic sessions were held with a total attendance of 133,211. For the most part, clinics are staffed by physicians from the bureau. The bureau also supplies technicians needed to operate the x-ray equipment. The bureau supplies statistical services such as the computerized central TB registry and quarterly status reports to local health departments.

The original rationale for regional clinics was to increase the availability of chest specialists in Virginia, but the development of drug therapy and community-based treatment for TB added surveillance to this purpose. While most TB patients no longer require hospitalization, they do need to be closely monitored. Local clinics provide the means for the kind of periodic surveillance and follow-up essential for a successful community program.

Dental Health

Under the dental health program, basic dental care is provided to anyone unable to obtain the services from any other source. Primary emphasis is placed on serving poor children. In addition, the program is involved in promoting the fluoridation of the State's drinking water and in conducting screenings for oral cancer.

Expenditures (FY 1977) WITHOUT Cooperative Budget Funds			*Expenditures (FY 1977 Estimates) WITH Cooperative Budget Funds*		
Total		*$191,949*	*Total*		*$1.8 million*
Source of Funds:	*Federal*		*Source of Funds:*	*Federal*	
	State	*100%*		*State*	*60%*
	Local			*Local*	*40%*
	Third Party			*Third Party*	
Services:	*Inpatient*			*Comprehensive*	
	Outpatient	*X*		*Specialized*	*X*
	Long Term Care			*Preventive*	*X*

Primary Target Group: Persons unable to obtain care from any other source. Priority placed on children of the poor.

Management Agency: State Department of Health in conjunction with local health departments.

The State's involvement in this area began in 1914-15 when a single dentist was employed part-time under the auspices of the Virginia Dental Society. In 1916, the General Assembly added the position of a dentist to the State Board of Health. Today, approximately 80 full-time public health dentists work in two-thirds of the local health departments in the State.

Responsibility for the program rests with the Division of Dental Health, a separate division within the Department of Health. Besides medicaid, the only federal involvement in dental health in the State are the separately-funded special projects under the maternal and child health program. Dental services are the focus of one of these projects and are included in each of the others as well.

Legislative Base

No specific statute exists in the *Code* authorizing the program.

Source and Level of Funding

State appropriations to the division amounted to $207,405 for fiscal year 1978. This amount does not include, however, the cost of public health dentists, dental hygienists and dental assistants employed in the various local health departments. The salaries of these personnel are paid for out of the cooperative budgets. Conservatively, this amounts to about $1.8 million of which the State contributes at least $1.1 million.* The Division of Dental Health estimates that the value of the dental services provided through the program would be worth at least $4.2 million had the services been purchased through the private sector.

The cost of the oral cancer screening program is absorbed through the $200,000 appropriation to the division. Staff time is donated at the local level and through the Department of Oral Pathology at the Medical College of Virginia. A $20,000 federal grant used to initiate the program in 1968 has since been discontinued.

Eligibility

Dental care will be provided to anyone unable to obtain the care from any other source. Priority is placed on serving children of the poor. Adults, if seen, are provided mainly emergency care. In FY 1976 less than a fifth of the patient visits were by persons age 20 or older. Fees may be charged to the nonpoor based on the same income guidelines set by SDH for clinic services.

Services Provided

Under the dental care portion of the program, basic dental care is provided to those meeting the eligibility requirements. These services include routine preventive measures such as cleaning and topical fluoride treatments; x-rays and examinations; and fillings and extractions as needed (Table 16). Little orthodontic or denture work is undertaken.

The public health dentists also provide dental education in the schools. Upon request, the public health dentist in each locality offers dental health instruction in the classroom stressing techniques for proper brushing and flossing. Films and other educational aids are available through the division to assist the local public health dentist.

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*Based on 76 dentists at a starting salary of $18,700, 61 dental assistants at $5,880 and supplies at $1,200 a year per dentist at an average State share of 60%.

Table 16

FREQUENCY OF SERVICES PROVIDED
FY 1977

Type of Service	Percent of Services Provided by Type
Restorations	30.1
Examinations	16.4
X-Ray and Diagnostic	16.4
Extractions	9.1
Prophylaxis	9.1
Fluoride Treatments	7.1
Endodontics	6.0
Dentures (Partial and Full)	.6
Orthodontics	.2
Other services (not listed above)	5.0
	100.0

Base: Total Services Provided 373,668

Total Patient Visits - 163,313

Source: Division of Dentistry, 1977, Statistical Annual Report.

In addition to providing basic dental care and educational services, the dental health program is involved in two other related areas: fluoridation of drinking water and screening for oral cancer. At the present time, approximately 81 percent of the 3,731,000 persons using public water supplies are drinking controlled fluoridated water and another 1½ percent are drinking naturally fluoridated water. Only two communities with populations over 5,000 that have central water supply systems have not chosen to fluoridate their water--Clifton Forge and Buena Vista.

The division also helps coordinate an oral cancer screening program. Working in conjunction with the American Cancer Society and the School of Dentistry of the Medical College of Virginia, mass screening clinics are held in cooperation with interested localities.

Home Health

The home health program offers a variety of services that are provided directly in the patient's home. Home health is seen as a less costly alternative to hospitalization or lengthy convalescence in a nursing home. Moreover, many consider this a desirable alternative to institutional confinement.

Expenditures (FY 1977) WITHOUT Cooperative Budget Funds:			*Expenditures (FY 1977 Estimates) WITH Cooperative Budget Funds:*		
Total		*$2,000,000*	*Total*		*Unknown, see Funding section*
Source of Funds:	*Federal*		*Source of Funds:*	*Federal*	
	State	*6%*		*State*	
	Local			*Local*	
	Third Party	*94%**		*Third Party*	
Services:	*Inpatient*			*Comprehensive*	
	Outpatient	*X*		*Specialized*	*X*
	Long Term Care			*Preventive*	

Primary Target Group: Anyone in need of this type of care with emphasis on those 65 and over on medicare.

Management Agency: State Department of Health in conjunction with local health departments.

**Primarily medicare and medicaid.*

The home health program is centrally administered through the Bureau of Home Health with services available in all 122 local health departments in the State.

Legislative Base

Home health services were first provided in Virginia during fiscal 1966 under Section 32-8.1 of the *Code of Virginia*. The impetus for authorizing home health services came as a result of passage of the medicaid and medicare legislation which allowed reimbursement for this type of care. The *Code* specifies that charges for home health services be determined by rates established by the Board of Health and that, to the extent possible, persons pay for the services they receive.

J

Source and Level of Funding

The cost of the program is heavily supported with third-party funds from medicaid and medicare. The State appropriates general fund money to pay for the cost of administering the program

by the Bureau of Home Health. Additional support for the program is provided through the cooperative budgets of local health departments for the cost of serving those not covered by medicaid, medicare or some other third party source. Table 17 shows the amount of third-party and general fund monies supporting the program. No estimate is available on the amount of funds used to support home health services from local health department cooperative budgets.

Table 17

SOURCE OF FUNDS
FY 1976

State General Fund		$ 96,000
Third-Party Reimbursements		
Medicare	$1,350,347	
Medicaid	447,773	
Private Pay	104,807	
		1,902,927
Total		$1,998,927

Source: State Department of Health.

Eligibility

Home health services are available to anyone at a cost of $22 a visit. This rate is based on average costs and is applied regardless of the type of service provided or the length of the visit, which may last several hours. Individuals are charged according to their ability to pay using the same income guidelines developed by SDH for clinic services. Referrals may come from private physicians, hospitals, extended care facilities, social workers, and others.

A large majority of those served are medicare recipients 65 and over. The rest are either medicaid recipients or private pay patients. Table 18 shows the type of patient visited. As seen in the table, most of the visits made are to victims of strokes (cerebral vascular accidents).

Services Provided

Most of the care provided through the home health program involves skilled care; that is, care that can only be provided by a licensed professional under the direction of a private physician. In

Table 18

HOME HEALTH VISITS
FY 1976

	Visits	Percent of Total
TOTAL	138,238	100%
Stroke	34,560	25%
Muscular-Skeletal Conditions	16,589	12
Diabetes	13,824	10
Arthritis	9,677	7
Neuro-Sensory	9,665	7
Cancer	6,912	5
Cardiac	6,906	5
Anemias	4,147	3
Genital Urinary	4,142	3
All Other Diseases	31,816	23

Source: Statistical Annual Report 1975, SDH, p. 177.

fact, before home health services can be extended to an individual, the following steps must be taken:

- evaluation visit by a public health nurse;
- staff evaluation;
- treatment plan completed by a physician;
- authorization for treatment by LHD director;
- determination of financial eligibility;
- physician notified of acceptance;
- schedule of visits developed; and
- case number assigned.

One reason for the emphasis on skilled care is that medicare will only reimburse for non-skilled services when provided in conjunction with needed skilled care. Medicaid has no such restriction. As a result, a greater variety of home health services is available to the medicaid recipient than to the medicare recipient. Among the types of health providers included under home health are public health nurses, licensed nurses, physical, speech and occupational therapists, medical social workers, home health aides, and male orderlies.

Appalachian Health Project

The Appalachian health service project funds three health-related demonstration projects in seven counties of Southwest Virginia that are considered part of Appalachia. These projects include a nutrition program, a counseling program, and a health screening program for children.

Expenditures (FY 1977): $310,829

Source of Funds:

Federal	85%
State	15%
Local	
Third Party	

Services:

Inpatient		Comprehensive	
Outpatient	X	Specialized	
Long Term Care		Preventive	X

Primary Target Group: Children living in any of the seven Appalachian counties of southwest Virginia--Lee, Scott, Dickinson, Wise, Tazewell, Buchanan, or Russell counties.

Management Agency: Appalachian Regional Commission

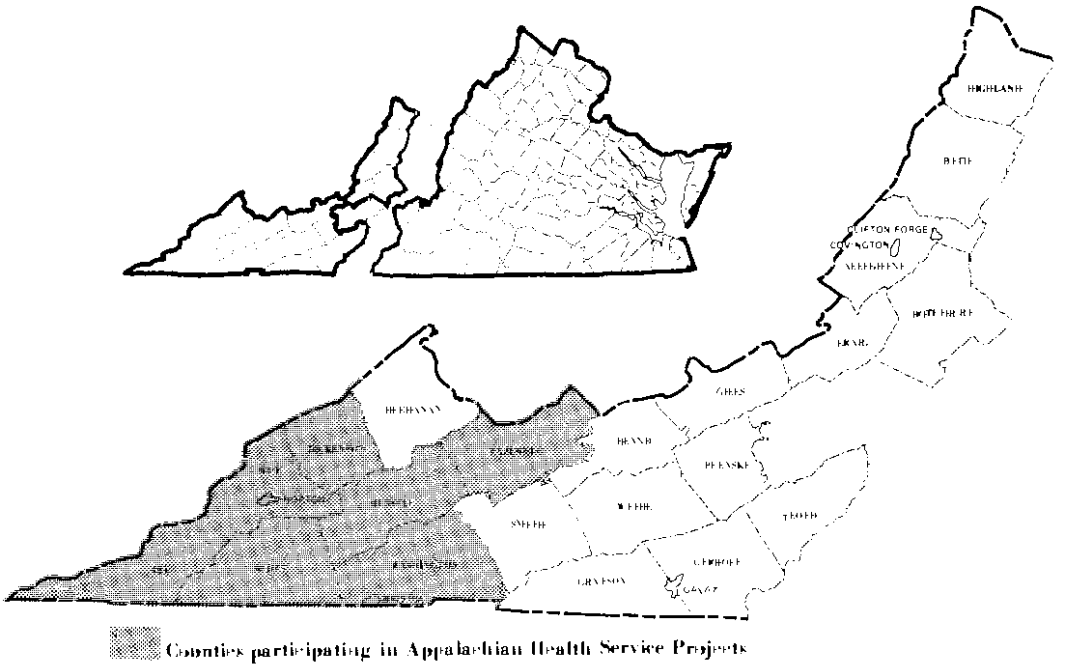
The Appalachian health program is one of a number of federally-supported programs serving the poor that do not come under the direct responsibility of the State. The program is one of several projects funded by the Appalachian Regional Commission (ARC). The commission is made up of the governors from 13 states considered part of Appalachia and a federal cochairman appointed by the President. Twenty-one counties of southwest Virginia are officially designated as part of the region (see Figure 15).

Virginia's participation in ARC is coordinated through the Department of Intergovernmental Affairs, the Division of Special Projects. Projects funded by ARC are intended to promote the economic development of Appalachia. Health and social services projects, however, also receive some ARC support.

The purpose of the Appalachian health service project has been to extend the scope of health services available in the seven furthermost counties of southwest Virginia. Although there are 21 counties in the ARC region, the seven-county area consisting of Lee, Scott, Dickinson, Wise, Tazewell, Buchanan, and Russell was alone selected as the target area for the health services project. The project is administered by the southwest regional office of the State Department of Health.

Figure 15

VIRGINIA COUNTIES DESIGNATED PART OF APPALACHIA



Source: Department of Intergovernmental Affairs.

Legislative Base

ARC is funded under the Appalachian Regional Development Act passed in 1965. This act is one of several pieces of legislation that has been enacted by Congress over the last several years to address health and other problems in rural America. Funds from this act have been used to support a variety of health-related projects in the demonstration area including:

- an 80-bed hospital addition;
- speech and hearing clinics;
- coal miners' respiratory program;
- patient transportation; and
- additional staff for local health departments.

In addition, monies under this act have been used to construct new local health departments in all but one of the seven counties in the area. Over the years, a total of $17 million has been spent in the seven counties by ARC in health-related projects.

The lack of State authority over this program is reflected in the fact that no reference to this legislation exists in the *Code of Virginia*. Under the new health planning act (PL 93-641), future expenditures will have to be in compliance with the health plan being developed by the area HSA.

K

Source and Level of Funding

The Appalachian health service project is funded by a grant awarded to the State Department of Health. The project is currently in its ninth year of funding. Under the grant, the State must match $25 for every $75 in federal money. This amounted to $77,369 in State dollars out of the total $309,475 spent by the program in fiscal 1976. Because some projects have been funded entirely with federal money, State expenditures have generally been less than 25%.

Eligibility

The program is open without charge any child living in the seven Appalachian counties of the demonstration area.

Services Provided

The Appalachian health service project currently involves three separate demonstration projects in the areas of nutrition, counseling, and pediatric screening. The largest of the programs is the screening program for children.

The screening project involves sending a health team to mobile clinic sites at schools, churches, and other public facilities. About 2,500 children were examined under this program in FY 1976. Some problems have been encountered in finding adequate staffing for the teams. Currently, efforts are being made to integrate the project into the daily operation of the local health departments of the seven counties.

Migrant Labor Health Project

The migrant labor health project provides comprehensive health care to migrant and seasonal workers and their families. Program services are offered only during the growing and harvesting seasons and are limited to Virginia's Eastern Shore.

Expenditures (FY 1977): $120,000[1]

Source of Funds:

Federal	100%
State	
Local	
Third Party	

Services:

Inpatient	X	Comprehensive	X
Outpatient	X	Specialized	
Long Term Care		Preventive	

Primary Target Group: Migrant workers and their families on Virginia's Eastern Shore.

Management Agency: U. S. Public Health Service

[1] See funding section.

The U. S. Public Health Service has primary responsibility for the migrant labor health project and provides a grant-in-aid for its funding. Services are delivered through the facilities of the two local health departments of the Eastern Shore. For the most part, the State Department of Health is involved only as the official recipient of federal funds.

Legislative Base

The project is funded under the Assistance to Migratory Workers Act which was passed in 1962 and later amended in 1968 (Section 319 of Title IV of the Public Health Service Act). Under the Health Planning Act of 1974 (PL 93-641), future program funds will be required to conform with the regional health plan now being developed by the area HSA. No reference exists in the *Code of Virginia* relating to the migrant labor health program.

Source and Level of Funding

The migrant labor health project received $120,000 in federal funds in FY 1977. Additional support for the program comes from third-party sources such as medicare and medicaid. The amount of third-party payments for FY 1977 is estimated at $206,000.

Additional services to migrant workers and their families are provided from other State resources such as the Blue Ridge TB Sanatorium and Eastern State Mental Hospital. When all sources of support are included, the total public cost of services is estimated at $480,000 for FY 1977. An additional $130,000 in donated services were estimated to have been contributed by local hospitals and doctors for the same year.

Eligibility

The project serves migrant workers and their families who come to the Eastern Shore. For most services, federal poverty guidelines are used to determine eligibility with minimal fees applied to those able to pay.

Services Provided

The project provides primary health and dental care from mid-June to mid-August through family clinics held at the two local health departments. The family clinics are primarily concerned with the diagnosis and treatment of illnesses and injuries which are not acute. Although most cases are treated at the clinic, patients requiring additional service are referred to either the local hospital or to cooperating metropolitan hospitals in the Tidewater area. Outreach workers from the project visit migrant camps to inform the workers of the services available through the clinics.

Title XX

Title XX is a federally-funded program for providing social services to the indigent. Under the program, health care can be included only to the extent it is necessary as a supplement to some other social service. For instance, funds from the program could be used to pay for a physical required before a child could be admitted to a day care center. Thus, while Title XX represents another resource to the poor for obtaining health care, the types of care covered are fairly limited in nature.

Expenditures (FY 1977): *$3,400,000*[1]

Source of Funds:

Federal	*75%*
State	*9%*
Local	*16%*
Third Party	

Services:

Inpatient		*Comprehensive*	
Outpatient	*X*	*Specialized*	*X*
Long Term Care		*Preventive*	

Primary Target Group: Individuals receiving some form of financial assistance.

Management Agency: Department of Welfare and Virginia Commission for the Visually Handicapped

[1] *Total program expenditures in Virginia amounted to more than $75 million. The exact amount spent for medical care is unknown but estimated at a maximum of $3.4 million.*

Title XX provides funds for a wide range of social services. Together these services are designed to address five broad national goals:

- to help people become or remain economically self-supporting;
- to help people become or remain self-sufficient (able to take care of themselves);
- to protect children and adults who cannot protect themselves from abuse, neglect, and exploitation and to help families stay together;
- to prevent and reduce inappropriate institutional care as much as possible by making home and community services available; and

- to arrange for appropriate placement and services in an institution when it is in an individual's best interest.

Of the 45 different services offered to meet these broad goals, ten provide for a medical care component when the following conditions are met:

- medical care is not available through other programs such as medicaid;
- medical care is an integral but subordinate part of the service; and
- the cost of medical care does not exceed 25% of the total cost of the service.

The Department of Welfare and the Commission for the Visually Handicapped have been designated by the Governor as the agencies responsible for administering Title XX in Virginia. These agencies are responsible for planning and overall administration of Title XX activities including the determination of funding priorities.

Legislative Base

Title XX of the 1974 Social Security Amendments replaced the social services provisions of Titles IV-A and VI and now forms the federal legislative base for social services. The sole State legislative basis for Title XX in Virginia is Section 63.1-36 of the *Code*, which grants broad authority to the Commissioner of Welfare to receive federal grants-in-aid.

Source and Level of Funding

Title XX federal funding is provided on a 75% federal/25% state-local block grant arrangement. An exception is the family planning service which is federally reimbursed at 90% of costs. The greatest portion of Virginia's Title XX federal funds are made available to local welfare agencies or departments for their use in providing social services at the local level. Several state agencies including the Department of Health also receive Title XX funding through contract agreements with the Department of Welfare.

Title XX funds are allocated to the states on the basis of two factors: total population and the number of welfare recipients receiving cash assistance. Equal weight is given to each factor in distributing the funds. In FY 1976, a total of $58 million was spent in Title XX funds allocated to Virginia.

The amount of Title XX funds devoted to medical care for the poor is not known. However, JLARC estimates that as much as $3.4

million of Title XX funds could have been spent on indigent care in FY 1977. This estimate is based on a maximum of 25% allowed for each of the ten services for which a medical component could be appropriate. Table 19 lists the estimate for each of the ten services and the requested expenditures for FY 1977 on which the estimate is based.

Table 19

TITLE XX SERVICES WHICH HAVE A MEDICAL CARE COMPONENT

Title XX Service	Amount Allocated For Fiscal 1977	Maximum Allowable For Medical Services[1]
Adoption	$ 1,243,200	$ 310,800
Alcoholism Counseling and Treatment	273,235	68,308
Drug Counseling and Treatment	263,936	65,984
Employment Services	2,070,458	517,614
Foster Care to Children	7,047,410	1,761,852
Home Health Services	76,758	19,189
Mental Health Counseling and Treatment	1,259,323	314,831
Sheltered Workshop/ Employment	1,035,949	258,988
Vocational Rehabilitation for WIN	33,706	8,426
WIN Supportive Services	145,489	36,372
Total	$13,449,464	$3,362,366[a]

[a]Figures do not add due to rounding.
[1]Based on 25% of FY 77 allocations.

Source: Prepared by JLARC from data provided by Department of Welfare.

Eligibility

Under State and federal regulations, various services are provided on a universal access basis. These services are: adoption services, court services, emergency shelter for children, foster care for children, protective services for children and adults, and general information and referral services. The preceding services are available to all without regard to income.

Other Title XX services are available to ADC and SSI recipients. Also eligible are persons with incomes less than an income cutoff point determined by the Virginia Title XX plan. The overall cutoff point in the plan is 50% of the State's median income. A higher cutoff point--70% of the State's median income--has been

established for the deaf, blind, mentally retarded, epileptic, cerebral palsied, and autistic.

Services Provided

The Title XX services listed in Table 19 have medical care components. The types of care provided could vary greatly from case to case. Examples of care provided are medical screening and physicals for children using other Title XX services (i.e., day care or foster homes) and medical treatment for children and adults requiring protective services as a result of physical abuse.

N

State and Local Hospitalization

The State and Local Hospitalization (SLH) program provides funding to localities for indigent hospital care. The program was established in 1946 and was originally intended to meet the hospitalization needs of all Virginia's poor. Today it serves more as a key resource for inpatient care of the indigent who are not eligible for medicaid.

Expenditures (FY 1977): $5,622,823

Source of Funds:

Federal	
State	43%
Local	57%
Third Party	

Services:

Inpatient	X	Comprehensive	X
Outpatient	X	Specialized	
Long Term Care		Preventive	

Primary Target Group: Indigents not eligible for medicaid or other indigent care programs.

Management Agency: Department of Welfare.

SLH is primarily a local program and the State's role is limited to general supervision and distribution of funds to participating localities. Participation in the SLH program is a local option and the level, type, and availability of covered services are decided locally. Local governing bodies also designate an authorizing agent to administer the program. In most cases, the local Board of Public Welfare is the designated agent.

Legislative Base

The SLH program is authorized by Chapter 7, Title 63.1 of the *Code of Virginia*. Program responsibility was transferred from the Department of Health to the Department of Welfare and Institutions under the Virginia Reorganization Act of 1948.

Program scope was expanded in 1964 to include visits to hospital outpatient clinics and emergency rooms. The program was further amended in 1976 to allow SLH payments for treatment provided in health department clinics. The latter change was intended to broaden the availability of services in areas where there are few participating hospitals.

In recent years, the General Assembly has addressed the issue of whether SLH should be standardized and incorporated into the Virginia medicaid program of the Department of Health. No definitive action on this matter has been taken to date.

Source and Level of Funding

Funds appropriated by the General Assembly for matching local SLH expenditures, dollar for dollar, are allocated to the localities on the basis of population. A portion of the State appropriation is used to establish a reserve fund and the remainder is allocated to the localities over four six-month periods. In this way, each locality has a predetermined amount which can be claimed. At the end of each six-month period, unclaimed funds revert to the reserve fund.

Localities which choose to expend more than their allocation for the period may make claims for reimbursement from the reserve fund. If the reserve fund is insufficient to satisfy all claims, the fund will be prorated. However, because some localities are not making full use of their allotment, the reserve fund has been more than sufficient to cover all claims in the recent past. In fact, about 10% of the total appropriation for the 1974-76 biennium--$549,895--reverted to the General Fund.

The State appropriation for the 1978-80 biennium is $6,970,300. Of this appropriation, an amount not exceeding $400,000 each year may be allocated for outpatient and emergency room service. Table 20 shows expenditures for inpatient and outpatient care for FY 1977.

Table 20

EXPENDITURES FOR SLH FY 1977

Type of Care	Amount
Inpatient: State Share	$2,441,516
Local Share	2,441,516
Local Share Not Matched[1]	161,541
Total	$5,044,573
Outpatient/Emergency Room:	
State Share	190,517
Local Share	190,517
Local Share Not Matched[1]	197,216
Total	$ 578,250

[1]Amount paid by localities in excess of State ceilings and not matched by State funds.

Source: Department of Welfare.

Eligibility

SLH funds are supposed to be available only for those persons who are indigent or medically indigent and who are not covered by another program. Responsibility for standards of eligibility is shared by the State and locality. The Department of Welfare is charged with establishing guidelines for the evaluation of an SLH applicant's medical indigency. However, the State guidelines are not binding, and local authorizing agents may reject the guidelines for determining eligibility. As a result, eligibility standards do vary across the State.

The State SLH guidelines allow higher monthly income levels than medicaid standards. Current income guidelines are shown in Table 21.

Table 21

SUGGESTED STATE GUIDELINES FOR EVALUATING MEDICAL INDIGENCY
(monthly income)

Number of Persons in Family	Areas Over 10,000 Population	Areas Under 10,000 Population
1	$225	$185
2	300	265
3	350	315
4	395	360
5 and over	440 plus $45 per additional person	400 plus $45 per additional person

Source: Department of Welfare.

In practice, the State guidelines are used primarily in the larger urban areas. Rural counties tend to use a less formal process for determining eligibility. In some cases, eligibility decisions are made by the supervisor from the applicant's voting district. In other areas, the determination is made by the local Departments of Health or Welfare.

A similar lack of uniformity exists in the way application is made for SLH assistance. Some localities have a referral system between authorizing agents and the hospitals and physicians in the area. In these cases, SLH eligibility is established prior to admission to the hospital. Other localities only consider applications after the individual has received the medical service. The local authorizing agent may then elect to pay for all or, in some cases, only part of the cost of hospital or clinic treatment.

After a case has been approved, the locality makes a claim to the State Department of Welfare for reimbursement of one-half of the cost of care up to a regional ceiling established by the department.

Ceilings are set at 125% of the average cost of hospital care in each of five State regions. In 1976, these rates ranged from $80 a day in Roanoke to $151 in Northern Virginia. Localities may exceed the ceiling, but the excess will not be matched by the State.

Services Provided

The great majority of SLH funds (89%) are dedicated to inpatient services; however, outpatient services are now authorized on a limited basis. Most inpatient services are for routine medical/surgical conditions such as deliveries. The average SLH inpatient in FY 1977 remained in the hospital 7.8 days at a cost of $803 in State and local funds.

Outpatient services are routine in nature and are essentially limited to the cities of Richmond and Norfolk. Inpatient care is somewhat more dispersed but still concentrated heavily in major urban areas. The forthcoming JLARC service delivery report on inpatient care will discuss, in more detail, the distribution of SLH funds in the State.

General Relief

C

The general relief program is a State and local public assistance program administered by the Department of Welfare. The medical component is very small and consists mainly of outpatient services for individuals who are not eligible for federally funded assistance.

Expenditures (FY 1977): $300,938[1]

Source of Funds:

Federal	
State	62.5%
Local	37.5%
Third Party	

Services:

Inpatient		Comprehensive	X
Outpatient	X	Specialized	
Long Term Care		Preventive	

Primary Target Group: Unemployable persons not eligible for aid under a federal program.

Management Agency: Department of Welfare.

[1] *Medical component only, total program expenditures amounted to $10.7 million.*

The general relief program is designed to give local welfare boards the flexibility to fill the gaps in federal assistance programs through local payments for maintenance, medical care, burial, and transient expenses. While total program expenditures for FY 1977 approached $11 million, the portion devoted to medical care accounted for less than 5%.

Legislative Base

The general relief program is authorized by Chapter 6, Title 63.1 of the *Code of Virginia*. Eligibility for general relief is established by Section 63.1-106.

Source and Level of Funding

The State provides 62.5% of the funds for general relief, and localities are responsible for the remaining 37.5%. State appropriations are allocated to localities on the basis of population.

Localities administer the program and are reimbursed by the State for 62.5% of their expenditures up to the amount allocated. Expenditures for the medical care component were $300,938 in FY 1977.

Eligibility

Only the poor are eligible for general relief. The Department of Welfare is required by State law to develop policies relating to eligibility and to define the categories of assistance available. The localities then determine the types and level of assistance to be offered. To be eligible an individual must need public assistance, be ineligible for federally funded assistance, and be unemployable.

An individual is considered unemployable if disabled or if a referral agency such as the Virginia Employment Commission has failed to place the person in a job. Localities may elect to provide assistance for a limited time to temporarily unemployed but employable persons.

Services Provided

General relief medical care funds are generally restricted to outpatient services since the State and Local Hospitalization Program provides for inpatient care. The flexibility and various options available to localities under the general relief program have created substantial disparities in the level of benefits available Statewide. In FY 1975, 19 localities which participated in general relief did not request funds for medical care, and 54 others requested less than $1,000. A few of the larger urban localities accounted for the majority of medical care expenditures. Even in these localities the relatively small scale of the medical component limits the impact of the program.

Vocational Rehabilitation

P

The objective of vocational rehabilitation is to provide services that will allow disabled persons to obtain or resume some form of productive activity. Medical services are one of the primary services used in rehabilitating those eligible. In most cases, the medical care provided is surgical in nature.

Expenditures (FY 1977): $2,317,000

Source of Funds:

Federal	80%
State	20%
Local	
Third Party	

Services:

Inpatient	X	Comprehensive	
Outpatient	X	Specialized	X
Long Term Care		Preventive	

Primary Target Group: The physically and mentally disabled capable of productive activity.

Management Agency: Department of Vocational Rehabilitation.

The vocational rehabilitation program is administered by the State Department of Vocational Rehabilitation. Vocational services for the blind and visually handicapped are provided separately by the Virginia Commission for the Visually Handicapped, and medical services constitute only a small part of its overall program effort.

Legislative Base

Virginia has participated in vocational rehabilitation activities since 1920. The Virginia Board of Vocational Rehabilitation was officially established in 1964 (*Code of Virginia* §22-330.1-330.11). At that time, all of the powers, duties, and functions of the Division of Vocational Rehabilitation of the Department of Education were transferred to the Board of Vocational Rehabilitation which was authorized to establish a State Department of Vocational Rehabilitation (§22-330.6).

Program growth accelerated after 1965 when amendments to the federal Vocational Rehabilitation Act of 1920 greatly expanded program eligibility and federal financing. Simultaneously, Virginia's

vocational rehabilitation effort was organized as a department and a period of rapid growth began.

A substantial change in program direction and priorities occurred with the passage of the federal Rehabilitation Act of 1973 which stressed service to the severely disabled. Previous legislative changes had broadened eligibility to include behavioral disorders and various social and cultural handicaps. The 1973 Act served to refocus attention on those severely disabled and away from persons judged to be less disabled.

Source and Level of Funding

Approximately $10.2 million was spent for vocational rehabilitation client services in Virginia during FY 1977. Roughly $2.3 million of these expenditures were used in providing medical services to vocational rehabilitation clients. The bulk of the funds for this program is made available on a matching basis which is 80% federal, 20% State.

Eligibility

Vocational rehabilitation services are open to poor and nonpoor alike. Eligibility criteria for vocational rehabilitation are based on federal guidelines which require that an applicant meet three criteria:

- a diagnosed disability exists;
- the disability is a substantial handicap;
- there is a reasonable expectation that vocational rehabilitation services will benefit the individual's employability.

The definition of disability in federal law is so broad that virtually any physical, mental, or emotional disorder can be defined as a handicap for the purpose of receiving rehabilitation services. In addition, while most DVR clients are unemployed, there is no formal requirement that restricts eligibility for program services to the indigent. Ability to pay is a criteria for receiving some services, but in most cases, assistance is provided free.

Services Provided

A JLARC evaluation of the department (November, 1976) found that, in most cases, the medical treatment received by vocational rehabilitation clients was of a routine surgical nature. For example,

a client may have needed hernia surgery in order to return to a job which required standing or lifting activity. While this routine type of service may have benefited many clients, it now conflicts with federal mandates to concentrate on serving the severely disabled. As a result, the Department of Vocational Rehabilitation is going through a period of reorientation which may reduce its number of routine medical cases and increase its amount of cases requiring more comprehensive medical care.

Teaching Hospitals

There are two State-supported medical schools in the Commonwealth--the Medical College of Virginia in Richmond and the University of Virginia Medical School in Charlottesville. While the primary mission of the State's teaching hospitals is to serve the instructional and research needs of the medical schools, they also serve as major providers of medical care to the indigent. The General Assembly has recognized this important function of the teaching hospitals and appropriated funds for this purpose.

Expenditures (FY 1977): $21,400,000[1]

Source of Funds:

Federal	
State	100%
Local	
Third Party	

Services:

Inpatient	X	Comprehensive	X
Outpatient	X	Specialized	
Long Term Care		Preventive	

Primary Target Group: All Virginians; State funds primarily directed at indigents not eligible for other medical assistance programs.

Management Agency: University medical schools.

[1] *Estimated as general fund amount devoted to indigent care at UVAH and MCVH only.*

Each State-supported medical school operates a hospital that provides the major clinical resource for the health education program offered. Both are large hospitals equipped to provide comprehensive patient services as well as serve as a teaching classroom and research laboratory. The two hospitals are administered by the parent university; each has a management staff subordinate to the chief administrative officer of the university's medical school. The chief administrative officer at MCVH is the Provost, MCV campus; at UVAH it is the Vice President for Health Sciences.

In addition to UVAH and MCVH, there is a private medical school in Virginia, the Eastern Virginia Medical School. Although the school does not operate its own hospital, it is affiliated with 21 hospitals in the Tidewater area. Students from the school receive their clinical training at these hospitals. In recognition of the relationship between medical education and indigent care, the General Assembly began appropriating funds specifically for indigent care to the school's governing body, the Eastern Virginia Medical Authority (EVMA) beginning in FY 1978.

Legislative Base

The biennial appropriations act serves as the sole legislative authority for the expenditure of State funds for indigent medical care in the teaching hospitals. The language from the 1978-80 act relating to the University of Virginia (§94, Item 299) and the Medical College of Virginia (§96, Item 319) states that:

> "The general fund appropriation includes funds for inpatient and outpatient treatment, care, maintenance, and other health-related services to indigent and medically indigent persons, but only to the extent they are not covered by any other third-party reimbursement system of insurance or health care plan, whether governmental or private."

The language relating to the Eastern Virginia Medical Authority (§114, Item 383) states that:

> "This appropriation provides State aid for treatment, care and maintenance of medically indigent Virginia patients in hospital and other programs affiliated with educational programs of the Authority; the aid is to be apportioned on the basis of a plan having the prior written approval of the Governor."

Although the appropriation to Eastern Virginia Medical Authority clearly limits funds to care of the medically indigent, there is no similar requirement for the funds appropriated to UVAH or MCVH. Funds appropriated to UVAH and MCVH maybe used for other purposes as well.

Source and Level of Funding

The cost of indigent care at MCVH and UVAH is paid for by State appropriations to the two schools for patient health services. The forthcoming JLARC service delivery report on inpatient care discusses in detail the administration of these funds for indigent care. General fund appropriations for patient health services for 1978-80 are shown in Table 22.

Eligibility

Although both teaching hospitals are open to all Virginians, State funds are primarily used to subsidize patient care that cannot be paid for through other means. As explained in the section Legislative Base, the appropriations act provides funds for use in treating the indigent and medically indigent. The act does not define indigency, however, and each hospital has the freedom to determine eligibility on a case-by-case basis. In practice, the funds are used

Table 22

GENERAL FUND APPROPRIATIONS FOR
PATIENT HEALTH SERVICES

	FY 1979	FY 1980	Total
University of Virginia[1]	$10,184,735	$10,909,530	$21,094,265
Medical College of Virginia	17,017,915	17,910,065	34,927,980
Eastern Virginia Medical Authority	2,000,000	2,500,000	4,500,000
Grand Total	$29,202,650	$31,319,595	$60,522,245

[1]Does not include funds for Blue Ridge Sanatorium.

by each hospital to offset the cost of patients unable to pay all or part of their bill. The JLARC inpatient report will also describe the procedures followed by each hospital in the administration of these funds.

Services Provided

Both MCV and UVAH and the hospitals affiliated with EVMA provide a full range of comprehensive inpatient and outpatient medical services. These services are available to the indigent and nonindigent alike. It is difficult to determine how many persons were served by State appropriations for indigent care, however, because neither school maintains separate patient accounts on just the indigent for both inpatient and outpatient services.

Rural Health Initiatives

The rural health initiative program is a totally federal effort on the part of the Public Health Service to develop new sources of primary care in medically underserved areas. For the most part, the program is aimed at establishing health centers in rural areas, but a comparable urban health initiative program is also underway. While these centers are open to anyone regardless of income, underserved areas generally contain a large number of poor.

Expenditures (FY 1977): $500,000[1]

Source of Funds:

Federal	100%
State	
Local	
Third Party	

Services:

Inpatient		Comprehensive	X
Outpatient	X	Specialized	
Long Term Care		Preventive	

Primary Target Group: Residents of medically underserved rural areas.

Management Agency: U. S. Public Health Service

[1]Estimated. Excludes revenue from patient fees and third-party reimbursements.

At the present time, twelve rural health initiatives have been established in Virginia (see Figure 16). Each RHI is administered by its own governing board under guidelines established by the U. S. Public Health Service.

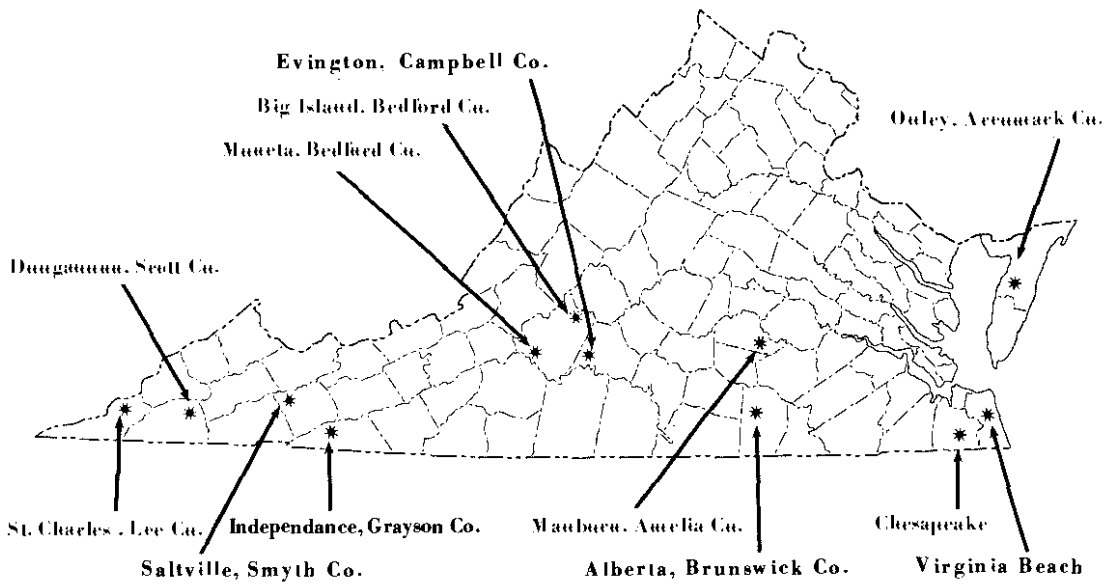
Legislative Base

Rural health initiatives are funded under the community health centers program established by Congress in 1975 (Section 330 of PL 94-63). This program is one of the few currently scheduled to be controlled by area HSA's under the new health planning act (PL 93-641). The program is totally federal, and no reference to it exists in the *Code of Virginia*.

The creation of the community health centers program also serves as a basis for continuing 150 existing community health centers which were the former responsibility of the now abolished Office of Economic Opportunity. Only one such center was established in Virginia. The center, in Arvonia, continues to be funded under Section 330 of PL 94-63.

Figure 16

RURAL HEALTH INITIATIVE PROJECTS IN VIRGINIA
(As of March 1978)



Source: HEW.

Source and Level of Funding

The twelve RHI's today receive annual grants totaling approximately $970,000 in federal funds. FY 1977 expenditures of $500,000 were based on the eight RHI's in existance at the time. Federal funds are seen as a means of starting an RHI initially and for absorbing some of the costs of indigent care. It is intended that RHI's become as self-supporting as possible. As a result, these RHI's are expected to generate a significant amount of their funds from paying patients and third-party reimbursements. One RHI on the Eastern Shore is expected to become self-sufficient in the near future.

The community center in Arvonia is funded separately and receives approximately $1.5 million in federal funds annually.

Eligibility

Both poor and nonpoor are eligible for services with fees based on family income. Any area identified by HEW as being medically underserved is eligible to receive funds for an RHI.

Because both infants and the aged are believed to place an extra burden on the health resources of a given area, the term medically underserved takes into account infant mortality plus the proportion of those in the area who are elderly or who have incomes below poverty levels.

Services Provided

RHI's provide comprehensive primary care comparable to that available from a private physician. Emergency care must be available 24 hours a day, seven days a week. Arrangements must be made by the RHI for sources of inpatient and specialized care. In funding an RHI, special emphasis is placed on coordinating services with other federally-funded programs such as those offered through local health departments.

Health Underserved Rural Areas

The Health Underserved Rural Areas program serves as a funding source to expand existing primary care facilities in medically-underserved areas. Although HURA funded facilities are open to all, emphasis is directed at serving the medicaid eligible.

Expenditures (FY 1977): $470,000[1]

Source of Funds:

Federal	100%
State	
Local	
Third Party	

Services:

Inpatient		Comprehensive	X
Outpatient	X	Specialized	
Long Term Care		Preventive	

Primary Target Group: Residents of medically underserved rural areas, particularly those eligible for medicaid.

Management Agency: U. S. Public Health Service.

[1] Excludes revenue from patient fees and third-party reimbursements.

The Health Underserved Rural Areas (HURA) program is similar to the Rural Health Initiatives (RHI) program except that the HURA program is used to fund existing health organizations rather than start new ones. HURAs also differ from RHIs in that no governing board is required for a HURA project to be funded. The program is administered by the Public Health Service under an arrangement with the Social Security Administration. The intent of the program is to identify new methods of delivering primary health care to underserved rural areas. At the present time, only two HURAs are being funded in Virginia: one through the University of Virginia Medical School in Charlottesville and one in Roanoke.

Legislative Base

Technically, the HURA program is funded under Section 1110 of Title XI of the Social Security Act. This section of the law calls for research and demonstration projects to "improve the administration and effectiveness of programs carried on or assisted under the Social Security Act". Although there is no specific legislative

base for HURA programs, extending health care to medicaid eligibles in rural underserved areas was seen as an appropriate research and demonstration project in keeping with the intent of Section 1110. The program is totally federal, and no reference to it exists in the *Code of Virginia*.

Source and Level of Funding

Although HURAs are funded as special demonstration projects for medicaid, HURA funds are separate and in addition to the basic federal medicaid appropriation to the State. The HURAs funded in Virginia receive a total of almost $470,000 in federal support. No match in State or local funds is required.

Eligibility

Both poor and nonpoor are eligible for services with fees based on family income. However, emphasis is placed on serving the medicaid eligible. Any area identified as being an underserved area for medicaid recipients is eligible to receive HURA funds.

Services Provided

Since HURAs are in some sense experimental, the type of care provided and the manner in which it is delivered varies. Nonetheless, emphasis is still on providing comprehensive primary care in areas with the least resources.

JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

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Administrative Staff

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910 CAPITOL STREET—RICHMOND, VIRGINIA 23219—(804) 786-1258