M I N U T E S

COMMISSION ON HEALTH CARE COSTS

October 5-6, 1977
Room 532, State House

Members Present

Frank Lowman, Chairman
Representative Roy Ehrlich
Representative Charles J. Schwartz
Senator Wesley H. Sowers
Senator Arnold Berman
Al Tikwart
John Erickson
Sister Caroline Juenemann
Tom Lally

Staff Present

Emalene Correll, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes Office
Bill Wolff, Kansas Legislative Research Department

Others Present

Senator Larry Rogers, Wamego, Kansas
Oren Dougherty, Eli Lilly & Company, Englewood, Colorado
Doug Johnson, Kansas Pharmaceutical Association, Topeka, Kansas
Nelson Tilden, Kansas Hospital Association, Topeka, Kansas
Don Stewart, Hadley Regional Medical Center, Hays, Kansas
Frank Gentry, Kansas Hospital Association, Topeka, Kansas
Randall Hempling, Health Planning Association of Western Kansas, Hays, Kansas
Sandra Hunter, Kansas University, Lawrence, Kansas
Ray Hauke, Kansas Legislative Research Department
Kathryn Klassen, Department of Social and Rehabilitation Services, Topeka, Kansas
Sheryl Jacobs, Kansas State Insurance Department, Lawrence, Kansas
Ruth C. Dickinson, State Planning and Research, Topeka, Kansas
Jeff Wampler, Kansas Farm Bureau, Manhattan, Kansas
Terry Whelan, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Gary A. Lavsier, Marion Labs, Inc., Kansas City, Missouri
Jim Scott, Kansas Hospital Association, Topeka, Kansas
Richard S. Swanson, Kansas Department of Health and Environment, Topeka, Kansas
Jim Mankin, D.D.S., Kansas Department of Health and Environment, Topeka, Kansas
Dwight F. Metzler, Kansas Department of Health and Environment, Topeka, Kansas
Al Jarvis, Statewide Health Coordinating Council, Wichita, Kansas
Marlon Dauner, Blue Cross-Blue Shield, Topeka, Kansas
Jack Roberts, Blue Cross-Blue Shield, Topeka, Kansas
Bruce Adair, Blue Cross-Blue Shield, Topeka, Kansas
Petey Cerf, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Harriet Nehring, Kansans for the Improvement of Nursing Homes, Lawrence, Kansas
Joe Tilghman, HEW/HCFA, Kansas City, Missouri
William R. Blake, Jr., HEW/HCFA, Kansas City, Missouri
Jeremy Slaughter, Kansas Medical Society, Topeka, Kansas
A. Wayne Hjort, Kansas Department of Health and Environment, Topeka, Kansas
Robert Harder, Department of Social and Rehabilitation Services, Topeka, Kansas
Jim Pottes, Department of Social and Rehabilitation Services, Topeka, Kansas
Charles Smrha, Blue Cross-Blue Shield, Topeka, Kansas
Barbara Gertz, Kansas Association of Home Health Agencies, Kingman, Kansas
Judy Reno, Kansas Association of Home Health Agencies, Wichita, Kansas
Peggy Giesen, Kansas Association of Home Health Agencies, Wichita, Kansas
Connie Byers, Kansas Association of Home Health Agencies, Kingman, Kansas
Tom Scott, Kansas Association of Home Health Agencies, Kansas City, Kansas
S. Robert Schultz, Visiting Nurse Association, Wyandotte County, Kansas City, Kansas
Julianne Pottorf, Kansas Association of Home Health Agencies, Oskaloosa, Kansas
Ruth Mueller, Southeast Kansas Multicounty Health, Iola, Kansas
Ernie Wandson, Southeast Kansas Multicounty Health, Iola, Kansas
Don Heiman, Legislative Post Audit, Topeka, Kansas
Doug Vogel, Legislative Post Audit, Topeka, Kansas

October 5, 1977

The meeting was called to order at 9:05 a.m. by the Chairman, Frank Lowman.

William R. Roy, M.D., Director, Medical Education and Professional Services, St. Francis Hospital and Medical Center, Topeka, and former member of the U.S. House of Representatives, presented a written statement (Attachment A).

In answer to questions related to supply and demand, Dr. Roy noted there are three phases in the expenditure of dollars for health: (1) as more dollars are spent health is increased; (2) more dollars spent with less benefit; (3) more dollars spent with no benefit. Health care demand continues even if there are no benefits. Currently we are at the second point at least. He stated his concern with arbitrary limitations on expenditures is that they are not related to benefits.

Dr. Roy does not favor increasing the number of physicians as a solution to cost containment. Adding a physician means a $250,000 to $300,000 annual increase in costs over and above direct payments to the physician. He stated he does not think competition can be built in a system based just on fee-for-service. The difference in the health care area is that there is not a limited number of consumers.

Responding to further questions, Dr. Roy stated it is probably impossible to stop the health care cost curve and provide adequate health care services to all without reducing services to a common denominator for all. Any system involves rationing on some basis. Under Health Systems Agencies, we are talking about queues of which there are already some in the present system. Given the current level of spending and an efficient system we could probably have a system where no one would recognize the queues.

Randall Hempling, Director, Health Systems Agency No. 1, stated the staffing started January 1, 1976. He stated that attempts to implement a plan built on population-base-needs soon showed health planning is a political activity. The present plan is based on the philosophy of availability, accessibility and quality of care. He noted that cost cannot be separated from other aspects of the health care system and trade-offs have to be made.

Mr. Hempling pointed out the following problems the Health Systems Agency is addressing:

(1) Inappropriate use of Title XIX, especially in the utilization of nursing homes. The national average is 6 percent of the population over 65 in nursing homes but in his area it is 10 percent. There are requests for additional nursing homes although nursing homes state they are going broke because of the level of SRS payment;

(2) Lack of home health services, primarily because of regulations which seem cumbersome and arbitrary, which impede the development of such services. The cost of home health care in appropriate cases would be one-half or less of the nursing home cost;

(3) Determining the need for hospitals, including those now in operation. Staff of hospitals short distances from each other are asked to get together to develop plans that eliminate duplication. If every facility has to have everything it means mediocrity not excellence in health care.

Mr. Hempling stated Health Systems Agency No. 1 is concerned with the federal grant system in its present form and the Board of Directors has voted to discontinue the federal grants. He recommended consideration of elimination of first dollar payment from health insurance; the development and use of life benefit analysis and cost benefit analysis.

In answer to questions, Mr. Hempling stated he did not mean to imply hospitals would be closed. However, this may happen as a result of prospective rate review or if the guidelines of HEW relative to 80 percent occupancy become more than guidelines. He noted the Health Systems Agency is trying to determine an appropriate occupancy rate for Area I although they feel a utilization rate would be a better approach. The Health Systems Agency Board is asking hospitals in close proximity to develop a plan to eliminate duplication of services as a step toward providing higher quality services. Also, other alternatives need to be looked at, i.e., use of the hospital as a base for other services such as public health services and home health services.

Responding to other questions, Mr. Hempling stated their area has fewer physicians but rates above the rest of the state in health criteria such as longevity. This probably reflects the impact of the lifestyle in this area.

Bill Newman, Director, Northeast Kansas Health Systems Agency, introduced Larry Harris, O.D., President, who noted that Health Systems Agencies are not the white knights that can save the public from health care cost increase. However, as one actively involved in health planning in Topeka since 1969, he shared some impressions gained by being on the front lines in the battle for health care cost containment.

The state certificate-of-need-law does have a deterrent effect, i.e., the expense of preparing an application. Also, the Northeast Kansas Health Systems Agency requirement that an application be a well put together package means the applicant has to spend time thinking about things such as duplication and alternatives. The Certificate-of-Need Program is inadequate, however, because control is incomplete since it applies only to institutions, and the lengthy review process, because of inflation, may decrease any savings effected by the review process.

Dr. Harris stated Health Systems Agencies are currently faced with the possibility of having to live with Washington dictated guidelines for facility and service ratios and the fact that each town feels it has special circumstances that make it an exception to the ratios. The Health Systems Agency finds it is required to allocate resources which are not sufficient to do everything for everybody within the mandate to provide equal accessibility to all. The Health Systems Agency is often at odds with Chambers of Commerce and prominent people in the community in determining need. Towns feel they need medical services as a selling point, and hospitals feel they need to offer all services to attract physicians and patients.

Noting it is politically expedient for any office holder or seeker to condemn high health care costs, Dr. Harris stated he feels people are much more concerned about the high cost of government than they are about the high cost of health care. For example, the Northeast Kansas Health Systems Agency has drawn more adverse publicity about its $225,000 budget than health care costs. People are accepting that inflation is a major cause of the latter.

Dr. Harris stated the Health Systems Agency had instructed him to point out the schizophrenic nature and inconsistency of a federal government which proposes to limit hospitals to a 9 percent increase while increasing the minimum wage 12.7 percent. This wage increase could produce an $8.00 per day increase in hospital costs and a $50-$75 per month increase in nursing home costs. If action is not taken to stop the wage increase, there is no way to effectively restrain health care costs because of the ripple effect.

Dr. Harris stated that short-term savings are not likely to be affected by Health Systems Agencies because they have inherited certificates-of-need from the old Comprehensive Health Planning Agencies and they have no direct effect on third party insurance. Deductible health care insurance should be encouraged because of its deterrant effect, although this will alienate labor unions. However, Health Systems Agencies should help in long-term savings through health education about abusive health behavior and possible alternative life styles, and as the "shock troops" in the all-out assault by government on the private health care industry.

Speaking about the Northeast Kansas Health Systems Agency plan, Dr. Harris stated they had tried to keep it brief, directing it to what they felt was possible and taking cognizance of what already existed. However, HEW refused the plan, stating it needed to be expanded.

Dr. Harris noted that issues considered in developing the plan included elimination of duplication which raised the question of whether monopolies have a positive or negative effect; is competition in health care really competition; do group practices lower or raise health care costs; does the increased utilization of physician extenders have limits because of medical malpractice and the issue of quality of care; an agreement with a Professional Standards Review Organization; and promotion of prevention of disease and educating people about health, health care and utilization of services as long-term programs to reduce costs.

In answer to questions, Dr. Harris stated there are things that can be done to contain costs but they are distasteful. Health Systems Agencies cannot do it alone. It will take the people, the Legislature and the Health Systems Agencies.

Dr. Harris, responding to questions, stated the average occupancy rates for hospitals in Topeka is probably higher than for the state because Topeka is a referral city. The average cost per patient day is about $75.00 with an additional $75.00 for ancillary care. There is already one head scanner in Topeka and two more scanners have been ordered. The Health Services Agency may not get to rule on these scanners as there is a question about whether or not they were included in the certificate-of-need approved earlier by the previous Comprehensive Health Planning body. If a scanner is put in a hospital, Blue Cross-Blue Shield will not reimburse for this service unless there is a certificate-of-need. However, there is no control over a physician or group of physicians putting one in their office.

In answer to questions about the composition and functioning of the Health Systems Agency Board, Dr. Harris stated by law, the majority are consumers. An effort was made to get consumers who would speak out, representation of a number of provider groups, and some providers who do not see eye to eye with other providers. An orientation is provided for new board members and there is an attendance provision to stay on the board. The biggest problem is finding someone who is poor to serve. Board meetings are publicized but very few non-board members attend.

Dr. Roy noted the federal guidelines are guidelines only. They may have some priority but they do not have the same force as law or regulations. A state agency is the ultimate decision maker in certificate-of-need.

The meeting was recessed for lunch at 12:00 Noon and was reconvened at 1:30 p.m.

Al Jarvis, President, Health Systems Agency No. 3, noted the following factors contributing to the cost of health care which they have tried to take into consideration: inflation, especially increased labor costs; aging population; third party payments which are an incentive to use; government regulations; malpractice suits; destructive life styles; OSHA requirements; increased technology; and environment. He then presented a written statement (Attachment B).

In answer to questions, Mr. Jarvis stated he would be concerned about the impact of limiting budget growth to 9 percent or establishing by legislation a mechanism to put a ceiling on increasing hospital charges would have on health care services and the delivery of such services. Either approach would not recognize the need for flexibility for extraordinary circumstances. It was noted that none of the conferees had said specifically what would happen if this approach were used although they had all objected to it. It could provide an incentive to be resourceful and use administrative management which would have little impact on quality.

Mr. Jarvis, in answer to questions, stated he had not seen much evidence that providers are working on keeping costs down. Provider interests do prevail in determining how services are provided and extent of such services. Imposed rate regulations are not effective, however, unless all providers are included. He stated he felt a better approach was to eliminate first dollar coverage by third party payers with incentives to use less costly but appropriate services.

Responding to various comments, Mr. Jarvis made the following comments, people will not be interested or concerned as long as they can get the services they want without paying for them; many states are expressing concern about medical students leaving their state so there is probably a good trade-off; the fact a community is trying to recruit a physician does not necessarily mean it needs one.

In answer to questions about the agency's action on applications, Mr. Jarvis stated all the applications submitted were for nursing home or hospital expansion and all of them were approved. There have not been any applications for scanners because all the Wichita hospitals had acquired them prior to the implementation of the agency. He did not feel approval of requests was due to provider influence since only three of the 20 member review committee are providers and the Chairman is a layman. Staff has recommended some projects not be approved but inadequate data was provided to support the recommendation. This should be corrected with some staff changes that are being made.

Mr. Jarvis, as Chairman of the Statewide Health Coordinating Council, distributed a statement, "The Role of the Statewide Health Coordinating Council" (Attachment C) and presented a written statement (Attachment D). In answer to a question, Mr. Jarvis stated funding for Health Systems Agencies is on a per capita basis. At the present this is about 30 cents but hopefully it will increase to about 75 cents per capita.

Responding to questions, Mr. Jarvis stated very few non-council members attend the meetings but there has been some consumer participation in committee meetings. Individuals contact council members but these contacts are primarily about planned facilities rather than health care costs.

Mr. Jarvis, in answer to questions, stated the council had not discussed a specific "front end" amount to be paid by the individual. It was noted that the deductible approach could have some impact on provider cost, i.e., the cost of collection.

A Commission member noted that the statewide survey relative to health care which the council had done* indicates people do not know what the problem is, do not realize how much the state is spending on the University of Kansas School of Medicine;

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* A copy of this study is filed in the Department of Legislative Research.

and do not realize health care costs are increasing at twice the inflation rate. The public needs to be educated about these facts.

In response to questions, it was noted people not covered by some type of third party coverage are taken care of on a case by case basis at the community level, i.e., public health services, open door policy of hospitals. Costs are being absorbed by the paying patient. It was also noted that when the income of a family is reduced to the level of General Assistance because of medical expenses, the family is eligible for state assistance. This assistance can be retroactive for a three-month period.

In answer to questions, Jim Scott, Kansas Hospital Association, reviewed his comments about Hill-Burton requirements and bad debts made at the last meeting of the Commission. He also noted that if a family pays a portion of the hospital bill, the hospital cannot list the patient as a charity case. The unpaid portion is included as a bad debt. The percentage of private pay patients varies from about 2.2 percent to 4 percent.

Dwight Metzler, Secretary, Department of Health and Environment, stated it was determined early that the cost of health care along with adequacy of primary care and care of senior citizens were a concern of citizens of Kansas. Health care cost is a complex and multifaceted problem for which there are no easy solutions. He then introduced members of his staff to make presentations.

Joe Harkins, Director of Planning and Education, presented a written statement on specific cost containment recommendations (Attachment E). In answer to questions, Mr. Harkins stated the success of the Professional Standards Review Organization depends on the integrity of doctors. The Department feels this approach will work. Statutorily created cost commissions have not been in existence long enough to determine their total impact. They may be pushing at one point and causing the problem to come out at another point. The Department's understanding is that only those cost commissions already in existence will be eligible for federal funding if the proposed legislation is passed. He stated planning must be done between providers, Health Systems Agencies and the Statewide Health Coordinating Council. The feeling is that hospitals have not done enough planning within their own group.

Dr. James Mankin, Director, Bureau of Medical-Dental Health, presented a written statement on the Certificate-of-Need Program (Attachment F). In answer to questions, Dr. Mankin stated that in most cases, people in the community are saying they want the proposed facility and the local or area planning group is saying it is not needed. The case involving the facility in Johnson County has been taken to court and the Department of Health and Environment will enter the case. Dr. Mankin noted the problems the Department has because there is only one attorney on the staff.

In answer to questions, Dr. Mankin stated the Department feels the certificate-of-need statutes will have to be amended during the next Session of the Legislature to include state institutions. The federal law says that state institutions should be included and HEW has told the Department that planning funds will be in jeopardy if the statute is not amended.

Dr. Mankin then presented a statement on the Hill-Burton Program (Attachment G). He stated the Department has not received any calls from the posted notice which is required.

The meeting was adjourned at 4:30 p.m.

October 6, 1977

The meeting was called to order by the Chairman, Frank Lowman, at 9:00 a.m.

Minutes

The following corrections were made in the minutes of the August meeting: page 2 - delete "is now limited to pain and suffering and"; change non-admission days to "Thursday to Saturday"; insert "approximately" before "5 million"; after "program" insert "through Blue Cross-Blue Shield"; page 3 - change percentage to "70 percent to 75 percent"; page 4 - delete next to last sentence in next to last paragraph; in the last paragrpah change "5" to "3"; page 5 - in the fifth paragraph, next to last line, after "rates" change "are" to "need to be"; in the sixth paragraph change the number to "4800"; in the next to last paragraph, sixth line, change "about 10 percent" to about "20 percent". A motion was made and seconded to approve the minutes of the August 30-31, 1977 meeting as amended. Motion carried.

Referring to the minutes of the September 13-14 meeting, a Commission member noted his concern that some providers appearing at the September meeting were not fully aware that the final dollars do not come from "that department" but from individuals. A motion was made and seconded to approve the minutes of the September 13-14, 1977 meeting as mailed. Motion carried.

Don Flora, Director, Mid-America Health Systems Agency presented a limited number of copies of the Health Systems Plan for Area 4 to the Commission*. He referred to Chapters 5 and 6 which discuss the problems of rising costs and some answers for these problems. He noted the survey his agency conducted indicated people's primary concerns are: (1) cost of health care; (2) financing systems for health care; (3) need for local physicians; (4) health services for the elderly; (5) health education services for the public. The agency is looking at these in relation to its operation in basic programs such as certificate-of-need. The agency would also like to find a way to reallocate the money now being spent in Area 4, with emphasis on prevention rather than on reactive or institutional medicine. A goal is to put more of present dollars, not more dollars, into early detection and prevention. The agency is placing a major emphasis on consumer health education to control the demand for services and health care costs, i.e., how to prevent illness, when and how to use services, including how to look at alternatives which are less costly but which are adequate and appropriate with the health care provider.

Mr. Flora stated that by 1982 the number of excess beds will be somewhere between 800 and 2,000 depending on population growth and occupancy growth. The area ranks among the highest in the nation in the number of hospital beds and ranks in the top fourth in occupancy. The agency feels the public cannot pick up the cost of excess beds and also provide a good program for prevention and health care.

He noted the Health Systems Agency has additional problems because it must also work with Missouri which is the only state without some type of capital review process. The agency is in a bind because in Kansas hospitals have to go through a review process and public forum but in Missouri this is optional; i.e., if they do not wish to have Blue Cross reimbursement or want to challenge Blue Cross under antitrust laws. The agency, under Missouri law, becomes involved in capital expenditures through Blue Cross-Blue Shield which has contracts with member hospitals. Since the Blue Cross-Blue Shield threshhold for capital expenditures in Missouri is $350,000 or 5 percent of operating costs, instead of $150,000 as in Kansas, many equipment purchases which would be reviewed in Kansas are not reviewed in Missouri.

In answer to questions, Mr. Flora made the following points: Of the seven facilities presently providing cardiac surgery, only one meets the standard of 200 operations per year. This was one of the major reasons for the denial of a new facility. In Missouri, the procedure for invoking penalties under 1122 have been started against two institutions. Facilities that are expanding are primarily switching from multi-room occupancy to single room occupancy. This move is based on the Georgia study and is considered a legitimate alternative. Hospital charges, including ancillary items, are $130 to $190 per day. In five years the charge could be $230 to $240 per day. There does seem to be a correlation between the number of surgeons and the number of surgical procedures performed, and the number of beds and the number of people hospitalized. The agency has approached foundations pointing out the effect grants they give for capital expenditures have on health care costs. It is difficult to create an awareness among working people, i.e., unions, that in the final analysis they are paying for the services they and others get whether or not the services are appropriate. Also, there is little indication that if the public has knowledge, it will act on that knowledge. Limiting first dollar coverage, whether private or welfare, would be difficult but would have a positive impact. There have not been any problems in health planning as it relates to the operation and development of the K.U. Medical Center even though they are exempt from the State Plan. Nor would there be any problems if it were brought under the State Plan. A need for home health services is projected and emphasis on their development will be included in the second plan. Under the present third party payment mechanism, the law of supply and demand is not effective.

William R. Blake, Acting Regional Medicaid Director, Region 7, HEW, distributed material on Title XIX, Medicaid (Attachment H**) and the National Guidelines for Health Planning (Attachment I). He reviewed the history of Medicaid-Medicare legislation. Medicaid was seen as a program to provide small amounts to cover costs not covered by Medicare, some other payor or the individual. The estimated national cost was $238 million but in three years it was $2.3 billion and not all states had implemented the program.

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* A copy if filed in the Kansas Legislative Research Department.

** A copy of the material presented by Mr. Blake is on file with the file copy of the minutes.

A 1967 amendment reduced the number of people eligible and a later amendment increased the five required services to seven. Medicaid is a federal-state program in which the amount expended is determined by state legislators. As long as state money is available, there is a federal match. The State determines eligibility, optional services offered and amount of payments. Kansas offers all of the optional services except No. 8 (Attachment H). Seventeen programs are administered jointly by the Department of Health and the Welfare Department, 27 by the Department of SRS, one by a free-standing agency and the rest by the Health Department.

Joe Tilghman, Region 7, HEW, stated that of the $126 million spent for Medicaid in Fiscal 1976, 28 percent was for inpatient care and 39 percent for long-term care. Prior to July 1, 1967, states could pay whatever rate they could negotiate with providers. After this date, states had to follow the payment plan for inpatient care established by the Secretary of HEW. A 1972 amendment allowed states to develop alternative payment plans for Medicaid payments. The cost containment act being considered exempts states which have had an alternative payment plan in effect for 12 months from the cap which would be established. However, an amendment giving more latitude to this exemption has been introduced.

Prior to July 1, 1976, states were allowed a great deal of flexibility in determining policy for payments for long-term care as long as payments did not exceed those paid by Medicare or charges made to other patients. Now the federal statute mandates that a state develop a reasonable system for Medicaid reimbursement for long-term care services. States must meet this statutory requirement but since rules and regulations were not available until the effective date of the law, states were given until July 1, 1978, to comply with the rules and regulations. Kansas' plan was approved in March. Consideration is now being given to changing the deadline for statutory compliance to 1985. The impact of this change, if it passes, on states which have already complied is not known.

In answer to questions, Mr. Tilghman stated a state does not have to update its plan. However, if a state wishes to change its payment ceiling, this constitutes a change in the plan and it would have to be sent to the Secretary of HEW for approval. The major problem in developing a sliding scale based on quality of care is determining measurable quantities which constitute quality of care and which can be applied to all providers.

In answer to a question, Dr. Harder noted that because they did not have all quarterly utilization reviews in nursing homes completed by a specific date, the federal match was disallowed for those quarters. A bill pending in Congress would relate the disallowance to the percentage of noncompliance. Mr. Blake stated HEW was in agreement with this concept. The specific review deadlines, established by statute, were enforced by the Secretary of HEW in the hope this would raise the issue in Congress and a more reasonable penalty for noncompliance would be enacted.

In answer to questions, it was noted that it takes a nurse and a social worker to do the long-term care utilization reviews required by federal law. These involve a state review based on federal criteria of the medical condition and plan, and social plan for each Title XIX related patient. HEW then does a validation survey on a 10 percent sample. The nurse spends one-half hour to one hour per patient and the social worker spends about one-half hour per patient.

In answer to a question, Mr. Tilghman stated that since 1967 it had been possible, although difficult, for a state to move toward an alternative for determining payments for hospitalization under Medicaid. Of the few alternatives developed, most are prospective payments based on a formula or on budget review. The formula approach uses the past year, the current year and the projected year and ties this into the CPI Index. The budget review approach projects the budget for the year to be paid. States vary as to which services and which established rates apply. Dr. Harder stated a Committee in SRS is looking at possible alternatives to the present policy, paying audited cost or actual charges whichever is less, but have nothing to report at the present time.

Jack Roberts, Title XIX, Blue Cross-Blue Shield, introduced Bruce Adair, a staff member, who reviewed the fiscal agent contract they have with the Department of SRS (Attachment J).

In answer to questions, Mr. Adair stated most duplicate claims are caused by poor bookkeeping. Blue Cross-Blue Shield works with providers to develop better bookkeeping procedures. If fraud were suspected, a further investigation would be made, and if the facts warranted, the case would be turned over the state. He noted that since approximately 90 percent of physicians' billings are coming through their office, they

have a good opportunity to pick up individual provider patterns. They can also pick up individuals who may be physician shopping. Four or five years ago this was a problem but it has been minimal for the last two years. They do not find a pattern of patients being referred through a specific chain of doctors. Checks are also made on a physician's visits to a nursing home. Dr. Harder stated he felt the Department had reasonably good control in this latter area.

Noting he had a degree in economics, Mr. Adair stated that in the health care area the law of supply of demand does not work normally. One reason is that the role of the patient in decision making is minimal. Three factors, quality, cost and accessibility, are involved. An impact on one creates an impact on all three. If the number of physicians is increased, accessibility or use is increased and therefore costs are increased. If a given variable such as a 30 mile radius were used, a program could be written that would show more specifically the effect of adding a physician in a community has on claims.

Questions were raised about the effect limiting payments had on availability of physician's services. It was noted that a physician's expenses go up every year as in any other business. Therefore a freeze on physician's fees would seem to be unreasonable, but a characteristic increase on which to base payments could be determined. Dr. Harder stated that the amount expended goes up each year so obviously many physicians are still providing services for Medicaid patients. In these cases the physician has about a 95 percent to 98 percent chance of collecting even though it is at a lower rate. There may be a problem in an area with only one physician who is no longer accepting patients because he is overworked. A suggestion was made to make the treatment of Medicaid patients a condition of licensure for physicians.

It was noted that a frequent assumption is that Medicaid recipients' health is not as good as that of persons carrying their own coverage. Mr. Adair stated they could not state this as a fact but they do know that the average Medicaid recipient has a higher utilization rate than the average Blue Cross-Blue Shield subscriber. Dr. Harder stated they are doing some research which indicates that for employed persons there is a relationship between income and work days missed.

Dr. James Mankin, Director, Bureau of Medical-Dental Health, Department of Health and Environment, presented a written statement on the Facility Licensing and Certification Program (Attachment K).

In answer to a question, Dr. Mankin stated that the concept of home health agencies is that there are many people who can be adequately cared for at home at less cost if a nurse is available to go to the home to carry out the treatment prescribed by a physician. Because of federal funding rules and regulations, few programs have been started since 1971. The Department received state funds to help organize a home health agency in about nine counties and to cover salaries for one year. During this time enough third party payments should be generated to keep the service going. Money is included in next year's budget request to develop home health agencies in additional counties.

Dr. Mankin, in answer to questions, stated the Department licenses homes caring for three or more persons. Homes caring for only one or two persons, found primarily in larger cities, are licensed for the level of care they can provide which is minimal and usually only personal care. Licensure of these homes is based primarily on compliance with fire safety laws. A new adult care facility which meets the standards is given a provisonal license to give the Department time to see how they function before granting a permanent license. He noted some homes go through a recurring cycle of barely meeting standards and then falling below standards. The Department requested a fine bill last Session to help with this problem but it did not pass. Some licenses have been revoked and some homes have closed because they could not afford to meet the new fire safety code.

Responding to questions, Dr. Mankin stated appropriateness reviews are to be done at specified intervals by the Health Systems Agencies. It was noted that if a Health Systems Agency recommended a home should be closed based on the review, the same procedure as that for denying new construction would be followed.

Dr. Mankin, in answer to questions, stated labs wishing to receive payment through federally funded programs must be certified. This involves inspecting the lab, checking to see all technicians meet certification requirements and having the lab perform a specified number of tests to check accuracy and procedure. The lab must have an arrangement with a physician and a few are owned by physicians. Ownership of the lab must be disclosed.

The meeting was recessed for lunch at 11:50 a.m. and was reconvened at 1:30 p.m.

Connie Byers, Kingman County Health Department and President of the Kansas Association of Home Health Agencies, stated there are 32 certified home health agencies covering 45 counties. Three of these are hospital based and the rest are part of a local health department. Twenty-nine of the agencies belong to the Kansas Association of Home Health Agencies. According to Blue Cross-Blue Shield records, 4,012 home health agency visits were paid for under Medical Assistance last year. This figure does not include the three agencies in the Kansas City area. The number of visits paid for under Medical Assistance in this area was not available. Certification under the Department of Health and Environment requires that more than nursing services be offered, i.e., staff in the Kingman County agency includes a nurse aid and a physical therapist. All referrals must be through a physician.

Ms. Byers noted that because the same regulations apply to both Title XVIII and XIX in Kansas, agencies do provide a lot of services without compensation. Last year the Kingman County Department of Health was reimbursed for only about 400 of the approximately 800 home health service visits made.

Development of agencies has been slow because of payment restrictions. The biggest problem is that a patient must need skilled care to be covered by Medicare or Medical Assistance. However, some patients referred to home health service agencies do not need skilled care. Not all treatment prescribed by the physician is skilled care. The agency provides the service needed but is not reimbursed for it. A nurse's visit averages one hour at a cost of $20 to $25. A nurse aide's visit averages 2.46 hours at a cost of $10 to $15.

Ms. Byers stated the Association feels that in appropriate cases, home health services can provide quality care at less cost. It is a cost containment program. However, for home health agencies to develop and to provide needed services, changes are needed in the regulations pertaining to reimbursement.

In answer to a question, Tom Scott, administrator of a hospital-based program, stated most of the people they serve are not single, older people. The service is for anyone needing home health care that cannot be provided by a member of the family. In his agency no more than 20 percent of the clients are living alone.

Judy Reno, Wichita-Sedgwick County Health Department, stated information they have indicates that approximately 3 percent of the Kansas budget is allocated for direct health services. So at the local level they have to depend on local money which is stretched thin or on federal funds. The state is not committed to health which is something that does not seem important until we do not have it. She stated her department had applied for federal money to initiate some programs in home health but did not qualify because the percent of elderly in the population was too low. In answer to questions, she stated adding a nurse to their staff would take $10,000 for beginning salary plus benefits. They have 30 nurses for a population of approximately 380,000.

In answer to questions, Ms. Byers said getting doctors to refer cases to a home health agency is difficult in some communities, especially the larger cities. It is not a problem in her county where she has a personel working relationship with all the doctors. Physicians indicated they often forgot about this service, so she contacts them when she hears someone is leaving the hospital.

It was noted that legislation to encourage the development of home health agencies is being considered in Congress.

Doug Vogel, Audit Manager, Legislative Post Audit, apologized for the lack of information at this time but the audit of the Social and Rehabilitation Medical Assistance Program is not complete. He noted that Legislative Post Audit's multi-disciplinary staff audits two areas: (1) financial affairs and transactions of each agency once every two years; and (2) programs which may cut across agencies, as instructed. The Legislative Post Audit Committee, a ten member bi-partisan committee, provides direction for the Division.

None

Mr. Vogel then introduced Don Heiman of his staff who discussed the audit of Medical Assistance programs (Attachment L). Staff noted that the percentage increase in state funding of Medical Assistance programs given by Mr. Heiman included a shift from county support to state support for some of these programs.

Dr. Robert Harder, Secretary, Department of SRS, noted the response of the Department to the first Legislative Post Audit report which will be sent to the Committee.

Dr. Harder stated that a secretary's letter summarizing the homemaker and the home health services and the procedure for providing these services will be mailed to agencies on October 10. He emphasized the need for establishing fixed maximums for programs early in their development if costs are to be contained. Hopefully programs such as these in the field will contain the number of people who have to be institutionalized. At this point it does not look like a decline in nursing home occupancy can be predicted but it looks like it has stabilized. The further development of home health services may change this. Although these programs are different, coordination of staff is feasible. For example, a home health aide may also provide homemaker services.

In answer to a question, Dr. Harder stated that because of contracting problems and the need to get services throughout the state quickly at the most reasonable cost, homemaker services were piggybacked on the SRS system. However, since county health departments were already providing some home health services and wanted to expand in this area, the Department felt it was better to expand these programs than duplicate them. Also the Department tries not to hire extensive medical staff except in the state institutions.

Dr. Harder then discussed the following items considered by the Department's Cost Containment Committee*:

1. State position of support for federal legislation which would put a heavy emphasis on the development of alternate delivery systems, i.e., greater use of Health Maintenance Organizations. A problem for HMOs has been getting sufficient lead money to get started. Trying to get HEW to be more flexible and getting a waiver of present restrictions to do a pilot project is being considered.

2. Work for and support federal legislation or rules and regulations changes which would allow states to expand the concept of deductibles or co-pay now used for drug prescriptions. Flexibility to apply this concept to other services for appropriate groups within Medical Assistance programs should be provided. For example, SSI recipients should be excluded but an employed mother receiving Aid to Dependent Children Medical Only would probably be in a position to handle co-pay for other services in addition to the co-pay for prescriptions.

3. A massive and intensive education program for preventive measures. An effective program in the areas of diet, smoking and drinking would probably do as much as anything else to contain costs. Studies indicate the public, sooner or later, has to pick up the bill for those persons with habits of excess in these areas. The Department has already contacted some organizations for pieces that can be used in SRS offices and as stuffers in mailings to recipients.

4. An ongoing health care commission with some authority to set rates. This authority could be restricted to hospital rates or could include an extensive list of services; could be restricted to payments for Medicare and Medicaid patients only or could include all patients. More consideration will probably be given to what the agenda of this commission should be. Dr. Harder stated he would be interested in starting with consideration of a hybrid between the rate review concept of the Kansas Hospital Association and the Corporation Commission. He would like to see consideration given to a membership that would include consumers, providers, third party payors and a neutral representative (the Corporation Commission idea). However, this may be too unwieldy. Connecticut, Maryland and New Jersey, which have developed the rate setting commission concept, have held hospital percentage increase to less than the national percentage increase.

5. Alternative payment plan. The committee is looking at alternative payment plans to hospitals which might be recommended for Kansas. One alternative being considered is an incentive plan similar to that used for nursing homes. Cost centers would be developed and payment would be at pre-determined percentile for each established category of service. Since any charge below the percentile line would be an incentive, there would be a pay-back. The crucial factor is establishing the maximum percentile line. Two obvious disadvantages are the lack of enthusiasm of the hospitals and the question of who will absorb costs above the percentile line which the state does not pay. It was noted the incentive is lost if this alternative applies only to patients covered by a Medical Assistance program.

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* Dr. Harder's presentation and his answers to questions are included under each point without any distinction between them.

Dr. Harder noted the rate review being implemented by the Kansas Hospital Association. The Association has had two meetings with the Department to discuss rate review since the last meeting of this Commission and several more meetings are scheduled.

6. Changes in nursing home payments. The committee and the Department are reasonably happy with the present system. However, attention needs to be given to two issues. The first is reserve days. A nursing home bed must be reserved for up to 15 days for a resident who is hospitalized. This does affect rates. The second relates to depreciation and how to include it in rate consideration.

7. Expansion of home health services.

8. Much more active audit of pharmaceutical services.

9. Changes in how mental health centers charges are determined and how audits of mental health centers are done.

Dr. Harder stated that open enrollment for Medical Assistance programs is a key factor in the cost containment problem. As of June 30, 1977, the Medical Assistance population was 6 percent of the total population of Kansas and 45 percent of the poverty population. The eligible percentage is higher.

Dr. Harder noted that through an agreement with the Attorney General, the Department's attorney does all the legal work on cases of suspected fraud and abuse and notifies the Attorney General at the point of court action. Several cases against providers are being investigated currently. Action against recipients has been going on for about two years.

Dr. Harder pointed out that they cannot guarantee the Medical Assistance Program budget will be accurate or sufficient. The budget is developed 18 months in advance and is based on projected economic and health conditions of the people of Kansas. A system of prospective reimbursement to hospitals would be helpful in budget forecasting. He stated that in 1971, about 115,000 persons were being served with approximately 25,000 hospital admissions. In 1977 this was about 151,000 persons being served with approximately 49,000 hospital admissions. The number served increased by about one-third but hospital admissions almost doubled.

Dr. Harder stated the Department now receives comprehensive printouts on hospital utilizations and charges. Based on these printouts, teams from Blue Cross-Blue Shield will discuss with hospitals how they compare with their peer group and whether or not adjustments can be made within hospitals. Action to be taken with hospitals which seem above the normal will be discussed at monthly meetings with Blue Cross-Blue Shield. Follow-up will be done by Blue Cross-Blue Shield. The pattern for these hospitals will be checked a few months later to see if further action is needed. This procedure is also followed for other providers.

Answering questions relating to certificate-of-need, Dr. Harder stated he felt this program needs to be directed, at least in part, to the payment agency. It was noted that there are some standards, i.e., state plans for different types of facilities, other than payment, available against which to judge if a facility is needed. Dr. Harder agreed but stated if a private group decides to build a facility, even though the plan says only five are needed and five are already built, saying they cannot be paid for services rendered may be the only way to stop them.

Next Meeting

The next meeting will be November 28, 1977, at 9:00 a.m. The Commission will give staff directions for the drafting of the Commission's report. It was noted that the Commission, through consensus or motion, may request staff to draft bills. The Commission cannot introduce bills but can ask a legislator to introduce the bill by request. The Chairman pointed out this report will be a preliminary report which will be followed by a final and more detailed report at a later date. He also noted the Commission may not want to consider possible legislation until later.

The meeting was adjourned at 4:00 p.m.

Prepared by Emalene Correll

Approved by Committee on:

6/14/78
(date)

EC/dmb

Statement of Bill Roy, M.D. Oct. 5, 1977.
Attachment

PEOPLE OF NEARLY EVERY INDUSTRIALIZED NATION HAVE ACTED TO GUARANTEE BASIC MEDICAL CARE FOR EVERY INDIVIDUAL BY ESTABLISHING A NATIONAL HEALTH SYSTEM OR NATIONAL HEALTH INSURANCE PROGRAM.

THEY HAVE ACTED, AND WE WILL ACT, BECAUSE OF THE PRINCILPES OF FAIRNESS AND EQUITY. WE ACCEPT THAT NO ONE SHOULD DIE OR SUFFER BECAUSE HE OR SHE CANNOT PAY FOR MEDICAL CARE OR BECAUSE MEDICAL CARE IS INACCESSIBLE.

BUT IF WE ARE TO ACT WISELY AS WE MOVE TO UNIVERSAL NATIONAL HEALTH INSURANCE, WE NEED TO KNOW ALL WE CAN ABOUT OUR CURRENT HEALTH SYSTEM AND THE TRADEOFFS THAT WILL BE NECESSARY IN ANY FUTURE HEALTH SYSTEM. IN ADDITION, WE MUST BE AS CLEAR AND REALISTIC AS POSSIBLE ABOUT OUR GOALS AND EXPECTATIONS.

FOR THESE REASONS, I AM PLEASED TO PARTICIPATE IN THIS SYMPOSIUM. I CONGRATULATE YOU FOR CALLING IT, AND ATTENDING IT, AND UPON YOUR FURTHER PLANS TO DISSIMINATE AND CONSIDER FURTHER THE INFORMATION GATHERED HERE.

WHILE WE CAN LEARN A GREAT DEAL FROM THE EXPERIENCE OF OTHER NATIONS, THE MOST IMPORTANT THINGS WE MUST LEARN FOR OURSELVES. WE ARE APPROACHING NATIONAL HEALTH INSURANCE AT NOT ONLY A DIFFERENT TIME CHRONOLOGICALLY, BUT AT A GREATLY DIFFERENT TIME MEASURED IN TERMS OF MEDICAL KNOWLEDGE AND TECHNOLOGY. OUR HEALTH CARE SYSTEM IS PRESENTLY HIGHLY ADVANCED AND HAS WELL ESTABLISHED PATTERNS OF FINANCING AND CARE. IN ADDITION, WE HAVE A UNIQUE ECONOMIC SYSTEM AND DEEPLY HELD CONVICTIONS ABOUT THE ROLE OF GOVERNMENT AND RESPONSIBILITIES OF INDIVIDUAL CITIZENS WHICH DIFFER AT LEAST IN DEGREE FROM THOSE OF OTHER NATIONS AND WHICH DIFFER ALSO FROM OTHER PERIODS IN THE HISTORY OF OUR OWN NATION.

Atch. A

WE IT IS DIFFICULT TO DEAL WITH CHANGES WHICH COME ABOUT AT AN EVER ACCELLERATING RATE, THERE ARE THREE MEDICAL FACTS OF LIFE WHICH ARE VIRTUALLY UNDISPUTED TODAY AND WHICH WILL BE TRUE IN THE FUTURE. THESE FACTS MUST BE USED AS GUIDEPOSTS AS WE MAKE OUR PLANS AND MEASURE OUR ACHIEVEMENTS.

FIRST, IT IS IMPERATIVE THAT WE REALIZE THAT WE CANNOT PROVIDE ALL OF THE MEDICAL CARE THAT IS SCIENTIFICALLY POSSIBLE FOR EVERYONE EVERYWHERE; SECONDLY, AS A RESULT OF THIS LIMITATION WE MUST DECIDE WHAT WE WILL DO FOR WHOM WHERE; AND THIRDLY, WE MUST ALWAYS KEEP BEFORE US THE FACT THAT PERSONAL MEDICAL CARE IS ONLY ONE OF THE DETERMINANTS OF HEALTH AND LONGEVITY.

PERMIT ME TO REVIEW THESE THREE POINTS WITH YOU, AND THEN DURING THE REMAINDER OF THIS TALK I WILL DISCUSS SOME OF THE IMPLICATIONS THAT I BELIEVE FLOW FROM THESE LIMITATIONS.

WE CAN NOT DO EVERYTHING THAT IS SCIENTIFICALLY POSSIBLE FOR EVERYONE EVERYWHERE. WE AS A SOCIETY HAVE LONG ACCEPTED THIS ECONOMIC REALITY ABOUT NEARLY EVERY SERVICE AND PRODUCT EXCEPT HEALTH CARE. FUCHS HAS PUT THE BASIC ECONOMIC LAWS SIMPLY AND SUCCINCTLY. "THE FIRST IS THAT RESOURCES ARE SCARCE RELATIVE TO HUMAN WANTS; SECOND, IS (THAT) RESOURCES HAVE ALTERNATIVE USES; AND THIRD, THAT PEOPLE HAVE DIFFERENT WANTS TO WHICH THEY ATTACH VARYING DEGREES OF IMPORTANCE".

WHILE WE, SIX PERCENT OF THE WORLD'S PEOPLE, CONTINUE TO CONSUME

APPROXIMATELY 30 PER CENT OF THE WORLD'S RESOURCES EACH YEAR, EVEN WE IN WEALTHY AMERICA ARE BEGINNING TO REALIZE THE FINITENESS OF ENERGY SOURCES AND OTHER RAW MATERIALS, AND TO APPRECIATE THAT NEARLY EVERYTHING CONSUMED MUST FIRST BE PRODUCED BY COMBINING CAPITAL, RAW MATERIALS AND LABOR. THE ECONOMIC ROMANTICISM OF THE 60'S IS YIELDING TO THE REALITIES OF THE 70'S. POLITICAL LEADERS OF EVERY PERSUASION REPEAT PROFOUNDLY, "THERE IS NO FREE LUNCH".

YET, BY CHOICE OR BY HAPPENSTANCE, WE ARE GREATLY INCREASING THE PERCENTAGE OF OUR WEALTH AND PRODUCTIVITY THAT IS CONSUMED FOR MEDICAL CARE. EXPENDITURES FOR HEALTH HAVE INCREASED 500 PER CENT SINCE 1960, AND THE PORTION OF THE GROSS NATIONAL PRODUCT (GNP) DEVOTED TO MEDICAL CARE HAS INCREASED NEARLY 50 PER CENT BETWEEN 1965 AND 1976. TODAY THE AVERAGE AMERICAN IS WORKING ONE MONTH OUT OF TWELVE TO PAY FOR MEDICAL CARE.

FOUR PROMINENT FORCES HAVE CAUSED THE MEDICAL SYSTEM TO BE CHARACTERIZED AS A VACUUM CLEANER THAT WILL SUCK UP ALL DOLLARS MADE AVAILABLE TO IT. THEY ARE, ONE, THE EXPECTATION OF PATIENTS; TWO, THE SCIENTIFIC AND TECHNOLOGIC REVOLUTION; THREE, OPEN-ENDED THIRD PARTY PAYMENT; FOUR, A PHYSICIAN ETHIC WHEREBY EACH PHYSICIAN TRIES TO PROVIDE ALL HEALTH CARE FOR EACH PATIENT.

PEOPLE UNDENIABLY VALUE HEALTH VERY HIGHLY, AND THEIR EXPECTATIONS

ABOUT THE SCOPE AND EFFICACY OF PERSONAL HEALTH SERVICES HAVE INCREASED YEAR BY YEAR. ILLICH HAS SPOKEN OF THIS PHENOMENON AS THE "MEDICALIZATION" OF SOCIETY.

HOWEVER, THE SINGLE, GREATEST FORCE RESPONSIBLE FOR INCREASED HEALTH EXPENDITURES IS THAT WE LIVE IN A TIME OF SCIENTIFIC AND TECHNOLOGIC REVOLUTION.

MEDICAL KNOWLEDGE IT IS SAID, HAS A HALF LIFE OF FOUR TO SEVEN YEARS. EXPENSIVE PRODUCTS OF MEDICAL TECHNOLOGY HAVE A SIMILARLY SHORT HALF LIFE AND, THEREFORE, ARE CONSTANTLY BEING MODIFIED OR REPLACED BY NEWER AND MORE EXPENSIVE INSTRUMENTS.

PRIVATE HEALTH INSURANCE FOR MANY PEOPLE, AND GOVERNMENT PAYMENT FOR SERVICES FOR SOME PEOPLE, HAVE REMOVED PAYMENT AT THE POINT OF SERVICE AS A MARKETPLACE REGULATOR OF THE USE OF MEDICAL SERVICES. FIRST DOLLAR NATIONAL HEALTH INSURANCE WOULD REMOVE BARRIERS OF COST. IF THIS HAPPENS, IT IS PREDICTABLE THAT NEARLY ALL PEOPLE WOULD SEEK ANY AND ALL MEDICAL CARE SERVICES OF ANY POSSIBLE MARGINAL BENEFIT, EXCEPTING ONLY THOSE THAT ARE INCONVENIENT, PAINFUL OR DANGEROUS.

COMBINING WITH THIRD PARTY PAYMENT IS THE FORCE OF PROVIDER DETERMINATION OF SERVICES. WE PHYSICIANS ARE TRAINED TO USE EVERY AVAILABLE RESOURCE POSSIBLE THAT MAY BENEFIT OUR INDIVIDUAL PATIENTS

REGARDLESS OF COST. WE DO NOT WANT TO BE 95 PER CENT CERTAIN IF WITH AN ADDITIONAL TEST OR PROCEDURE, AND THE ASSOCIATED ADDITIONAL EXPENDITURE WE CAN BE 97 PER CENT CERTAIN. FURTHERMORE, OUR PATIENTS EXPECT NOTHING LESS. TO MY KNOWLEDGE THIS HAS ALWAYS BEEN SO AND IT IS MY EXPECTATION THAT IN THE ONE TO ONE DOCTOR-PATIENT RELATIONSHIP THIS WILL ALWAYS BE SO.

TWO OTHER DESCRIPTIONS OF OUR PRESENT HEALTH CARE SYSTEM ARE HELPFUL. ONE IS HIATT'S DESCRIPTION OF THE MEDICAL COMMONS. HE ANALOGIZES THE FINITE RESOURCES AVAILABLE IN OUR ECONOMY FOR HEALTH SERVICES WITH A LIMITED COMMONS AVAILABLE TO HERDSMEN FOR GRAZING THEIR CATTLE.

HE POINTS OUT THAT A COMMONS IS NOT A MARKETPLACE BECAUSE ALL MEMBERS OF A SOCIETY ARE ENTITLED TO USE THE COMMONS. OVER UTILIZATION AND RUIN OF THE COMMONS IS INEVITABLE BECAUSE EACH INDIVIDUAL RUSHES TO USE THE COMMONS IN HIS OR HER OWN SELF-INTEREST. EACH HERDSMAN ADDS ONE MORE ANIMAL UNTIL THE GRAZING LAND IS DESTROYED.

WE HAVE ESTABLISHED A HEALTH SERVICES COMMONS FOR MOST AMERICANS BY THE ADOPTION OF PRIVATE HEALTH INSURANCE FOR MANY PEOPLE AND GOVERNMENT PAYMENT FOR SERVICES FOR SOME PEOPLE. MANY PEOPLE CONTEND THAT THE PASSAGE OF UNIVERSAL FIRST DOLLAR PAYMENT NATIONAL HEALTH INSURANCE WOULD ASSURE THE DESTRUCTION OF THE MEDICAL COMMONS.

THE SECOND HELPFUL PERSPECTIVE IS THE ECONOMIST'S DESCRIPTION OF OUR PRESENT SYSTEM. TODAY MOST HEALTH INSTITUTIONS ARE PAID ON A FEE-FOR-PROCEDURE BASIS AND MOST NON-INSTITUTION PROVIDERS, FOR EXAMPLE, DENTISTS, PODIATRISTS AND PHARMACISTS ARE PAID ON A FEE-FOR-SERVICE BASIS. MOST CONSUMERS ARE REQUIRED TO PAY LITTLE OR NOTHING OUT OF POCKET IN ORDER TO OBTAIN HOSPITAL SERVICES AND NEARLY 70% OF PHYSICIANS BILLS ARE ALSO PAID BY THIRD PARTIES. FEE-FOR-SERVICE AND FEE-FOR-PROCEDURE PAYMENT RESULT IN WHAT THE ECONOMISTS CALL "A POSITIVE, MARGINAL FINANCIAL IMPACT ON PROVIDERS EACH TIME A SERVICE IS RENDERED," THAT IS, THE MORE SERVICES THAT A PROVIDER RENDERS, THE MORE INCOME THE PROVIDER REALIZES. FIRST DOLLAR INSURANCE RESULTS IN A "ZERO MARGINAL FINANCIAL IMPACT ON THE CONSUMER". THAT IS, EACH TIME A SERVICE IS RENDERED THERE IS NO FINANCIAL LOSS OR GAIN BY THE CONSUMER. THIS COMBINATION RESULTS IN THE MAXIMUM UTILIZATION OF SERVICES. THE PROVIDER GETS MORE MONEY AND THE CONSUMER GETS MORE SERVICES AND THE THIRD PARTY, GOVERNMENT OR INSUROR, GETS MORE BILLS TO PAY. THERE IS SUBSEQUENTLY A 15% ANNUAL INCREASE IN EXPENDITURES FOR HEALTH.

AS A RESULT OF THESE FOUR FACTORS, COSTS GO UP AND UP AT SUCH A RATE THAT FEW OR NONE WITHIN OUR SOCIETY WILL CONTEND THAT IT IS MATHEMATICALLY OR POLITICALLY POSSIBLE TO CONTINUE INDEFINITELY PRESENT TRENDS IN INCREASED EXPENDITURES FOR HEALTH, OR THAT IT IS POSSIBLE EVEN IN WEALTHY, MODERN AMERICA TO DO EVERYTHING WHICH IS MEDICALLY AND SCIENTIFICALLY FOR EVERY ONE EVERYWHERE.

WE MUST DECIDE WHAT WE ARE GOING TO DO FOR WHOM WHERE. THIS CONCLUSION IS A COROLLARY OF THE RECOGNITION OF LIMITED RESOURCES FOR HEALTH.

IN ANY SOCIETY WHEN THERE IS NOT ENOUGH OF SOMETHING TO GO AROUND, THERE ARE WAYS, FORMAL OR INFORMAL, ORGANIZED OR UNORGANIZED, LESS FAIR AND EQUITABLE OR MORE FAIR AND EQUITABLE, OF DETERMINING WHO GETS WHAT.

MANY PEOPLE POINT OUT ACCUSINGLY THAT ANY NATIONAL HEALTH INSURANCE LAW WILL BE A METHOD OF RATIONING HEALTH CARE. THIS IS SO, BUT IT IS ALSO TRUE THAT WE ARE NOW RATIONING HEALTH CARE BY SEVERAL MECHANISMS, INCLUDING THE BARRIER OF COST FOR SOME PEOPLE, THE INACCESSIBILITY OF SERVICES FOR OTHERS AND FOR OTHERS, THE INABILITY TO FIND A POINT OF ENTRY INTO A COMPLEX HEALTH CARE DELIVERY SYSTEM. FOR EVEN OTHERS, IT IS A MATTER OF CHANCE WHETHER OR NOT THEY ARE THE BENEFICIARY OF ALREADY LIMITED RESOURCES - FOR EXAMPLE, WHO RECEIVES THE SINGLE KIDNEY AVAILABLE FOR TRANSPLANT, OR WHICH VICTIM OF APLASTIC ANEMIA GETS INTO THE ONE REMAINING STERILE COCOON.

ALL NATIONS WITH NATIONAL HEALTH INSURANCE, OR AS SOME MIGHT CALL THEIR SYSTEMS, "SOCIALIZED MEDICINE", ARE FACED WITH THE SAME PROBLEMS OF LIMITED RESOURCES AND THE RATIONING OF SERVICES. WHILE THEY ADDRESS THE PROBLEMS IN A VARIETY OF WAYS, THE MOST COMMON RESOLUTION IS FOR THE GOVERNMENT TO DETERMINE TOTAL EXPENDITURES

FOR HEALTH. WHERE THERE IS REASONABLE EQUALITY OF ACCESS TO EXISTING SERVICES, THERE HAS UNTIL THIS TIME BEEN LITTLE SOCIAL OR POLITICAL STRIFE, AND NEARLY WITHOUT EXCEPTIONS THE CITIZENS OF THESE NATIONS STRONGLY SUPPORT AND ENDORSE THEIR RESPECTIVE SYSTEMS OF NATIONAL HEALTH SERVICES.

IN SUM, IT IS A MATTER OF FIRST MAGNITUDE OF IMPORTANCE THAT WE RECOGNIZE AND ARTICULATE THAT THE MOST WE CAN EXPECT OF ANY FUTURE NATIONAL HEALTH INSURANCE PROGRAM IN THIS COUNTRY IS EQUAL ACCESS TO LIMITED, BASIC MEDICAL SERVICES, RATHER THAN ALL MEDICAL SERVICES.

PERSONAL HEALTH CARE IS ONLY ONE DETERMINANT OF HEALTH. THERE IS A GREAT DEAL OF EVIDENCE THAT PERSONAL HEALTH SERVICES ALONE CAN PROVIDE ONLY MARGINAL IMPROVEMENTS IN HEALTH. ONE OF THE MOST PERSUASIVE ARGUMENTS THAT I KNOW FOR THE NEED FOR HEALTH EXPENDITURES FOR OTHER THAN TRADITIONAL MEDICAL SERVICES IS THE DOCUMENTATION IN THE LA LONDE REPORT "A NEW PERSPECTIVE ON THE HEALTH OF CANADIANS" OF THE CAUSES OF LOSS OF YEARS OF LIFE BETWEEN AGES ONE AND SEVENTY. CANADIANS SUFFER EARLY DEATH AS A RESULT OF FIVE MAIN CAUSES:

(1) MOTOR VEHICLE ACCIDENTS
(2) ISCHEMIC HEART DISEASE
(3) ALL OTHER ACCIDENTS
(4) RESPIRATORY DISEASE AND LUNG CANCER
(5) SUICIDE

THE REPORT POINTS OUT THAT MOST OF THESE CAUSES OF PREMATURE DEATH CANNOT BE PREVENTED OR CURED BY THE MEDICAL CARE SYSTEM. ACCIDENTS AND SUICIDES, FOR EXAMPLE, OFTEN RESULT IN DEATH BEFORE ANY CONTACT IS MADE WITH THE MEDICAL CARE DELIVERY SYSTEM. WE ALSO RECOGNIZE THAT DIET, LACK OF EXERCISE, SMOKING AND ENVIRONMENTAL FACTORS HAVE A GREAT DEAL TO DO WITH THE INCIDENCE OF THE DISEASES OF THE HEART AND THE INCIDENCE OF CANCER AND OTHER DISEASES OF THE LUNGS. A GREAT PART OF THE MONEY AVAILABLE FOR PUBLIC HEALTH, IMMUNIZATIONS, HEALTH EDUCATION, ENVIRONMENTAL CONTROL AND SIMILAR PURPOSES COMES FROM PUBLIC SOURCES RATHER THAN PRIVATE SOURCES. HOWEVER, THE INCREASING COSTS OF MEDICAL CARE TO GOVERNMENT, THE FIVE BILLION DOLLAR ANNUAL INCREASE IN FEDERAL EXPENDITURES FOR MEDICARE AND MEDICAID, HAVE RESULTED IN LESS ADEQUATE PUBLIC EXPENDITURES FOR OTHER HEALTH INITIATIVES. IN VIEW OF THIS EXPERIENCE, WE MUST MEASURE EACH NATIONAL HEALTH INSURANCE PROPOSAL BY WHETHER OR NOT IT WILL SO GREATLY INCREASE EXPENDITURES FOR SICKNESS CARE THAT WE WILL SPEND LESS AND LESS FOR OTHER TRADITIONALLY PUBLICLY FINANCED HEALTH INITIATIVES.

IN AN ERA OF RECOGNIZED LIMITED RESOURCES WE MUST DISCUSS COSTS. WE MUST ASK "WHAT IS THE OPTIMUM NUMBER OF DOLLARS, OR THE OPTIMUM PERCENTAGE OF GROSS NATIONAL PRODUCT THAT WE SHOULD BE SPENDING FOR HEALTH CARE?" WE MUST ASK HOW TOTAL EXPENDITURES ARE PRESENTLY BEING DETERMINED. AND, WE MUST ALSO ASK "HOW SHOULD WE DETERMINE TOTAL EXPENDITURES UNDER FUTURE NATIONAL HEALTH INSURANCE?"

THE BALANCE OF THIS PRESENTATION WILL DEAL WITH FOUR MECHANISMS FOR CONTAINING COSTS AND THEREBY DETERMINING TOTAL NATIONAL EXPENDITURES FOR HEALTH.

I BELIEVE THESE ALTERNATIVE MECHANISMS SHOULD BE MEASURED BY AT LEAST FOUR CRITERIA. FIRST, THE NATION'S TOTAL EXPENDITURES FOR HEALTH SHOULD REFLECT THE IMPORTANCE THAT THE PEOPLE OF THIS NATION PLACE ON HEALTH AND SECOND, TOTAL EXPENDITURES SHOULD ASSURE ADEQUATE RESOURCES TO PROVIDE FOR A HEALTHLY NATION COMMENSURATE WITH THE STATE OF THE ART AND SCIENCE OF MEDICAL CARE, AND COMMENSURATE WITH OUR ABILITIES TO MODIFY OTHER HEALTH DETERMINENTS.

THE FIRST CRITERION PRESERVES OUR RESPECT FOR INDIVIDUAL VALUES AND NEEDS. THE SECOND CRITERION INDICATES A RECOGNITION OF SOCIATIAL AND NATIONAL VALUES AND NEEDS. THE HARMONY OF THESE TWO OFTEN CONFLICTING VALUES IS ULTIMATELY RECONCILED BY THE GOVERNMENT, WHICH DETERMINES THE COMBINATION OF MARKETFORCES AND REGUALTION IN THE HEALTH INDUSTRY AT ANY GIVEN TIME. A THIRD CRITERION IS HOW THE COST CONTAINMENT MECHANISM EFFECTS THE EFFECTIVENESS AND EFFICIENCY OF THE HEALTH CARE SYSTEM. THE SYSTEM IS EFFECTIVE TO THE DEGREE THAT IT INCREASES LONGEVITY AND DECREASES SUFFERING AND DISABILITY. A MORE EFFICIENT SYSTEM PROVIDES AN IDENTICAL SERVICE OR PRODUCT AT A LESSOR COST.

A FOURTH CRITERION IS WHETHER OR NOT THE COST CONTAINMENT MECHANISM

IS COMPATIBLE WITH THE DEGREE OF EQUITY AND FAIRNESS WHICH ARE THE FIRST GOALS OF NATIONAL HEALTH INSURANCE.

I WILL DISCUSS THE FOLLOWING FOUR COST CONTAINMENT MECHANISMS: (1) ARBITRARY EXPENDITURE LIMITATIONS IMPOSED BY GOVERNMENT. (2) PROCESS REGULATION. (3) IMPUT REGULATION, AND (4) A RETURN TO MARKET FORCES.

WHILE THESE MECHANISMS ARE NOT MUTUALLY EXCLUSIVE, THEY DO REPRESENT DISTINCT APPROACHES TO COST CONTAINMENT WHICH ARE NOT EITHER NOW PARTIALLY IMPLEMENTED OR CURRENT PROPOSALS.

ARBITRARY EXPENDITURE LIMITATIONS. THIS IS THE COST CONTAINMENT MECHANISM IN CURRENT VOGUE. THE POPULARITY OF SO CALLED PAYMENT "CAPS" REFLECT THE FACT THAT NOTHING ELSE IS WORKING AT THIS TIME AND THAT THE LEGISLATIVE AND EXECUTIVE BRANCHS OF GOVERNMENT VIEW WITH HORROR CURRENT RATES OF INCREASED EXPENDITURES FOR HEALTH. IN THEIR DESPIRATION, THEY ARE SEIZING UPON ARBRITRARY CAPS AS A MECHANISM THAT CAN BE IMPLEMENTED RAPIDLY.

STATES ARE PLACING ARBITRARY LIMITATIONS ON EXPENDITURES FOR MEDICAID AND CUTTING BACK PRESENT BENEFITS. FEDERAL GOVERNMENT OFFICIALS REPEATEDLY PROPOSE CAPS ON MEDICARE EXPENDITURES, AND A HOSPITAL COST CONTAINMENT BILL IS CURRENT BEING CONSIDERED BY THE CONGRESS. THIS BILL PROPOSES FEDERAL GOVERNMENT LIMITATIONS ON THE INCREASE OF HOSPITAL EXPENDITURES FOR CARING FOR ALL PATIENTS, INCLUDING PRIVATE

PATIENTS WHO ARE NOT ENTITLED TO ANY GOVERNMENT PAYMENT FOR THEIR HOSPITAL BILLS.

EXPENDITURE LIMITATIONS FOR MEDICAID ARE WIDENING OUR DUEL SYSTEM OF ONE LEVEL OF HEALTH CARE FOR THE INDIGENT AND ANOTHER LEVEL OF HEALTH CARE FOR ALL OTHERS. PHYSICIANS AND OTHER HEALTH PROFESSIONALS ARE WITHDRAWING SERVICES FROM THE POOR. INSTITUTIONS ARE ATTEMPTING TO SHIFT COSTS TO OTHERS.

GOVERNMENT CAPS ARE MUCH MORE LIKELY TO REFLECT THE AVERAGE AMERICAN CITIZEN'S ABHORRANCE OF TAXES AND THE RELATIVE POSITION OF HEALTH AS A NATIONAL PRIORITY, RATHER THAN THEREAL IMPORTANCE THAT THE PEOPLE OF THIS NATION PLACE ON HEALTH. IF GOVERNMENT ARBITRARILY DETERMINES TOTAL EXPENDITURES FOR HEALTH SUCH EXPENDITURES ARE NOT LIKELY TO BE CORRELATED WITH THE STATE OF THE ART AND SCIENCE OF MEDICAL CARE AND THE TRUE NEEDS OF THE AMERICAN PEOPLE.

CAPS MAY OR MAY NOT INCREASE THE EFFECTIVENESS AND EFFICIENCY OF THE HEALTH CARE DELIVERY SYSTEM DEPENDING UPON HOW PROVIDERS ARE PAID AND THE ORGANIZATION OF THE HEALTH CARE DELIVERY SYSTEM AT THE TIME OF CAPITAL EXPENDITURES.

THE FOURTH CRITERION, THE DEGREE OF EQUITY AND FAIRNESS IS DEPENDENT UPON WHETHER OR NOT GOVERNMENT CAPS TOTAL EXPENDITURES FOR HEALTH OR ONLY PLACES ARBITRARY LIMITATION ON GOVERNMENT FUNDED PROGRAMS.

PROCESS REGULATION. GOVERNMENT, LOCAL , STATE AND FEDERAL, PAYS 40 PER CENT OF THIS NATION'S HEALTH CARE BILLS. PROVIDERS ARE PAID ON COST REIMBURSEMENT FEEFOR-PROCEDURE AND FEE-FOR-SERVICE BASIS. PROVIDERS, THUS HAVE FINANCIAL INCENTIVES TO PROVIDE MORE AND MORE SERVICES. IN ADDITION, GOVERNMENT PROGRAMS HAVE BEEN BESET BY FRAUD. RETROSPECTIVELY, IT IS NOT SURPRISING THAT GOVERNMENT PROGRAM COSTS HAVE GONE UP AT AN EVEN MORE RAPID RATE THAN TOTAL NATIONAL HEALTH EXPENDITURES.

IT BECAME QUICKLY APPARENT THAT IN ORDER TO CONTAIN COSTS, GOVERNMENT SHOULD NOT PAY FOR UNNECESSARY SERVICES. SERVICES OF LESS THAN STANDARD QUALITY OR SREVICES PROVIDED IN COSTLY BUT INAPPROPRIATE SETTINGS.

IN ORDER TO REVIEW SERVICES AND BILLS FOR NECESSITY, QUALITY, AND APPROPRIATENESS, PROFESSIONAL STANDARD REVIEW ORGANIZATIONS AND UTILIZATION REVIEW COMMITTEES WERE ESTABLISHED BY LAW AND AT GOVERNMENT EXPENSE. TO DATE, THESE DAY-BY-DAY, CASE-BY-CASE AND SERVICE-BY-SERVICE REVIEWS HAVE DONE LITTLE TO CONTAIN COSTS.

PATIENTS, PHYSICIANS AND INSTITUTIONS FREQUENTLY DO NOT PERCEIVE UTILIZATION AND PSRO ACTIVITIES TO BE IN THEIR OWN BEST INTEREST. FOR EXAMPLE, IT IS NOT PERCEIVED BY THE PATIENT TO BE IN HIS OR HER BEST INTEREST TO BE REMOVED FROM AN INSTITUTION WHERE HIS CARE IS PAID FOR BY INSURANCE TO A SITE WHERE HIS CARE IS NOT PAID FOR BY INSURANCE. IT IS OFTEN NOT PERCEIVED BY THE PHYSICIAN TO BE IN HIS

BEST INTEREST TO TAKE THE TIME NECESSARY FOR THE EFFORTS OF UTILIZATION OR QUALITY REVIEW OR TO TRY TO SUPERCEDE HIS JUDGEMENT FOR A COLLEAGUE'S JUDGEMENT. IT IS NOT PERCEIVED BY A HOSPITAL WHICH IS PAID ON A FEE-FOR-PROCEDURE BASIS AND WHICH HAS BEDS TO BE IN ITS BEST INTEREST TO SEND PATIENTS OUT OF THE HOSPITAL AT THE EARLIEST POSSIBLE MOMENT.

EVEN GOVERNMENT CANNOT EXPECT INDIVIDUALS OR INSTITUTIONS TO DO THE THINGS THAT THEY BELIEVE ARE NOT IN THEIR BEST INTEREST. THESE REGULATORY EFFORTS EVEN WITH MODIFICATION, HAVE A DOUBTFUL FUTURE AS EFFECTIVE COST CONTAINMENT MECHANISMS. FURTHERMORE, IF THIS COST CONTAINMENT MECHANISM IS ADOPTED FOR NATIONAL HEALTH INSURANCE LITERALLY BILLIONS OF SERVICES WOULD HAVE TO BE REVIEWED EITHER ON A SAMPLING OR ON A SERVICEBY-SERVICE BASIS.

INPUT REGULATION. DURING THE TIME THAT I SERVED IN CONGRESS, I BEGAN TO RECOGNIZE THE MYRIAD OF PROBLEMS ASSOCIATED WITH THE TWO METHODS OF FEDERAL REGULATION THAT I HAVE JUST REVIEWED. ARBITRARY TOTAL EXPENDITURE LIMITATIONS DO NOT SEEM LIKELY TO ASSURE ADEQUATE RESOURCES TO PROVIDE FOR HEALTH CARE FOR THIS NATION COMMENSURATE WITH THE STATE OF THE ART AND SCIENCE OF HEALTH CARE, AND CASE-BY-CASE REGULATION SEEMS TO BE BOTH EXPENSIVE AND INEFFECTIVE. BOTH FLY IN THE FACE OF THE INCENTIVES THAT EXIST IN PRESENT PAYMENT MECHANISMS AND THE ORGANIZATION OF THE DELIVERY SYSTEM. NEITHER OF THESE FORMS OF REGULATION IS LIKELY TO REFLECT THE IMPORTANCE THAT THE PEOPLE OF THIS NATION PLACE ON HEALTH OR TO ASSURE PUBLIC EXPENDITURES FOR OTHER HEALTH INITIVES OTHER THAN MEDICAL CARE, SOME OF WHICH ARE LIKELY TO BE MORE COST EFFECTIVE IN PROVIDING GREATER HEALTH FOR THE AMERICAN PEOPLE THAN MORE MEDICAL CARE.

THE HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT WAS THE RESULT OF THIS LINE OF THOUGHT. THIS MEDHOD OF "INPUT REGULATION" I STATED THEN AND I CONTEND NOW REPRESENTS THE MOST RATIONAL AND POTENTIALLY THE MOST EFFECTIVE FORM OF FEDERAL REGULATION.

THE MAJOR COMPONENT OF INPUT REGULATION IS THE PLANNING OF THE HEALTH CARE SYSTEM INSTEAD OF THE LEAVING OF THE LEAVING ITS SIZE AND FUNCTION JUST TO HAPPEN AS A RESULT OF REIMBURSEMENT AND OTHER FORCES. OTHER COMPONENTS ARE THE DEVELOPMENT OF APPROVED PLANS, AND SANCTIONS TO PROHIBIT UNPLANNED DEVELOPMENT.

ONE MAJOR GROUP OF INPUT FOR PROVIDING PERSONAL HEALTH SERVICES IS FACILITIES, INCLUDING HOSPITALS, SKILLED NURSING HOMES AND TO A LESSER EXTENT, PHYSICIANS OFFICES. SPECIFIC INPUT SUCH AS THE EQUIPMENT NECESSARY TO ESTABLISH CARDIAC SURGERY UNITS, RENAL DISLYSIS SERVICES AND RADIATION THERAPY DEPARTMENTS FURTHER REFINE THE NATURE AND FUNCTIONS OF THE HOSPITAL. EACH PHYSICAL IMPROVEMENT REQUIRES THE EXPENDITURE OF CAPITAL. THE HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT WHICH REQUIRES EACH STATE TO ISSUE A CERTIFICATE OF NEED FOR EACH HOSPITAL CAPITAL IMPROVEMENT IS A CAPITAL EXPENDITURE REGULATION LAW.

THE OTHER MAJOR IMPUT FOR PERSONAL HEALTH SERVICES IS MANPOWER, THE EDUCATED, TRAINED, SKILLED PEOPLE WHO PROVIDE SERVICES BY USING THE FACILITIES AND SPECIAL EQUIPMENT THAT ARE AVAILABLE. RECENT FEDERAL HEALTH MANPOWER LEGISLATION,WHICH WILL REAPPORATION RESIDENCY

POSITIONS AMONG THE VARIOUS SPECIALITIES, IS A CRUDE MANPOWER INPUT REGULATION BILL. WHILE THIS LAW WILL EVENTUALLY DETERMINE THE KINDS OF PHYSICIANS WE HAVE AVAILABLE TO PROVIDE CARE, IT DOES NOT DEAL EFFECTIVELY WITH THE NUMBERS AND KINDS OF HEALTH PROFESSIONALS WHO CAN PROVIDE SERVICES EFFICIENTLY, BUT RATHER CONTINUES THE THINKING THAT THE MORE PHYSICIANS WE HAVE THE HEALTHIER THE AMERICAN PEOPLE WILL BECOME.

AT ANY ONE TIME THE FACILITIES AND MANPOWER AVAILABLE DETERMINE TOTAL HEALTH SERVICES AVAILABLE. AND ALL, OR NEARLY ALL, SERVICES AVAILABLE ARE LIKELY TO BE USED TO CAPACITY IF THE SERVICES ARE PAID FOR, PARTICULARLY ON A FIRST DOLLAR BASIS, BY PRIVATE INSURANCE OR THE GOVERNMENT.

IN SUM, IN THE ABSENCE OF A MARKETPLACE, THERE ARE ONLY TWO ALTERNATIVES FOR EFFECTIVELY LIMITING TOTAL HEALTH-SERVICES EXPENDITURES. ONE IS AN ARBITRARY GOVERNMENT CAP ON PAYMENT, WHICH TO BE EFFECTIVE REQUIRES GOVERNMENT PAYMENT FOR ALL OR NEARLY ALL SERVICES. THE OTHER IS LIMITATION OF THE SIZE OF THE HEALTH CARE SYSTEM BY CONTROL OF INPUTS.

IF WE CANNOT DO EVERYTHING FOR EVERYONE EVERYWHERE - AND WE CANNOT - THE LEAST UNACCEPTABLE ALTERNATIVE IS FOR US TO DECIDE WHAT PERSONAL HEALTH SERVICES WE NEED AND WANT AND ARE WILLING TO PAY FOR. AND FOR US THEN TO MAKE CERTAIN THAT THE FACILITIES AND SKILLED PEOPLE ARE AVAILABLE TO PROVIDE THESE SERVICES ON AN EQUITABLE BASIS TO ALL CITIZENS OF OUR NATION.

"IN THE ABSENCE OF A MARKETPLACE" ... NEARLY ALL NATIONAL HEALTH INSURANCE PROPOSALS ASSUME THAT THERE IS NO WAY TO REESTABLISH A MARKETPLACE FOR HEALTH CARE SERVICES. UNTIL RECENTLY, I MADE THE SAME ASSUMPTION. NOW I AM NOT SURE.

A RETURN TO MARKET FORCES. IN AN ARTICLE PUBLISHED ONE YEAR AGO, I DISCUSSED MARKET FORCES AS FOLLOWS:" TOTAL NATIONAL EXPENDITURES FOR HEALTH WOULD THEN EQUAL THE SUM OF HUNDREDS OF MILLIONS OF INDIVIDUAL DECISIONS MADE ANNUALLY AND BASED ON THE LAWS OF SUPPLY AND DEMAND AND THE SPECIFIC IMPORTANCE THAT THE INDIVIDUAL PLACES ON HEALTH SERVICES. THIS VERY EFFECTIVE MEANS OF ALLOCATING RESOURCES WOULD REQUIRE A LAW PROHIBITING PRIVATE HEALTH INSURANCE. A RETURN TO MARKET FORCES WOULD ALSO REQUIRE EITHER SOME KIND OF GUARANTEED ANNUAL INCOME FOR EACH CITIZEN, SO THAT EACH CITIZEN COULD REALISTICALLY MAKE HIS OR HER CHOICE TO SPEND OR NOT TO SPEND FOR HEALTH, OR A CONTINUATION OF GOVERNMENT PAYMENT FOR HEALTH SERVICES FOR THE POOR.

A RETURN TO MARKET FORCES WOULD ALSO REQUIRE MODIFICATIONS ON THE SUPPLY SIDE INCLUDING ANTI-TRUST ACTIONS AND PROVISIONS FOR INCREASED FREEDOM OF ACCESS OF PROVIDERS OF SERVICES TO THE MARKET.

A RETURN TO A FREE MARKET IS EXCEEDINGLY UNLIKELY BECAUSE OF THE OBVIOUS VALUE THE AMERICAN PEOPLE PLACE ON HEALTH, THE SIZE OF PRESENT DAY HEALTH BILLS, THE PRESENT RELIANCE UPON HEALTH INSURANCE AND THE DEMAND FOR EQUITY IN HEALTH CARE."

SINCE I HAVE RETURNED TO THE PRIVATE SECTOR IN JANUARY OF 1975, I HAVE BECOME INCREASINGLY INTERESTED IN WHETHER OR NOT IT IS POSSIBLE TO RESTORE MARKETPLACE CONSIDERATIONS TO THE MEDICAL CARE SYSTEM. WHILE I HAVE BECOME INCREASINGLY CONVINCED THAT WE HAVE NO MARKETPLACE TODAY, I HAVE ALSO BECOME INCREASINGLY CONCERNED THAT WE ARE LIKELY TO PASS A NATIONAL HEALTH INSURNANCE LAW WHICH WILL RETAIN PRESENT METHODS OF PROVIDER PAYMENT AND WHICH WILL FAIL TO REORGANIZE THE HEALTH CARE DELIVERY SYSTEM. IN ADDITION, I HAVE CONTINUED TO OBSERVE THE INEFFICIENCIES AND INEFFECTIVENESS OF MOST PRIVATE INDUSTRY THAT IS GOVERNMENT REGULATED, SUCH AS THE AIR TRANSPORT INDUSTRY, THE RAILROADS, THE UTILITIES, AND YES, EVEN THAT SYMBOL OF PRIVATE INTERP-RISE, THE BANKS. I HAVE BEEN ESPECIALLY IMPRESSED WITH THE DIFFICULTY GOVERNMENT HAS MANDATING ONE ACTION WHEN FINANCIAL INCENTIVES DICTATE ANOTHER ACTION.

WE HAVE GREAT AREAS OF MARKET FAILURE IN OUR ECONOMY, BUT PERHAPS EVEN MORE DISTRESSING IS GOVERNMENT REACTION TO MARKET FAILURE.

AN ARTICLE BY CHARLES L. SCHULTZE IN THE MAY 1977 HARPERS (TAKEN FROM HIS GODKIN LECTURES), ENTITLED, "THE PUBLIC USE OF THE PRIVATE INTEREST" DEALS WITH MARKET FAILURE AND THE FEDERAL GOVERNMENT'S EFFORTS TO SUBSTITUTE " A COMMAND AND CONTROL APPROACH TO DEAL WITH THE SPECIFIC MARKET FAILURE". DR. SCHULTZE FINDS THAT DECISIONS BEGIN "TO BE MADE ON A CASE-BY-CASE BASIS BY THE SPECIFIC DECISIONS OF REGULATORS, BY ADMINISTRATIVE HEARING PANELS AND BY THE COURTS - OFTEN ALL THREE IN SEQUENCE". HE CONCLUDES THAT "WE CANNOT AFFORD

TO GO ON IMPOSING COMMAND AND CONTROL SOLUTIONS OVER AN EVER-WIDENING SPHERE OF SOCIAL AND ECONOMIC ACTIVITY".

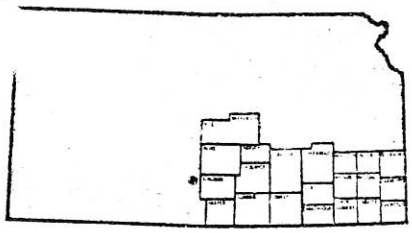
IT IS MY OBSERVATION THAT NEARLY ALL FEDERAL REGULATION OF HEALTH CARE FITS IN THE "COMMAND AND CONTROL" AND "CASE BY CASE" DESCRIPTION, AND TO DATE IT APPEARS TO BE UNSATISFACTORY. SO A SECOND LOOK SEEMS WORTHWHILE.

THE MOST TROUBLESOME AREA IN CONSIDERING A RESTORED MARKET PLACE IS EQUITY, BUT EQUITY CAN BE ASSURED IF GOVERNMENT PROVIDES POOR AND LOW INCOME PEOPLE WITH ADEQUATE PURCHASING POWER SPECIFICALLY FOR HEALTH IN AN AMOUNT EQUAL TO THAT POSSESSED BY OTHER AMERICAN CITIZENS. TRUE COMPETITION CAN PERHAPS BE ESTABLISHED ONLY BETWEEN ORGANIZED HEALTH DELIVERY SYSTEMS OR INSURORS WHO ARE REQUIRED TO BE BOTH COMPETITIVE AND AT RISK. IT MAY BE NECESSARY TO ADOPT PERSPECTIVE CAPITATION PAYMENT FOR DEFINED MEDICAL SERVICES FOR A GIVEN PERIOD OF TIME IN ORDER TO ESTABLISH COMPETITION AND ALSO TO RETAIN CONSUMER CHOICE. SUCH A SYSTEM WOULD NOT RULE OUT FEE-FOR-SERVICE IF FEE-FOR-SERVICE OR ANY OTHER PAYMENT MECHANISM IF THAT MECHANISM RESULTS IN GREATER PROVIDER EFFICIENCY.

IT IS NOT THE PURPOSE OF THIS PRESENTATION TO DETAIL A PLAN FOR STRUCTURED COMPETITION IN THE HEALTH CARE DELIVERY SYSTEM. IT IS MY INTENTION TO INTEREST YOU IN INQUIRING INTO THE POSSIBILITY OF RESTORING COMPETITION AND MARKETPLACE CONSIDERTO THE PROVISION OF HEALTH CARE SERVICES AND AS A PART OF A NATIONAL HEALTH INSURANCE PROGRAM . AT THE VERY LEAST, I URGE YOU TO EXAMINE CAREFULLY THE INCENTIVES AND DISINCENTIVES THAT EXIST IN OUR SYSTEM AND TO DETERMINE WHETHER OR NOT THEY MAY

BE MODIFIED IN SUCH A WAY THAT GOVERNMENT REGULATION CAN BE LESSENED RATHER THAN INCREASED AND MADE MORE SEVERE.

I REALIZE THAT MY TALK MAY LEAVE YOU WITH A SENSE OF FRUSTRATION. I SHARE THAT FRUSTRATION. AS A PHYSICIAN, I WOULD LIKE FOR EVERY PHYSICIAN TO BE ABLE TO DO EVERYTHING THAT IS SCIENTIFICALLY AND TECHNOLOGICALLY POSSIBLE FOR EACH PATIENT. AS A FAMILY MAN I WOULD LIKE FOR EACH MEMBER OF MY FAMILY TO HAVE ACCESSIBLE AT ALL TIMES NOT JUST BASIC MEDICAL SERVICES BUT EVERY MEDICAL SERVICE THAT MIGHT BE OF MARGINAL BENEFIT TO THEM. I WOULD LIKE THE SAME. PEOPLE AUTOMATICALLY ANSWER THAT THEY THINK THAT EVERYONE SHOULD HAVE BETTER THAN AVERAGE MEDICAL CARE, WITHOUT REALIZING THE IMPOSSIBILITY OF SUCH A GOAL. BUT THE FACT REMAINS THAT IT IS NO MORE POSSIBLE TO MAKE IMMEDIATELY AVAILABLE AND ACCESSIBLE TO ALL PEOPLE ALL MEDICAL SERVICES THAN IT IS POSSIBLE TO ATTAIN INDIVIDUAL IMMORTALITY. OUR ONLY CHOICE IS TO ACT CONSISTENT WITH OUR INDIVIDUAL VALUE SYSTEMS AND OUR SENSE OF FAIRNESS, EQUITY, JUSTICE AND OUR CONCERN FOR OUR FELLOW MAN, AND TO WORK TO MAKE CERTAIN THAT OUR GOVERNMENT IS, TO REPEAT A RECENT THEME, AS GOOD AND DECENT AS THE AMERICAN PEOPLE.



HEALTH SYSTEMS AGENCY OF SOUTHEAST KANSAS

TESTIMONY TO THE COMMISSION ON HEALTH CARE COSTS
BY E. A. JARVIS, PRESIDENT
OCTOBER 5, 1977

I. BACKGROUND ON HSA NO. 3.

Health Systems Agency No. 3 covers the 23 Counties of Southeast Kansas including Harper, Kingman, Reno and Rice Counties on the West; McPherson, Marion, Butler, Greenwood, Allen and Bourbon Counties on the North and all other Kansas Counties East and South of that line to the Missouri and Oklahoma borders.

The Board of Directors of HSASEK are 30 members selected by 4 sub-area advisory councils with memberships proportioned to the population of the councils. Senator Wes Sowers is the only member of your commission who resides in our health service area.

The geographic makeup of our HSA presents a variety of health care problems, the solution to which may be counter-productive to constraining health care costs. Much of the area is underserved on primary health care which includes physicians, dentists and optometrists. To correct this shortage of primary care means adding practitioners and the associated increase in costs.

It is significant that the percentage of residents over age 65 in the 9 counties of extreme southeast of our HSA is exceptionally high. This age group paradoxically are the highest utilizers of health care services of all age groups and in this instance reside in the geographic area with poorest availability of primary health care services.

At the other extreme, Wichita and Sedgwick County exists as a referral center and while some interests claim there is a shortage of primary care in Wichita I find that difficult to believe.

There is an oversupply of hospital beds in our Health service area and there is no significant problem of maldistribution. The impact on health care costs by this oversupply of hospital beds is presumed to be great. The availability of general care hospital beds is one of the critical criteria in attracting physicians to the underserved areas.

420 Insurance Building/212 North Market Wichita, Kansas 67202 [316] 264-2861

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Nursing home facilities present another factor in health care, with essentially no critical shortage of beds, but some problems on distribution largely associated with inadequate staff availability and especially with public desires to have nursing homes in the immediate vicinity of each community.

The above is a very brief description of our health system, it's strengths and it's deficiencies. How we address the deficiencies and the problem of accelerating health care costs is the main purpose of our agency and my appearance before this commission.

II. THE PROBLEM OF HEALTH CARE COSTS.

Data is not currently available in a form that would reveal how health care costs for our HSA compare to other HSA's in Kansas or to the national average. Hopefully such data will become available in the near future.

We do have data that indicates that hospital costs per patient day are higher in Wichita than in other hospitals in the health service area. We are confident that much of that is caused by the more complex surgical procedures being performed there such as open heart surgery, orthopedic surgery, cancer surgery and other more costly procedures.

The causes of increased health care costs are many, all converging to cause the increases to exceed other cost increases in the economy.

III. HSA 3 HAS IDENTIFIED THREE MAJOR FRONTS FROM WHICH TO ATTACK HEALTH CARE COSTS.

1. Prevention, keeping people healthy and lessening the need and demand for services.
2. Regulatory control over expansion of services, equipment and facilities.
3. Promoting less expensive alternatives to existing services such as home health care and ambulatory surgical centers. This includes promoting changes in third party coverage and reimbursement practices.

IV. SUMMARY OF HEALTH COSTS VIEWS FROM HSA 3.

The causes of rising health care costs are many. Our HSA intends to concentrate on causes they feel they can control or influence rather than waste time on things they cannot change.

Some of the HSA's responsibility and actions will work against constraints in health care costs.

The regulatory control is limited because of the political forces and realities faced by all public bodies.

The HSA does not believe that legislative action is the way to solve health care costs, but believes some aspects of control can be enhanced with enabling legislation.

State of Kansas . . . ROBERT F. BENNETT, Governor

DEPARTMENT OF HEALTH AND ENVIRONMENT

DWIGHT F. METZLER, Secretary

Topeka, Kansas 66620

THE ROLL OF THE STATEWIDE HEALTH COORDINATING COUNCIL

INTRODUCTION

The National Health Planning and Resource Development Act of 1974 (Public Law 93-641) mandated the creation of agencies at the local, State and Federal levels to aid the development of health policy and implementation of that policy. These agencies consist of:

1. Health Systems Agencies to serve a portion of a State. Some few of these serve an entire State. (HSA)
2. Statewide Health Coordinating Council for each State. (SHCC)
3. A National Council on Health Planning and Development.
4. Centers for Health Planning, one for each Region of the Federal Government (10 in total).
5. Other existing Agencies of the State and Federal Government were designated additional responsibilities for implementation of the Act. These are:
   a) State Health Planning and Development Agency (SHPDA) designated to be the Kansas Department of Health and Environment by Governor Bennett.
   b) The U.S. Department of Health, Education and Welfare. (DHEW)

This paper will deal only with the Statewide Health Coordinating Council, its purpose, its function and its organization.

PURPOSE OF THE STATEWIDE HEALTH COORDINATING COUNCIL

The Statewide Health Coordinating Council (hereinafter referred to as SHCC) is established for the purpose of advising the State Health Planning and Development Agency (SHPDA) which in Kansas is the State Department of Health and Environment.

FUNCTIONS OF THE SHCC

P.L. 93-641 mandates the following functions for the SHCC:

1. Review and coordinate the "Health Systems Plans" (HSP) and "Annual Implementation Plans" (AIP) of each Health System Agency (HSA).
2. Prepare a "State Health Plan" (SHP).
3. Annually review budgets of HSA's.

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4. Review HSA grant applications, both planning grants and development grants.

5. Advise the SHPDA on the performance of its functions.

6. Review and approve or disapprove any State Plan and any grant application for funds

   a) State planning and development grants.

   b) Community Mental Health Centers grants.

   c) Comprehensive Alcohol Abuse, Prevention, Treatment and Rehabilitation grants.

7. Approve the State Medical Facilities Plan and advise the State in carrying out the Plan.

Kansas law further requires the SHCC to perform 3 additional functions:

8. Specify in the State Health Plan (SHP) the criteria to be used in approving or disapproving applications for a "Certificate of Need".

9. Specify interim criteria for "Certificate of Need" applications pending completion of a State Health Plan (SHP).

10. To be the "Review Agency" for any appeal of any decision made by the State Department of Health and Environment on a "Certificate of Need" application.

CERTIFICATE OF NEED

The Kansas statutes provide that before undertaking a project described below, they will obtain a "Certificate of Need" issued by the Secretary of the Department of Health and Environment.

Projects requiring a "Certificate of Need" (CON) are:

1. Construction of a new health facility.

2. Construction of additional bed capacity in a health facility.

3. Capitol expenditures in excess of $150,000 (includes lease or donation of facility that would cost $150,000 to construct) for:

   a) Modernization of existing facility.

   b) Substantial changes in services (new diagnostic, curative or rehabilitative services).

   c) Termination of a service.

Health System Agencies review and comment on each request for CON in its service area.

The Department of Health and Environment issues or denies a CON based on criteria in the State Health Plan (or criteria established by the SHCC before a State Health Plan is adopted).

The SHCC serves as the "Review Agency" on any appeal of a decision on CON. SHCC can hear appeals as a total body or may appoint a hearing officer.

TE HEALTH PLAN

The State Health Plan (SHP) will be made up of the Health Systems Plans of the 4 HSA's and may require revisions in the HSP's to achieve coordination with statewide health needs.

The initial planning process adopted provides for developing the State Health Plan parallel to the HSP's to have it completed by December, 1977. This requires a great deal of coordination between the SHCC, the SHPDA and the 4 HSA's.

ORGANIZATION OF THE SHCC

The Kansas law specifies that the SHCC will have no more than 28 members, a majority of which will be "consumers" and not less than 1/3 who are "direct providers".

The Governor appoints all but one of the SHCC members. These are:

1. Four from each Health Systems Agency from at least 3 nominations for each position from the HSA. At least 2 from each HSA must be consumers.
2. The Chairperson (or his/her designee) of public health and welfare committees of the House and of the Senate.
3. Other persons (a maximum of 9), half of whom are consumers.

The Chief Medical Director of the Veterans Administration designates the other member.

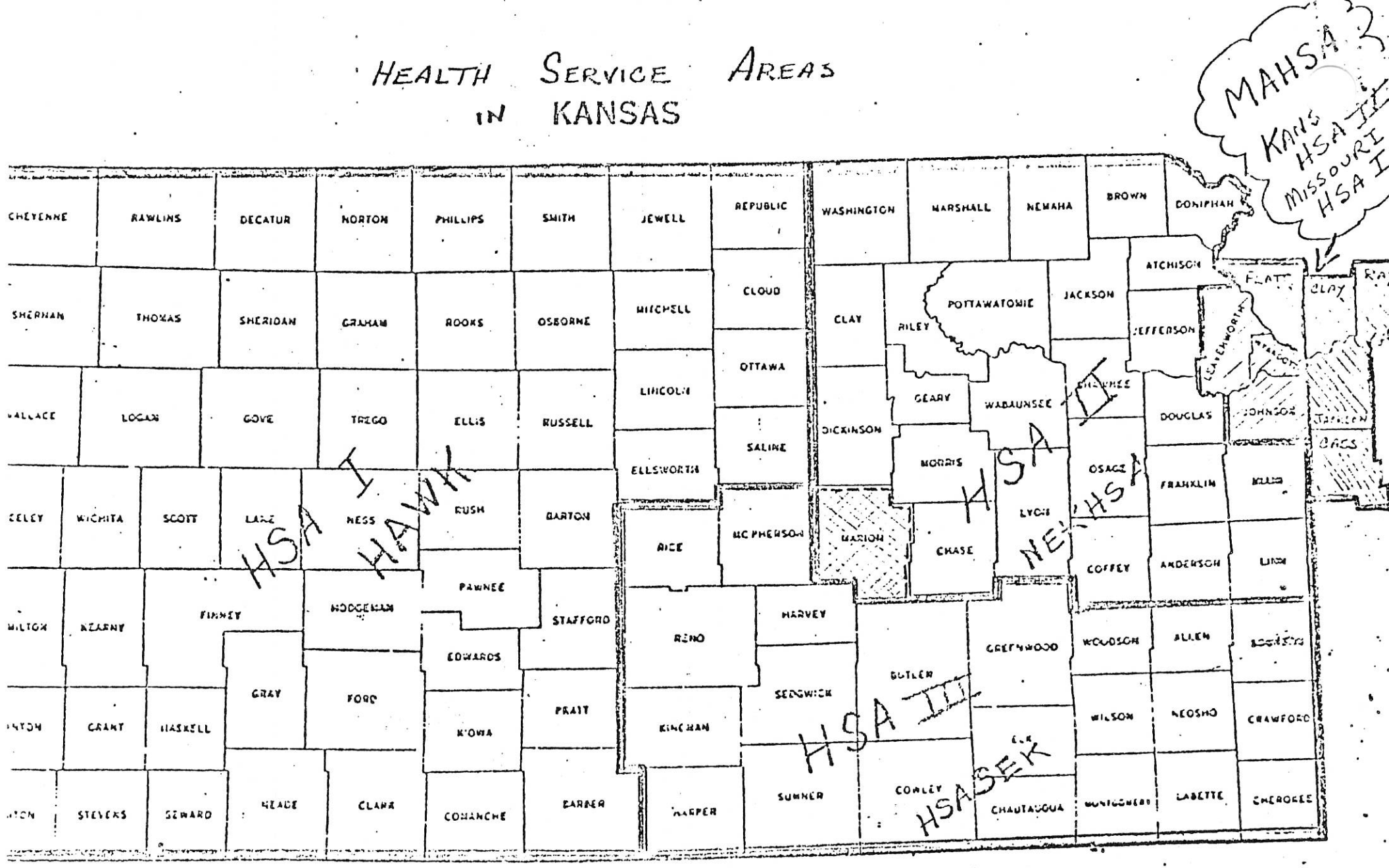
The Council (SHCC) elects its own Chairperson from among the membership.

The SHCC membership roster is attached.

STATEWIDE HEALTH COORDINATING COUNCIL
MEMBERSHIP LIST

HSA	NAME	CITY	OCCUPATION	CATEGORY
1	Steven Alford	Ulysses	Farmer	Consumer
1	Richard Brownrigg, MD	Dodge City	Physician - City Commissioner	Provider
1	Roger M. Grund	Larned	Cross Manufacturing Co.	Consumer
1	Donald W. Tiffany, Ph.D.	Hays	Psychologist	Provider
2	Leon J. Boor	Abilene	Hospital Administrator	Provider
2	Max Engle	Oskaloosa	Farmer - County Commissioner	Consumer
2	Karl W. Masoner	Cottonwood Falls	Attorney - Mental Health Center Board	Provider
2	Naturdad Morales	Topeka	Equal Employment Opportunity Investigator	Consumer
3	Ernest W. Kavidson	Iola	Administrator - County Health Dept.	Provider
3	E. A. Jarvis	Wichita	S.W. Bell Telephone Co.	Consumer
3	Sister Mary Faith Matney	Independence	Hospital Administrator	Provider
3	Agnes B. O'Malley	Scammon	Retired School Principal	Consumer
4	Gordon Hurlbut	Tonganoxie	Farmer	Consumer
4	Richard Lantiser	Overland Park	Hallmark Cards - City Commissioner	Consumer
4	Russell Mills, Ph. D.	Kansas City	K U School of Medicine Admin.	Provider
4	John Heiser, DDS	Shawnee Mission	Dentist	Provider
	James B. Appleberry Ph. D.	Pittsburg	President, Kansas State College	Consumer
	J. B. Barbee	Wichita	United Transportation Union	Consumer
	A. B. "Jack" Davis	Wichita	Wesley Medical Center Administration	Provider
	John A. Erickson	Clay Center	Retired	Consumer
	Dr. Robert C. Harder	Topeka	Secretary, Social & Rehab. Services	Provider
	E. S. "Gene" Henderson	Scott City	Retired	Consumer
	Mrs. Cecile Lindsey	Pomona	Housewife	Consumer
	Mrs. Lee Osmond	Wichita	Twin Power Inc.	Consumer
	Leroy Tombs	Bonner Springs	Tombs and Sons, Inc.	Consumer
	Rep. Mike G. Johnson, DDS	Abilene	Dentist - Chairman - House Pub. Health & Welfare	Provider
	Sen. Wes Sowers	Wichita	Chairman - Senate Pub. Health & Welfare (Hospital Board)	Provider
	Ms. Margaret Michelson	Leavenworth	Dist. Director - V. A. Center	Provider

HEALTH SERVICE AREAS IN KANSAS



SCALE 0 10 20 30 40 50 MILES

HPAWK = Health Planning Association of Western Kansas, Headquarters = Hays

NEKHSA = NorthEast Kansas Health Systems Agency, Headquarters = Topeka

HSASEK = Health Systems Agency of SouthEast Kansas, Headquarters = Wichita

MAHSA = Mid-America Health Systems Agency, Headquarters = Kansas City, Missouri

THE PROBLEM OF HEALTH CARE COSTS

Testimony to the

Health Care Cost Commission

October 5, 1977

Presentor: E. A. "Al" Jarvis, Chairman
Statewide Health Coordinating Council

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PROBLEM DESCRIPTION

Medical care costs have increased dramatically over the last 20 years in both Kansas and the nation and are continuing to climb. Both the amounts expended for medical care and the prices of medical care goods and services have increased sharply. The rise in medical care prices has outpaced the overall increase in consumer prices.

In 1975, 8.3% of our Gross National Product (GNP - the total market value of the nation's annual output of goods and services) was spent for health care. The portion of the GNP devoted to health has been rising since 1955, but the rate of increase climbed markedly after 1965.

In 1976, health expenditures as a percent of the GNP continued to rise, reaching 8.6%, or $139.3 billion. In comparison, total medical expenditures were $122.2 billion in 1975, $69.2 billion in 1970, and only $25.9 billion in 1960.[1]

A major source of the increase in total medical care expenditures has been in the hospital sector. Hospital expenditures have quadrupled in the last decade and continue to be the largest share of spending for health purposes, totaling $55.4 billion in 1976. In comparison, expenditures for physicians' services (which have nearly tripled in the last decade) ranked second at $25.4 billion in 1976.[2]

The prices charged for medical care increased by 9.9% in 1975, as compared to a 6.8% rate of increase for all other items in the Consumer Price Index. The rise in hospital service charges was the largest in the 1975 Consumer Price Index, increasing by 13%

Adequate data specifically reflecting total expenditures, consumer prices, and per capita expenditures in Kansas does not exist. Consequently, the SHCC has made a basic assumption that the Kansas experience is similar to the U.S. in general. However, efforts have been initiated to begin collection of Kansas specific data to support future planning activities. A recommendation related to this need is included later in the plan.

PROBLEM ANALYSIS

Political/Economic Factors

National public policy in health affairs changed dramatically with the passage of Medicare and Medicaid in 1966. Through these programs, the federal and state governments became major third-party purchasers of health care, infusing billions of new dollars into the health care market. The Council on Wage and Price Stability offers a startling description of the government's impact on the health care system since 1965:

> Government expenditures for personal health care jumped 484% from $7.0 billion to $40.9 billion between 1965 and 1975.
>
> Government sources thus accounted for 39.7% of personal health

care expenditures in 1975, compared to 20.8% in 1965. The government's impact is particularly noticeable in the hospital sector, where it met 55.0% of expenditures in 1975.[5]

In addition to direct payments for personal health care, the government subsidizes medical research, education and construction of health facilities as well as providing subsidies through income tax exemptions for health insurance premiums. The total annual level of direct government support to the health industry accounts for nearly half of the total health expenditures.[6]

Government Support to the Health Industry: Fiscal 1975

Source	Amount ($ billion)
Federal Expenditures	$33.8
State and Local Expenditures	16.1
Federal Tax Preferences	8.0
TOTAL	$57.9

Source: The Problems of Rising Health Care Costs, Council on Wage and Price Stability Staff Report, April, 1976.

The increase in spending for health care has not been limited to government. Between 1965 and 1975, expenditures under private health insurance plans have increased 229%, from $8.3 billion to $27.3 billion. Dispite this large increase in dollar expenditures, the portion of total spending for personal health care under private insurance increased only about two percent. In 1975 then, spending for health care in the U.S. was as follows:

Government	39.7%
Insurance	26.5%
Out-of-Pocket	33.8%

Geographic

The geography of Kansas has had a major impact on the development of the state's sytem of health care services. The land area of Kansas is 82,048 square miles and the average population density is 28.2 persons per square mile.[8] In 1975, 47 of the state's 105 counties had population densities of less than ten persons per square mile, with 17 counties recording densities below five persons per square mile.[9] Not surprisingly, 16 of these 17 counties are located in Health Service Area #1, the western half of the state.

Because of the realities of distance in rural Kansas, many small health facilities have been developed to provide access to health service within reasonable travel times and distances. The American Hospital Association reports that Kansas has 26 community hospitals with less than 25 beds and another 40 community hospitals with between 25 and 50 beds.[10] When combined, these 66 hospitals account for 1,881 of the state's 12,685 total of community hospital beds.[11] The average occupancy rate of 43% for hospitals with 25 beds or less is considerably lower than the state average of 70.4%. The 54.9% occupancy rate for hospitals between 25 to 50 beds is also far below the state average.[12]

The feasibility to change this situation is limited by the accepted goal of promoting equitable access to health care services. Small hospitals are necessary in many rural areas of the state. The potential does exist

to reduce the need for some small facilities through realistic efforts at consolidation.

Demographic

The population in Kansas, as well as the Nation, is getting older. The portion of the Kansas population age 65 and over increased from 10.2% in 1950 to 11.8% in 1970.[13] The Kansas population aged 75 and over increased by 28.9% between 1960 and 1970.[14] The average age at death has been steadily increasing in Kansas for 25 years and is likely to continue increasing.[15]

The elderly population is particularly susceptible to chronic diseases (heart disease, cancer and stroke) and is, in general, a medical high risk population.

It is evident that the number of elderly people in the population is likely to continue increasing and that the consequent demands for medical care will also increase. The 1975 per capita expenditure for personal health care for persons age 65 and over was $1,360, compared to $365 for those under 65.[16] The medical care expenditures for this age group have increased markedly, and will continue to increase, particularly as we increase our technical capacity to sustain life. Short of decisions to arbitrarily limit the medical services available to this age group, the Statewide Health Coordinating Council finds no potential to affect this factor to constrain costs.

Life-Style

The association between behaviors and habits individuals choose and health has become firmly established. Though the scientific proof may not be complete, the "relationship can confidently be accepted as a guide to public policy."[17] We know that individual behaviors such as smoking, alcohol abuse, obesity and lack of exercise are related to the incidence of such chronic diseases as cirrhosis of the liver, cancer, heart disease and cerebrovascular disease. The evidence suggests that the increased demand for medical care services resulting from chronic illness is, to some degree, avoidable through changes in individual life-style and increased efforts at prevention among population groups.

Health is not a commodity that can be bestowed on an individual, nor can it be legislated or required. The primary responsibility for health rests with the individual. Meaningful social policies to promote health (and to reduce demands for health care) must be directed at increasing the individual's sense of responsibility. At the same time, the individual's ability to act on his own behalf must be supported and encouraged by meaningful public health policy and programs.[18] As long as individual responsibility for health is not promoted and supported, there is reasonable doubt that spending additional sums of money for medical care will significantly improve health status.

Technology

Research in the field of human biology has dominated our quest for improved health for decades and the results of this emphasis are appearing in the many (expensive) technological changes in medical care. As a nation, we are spending huge sums of money on biomedical research, one effect of which has been to increase the complexity and cost of medical care services. A study by the National Planning Association estimates that the Fiscal Year 1976 federal support for research breaks down as follows:[19]

	$ in Millions	% Distribution
Human Biology	$1,044	38
Life-Style	105	4
Environment	844	30
Health Services	786	28
TOTAL	$2,779	100

The lack of balance in the support of research in the area of life-style is striking. The strong emphasis on biomedical research may partially explain the current tendency to rely on medical science to lead us to improved health. This is not to disparage the obvious contributions of biomedical research and medical care to our current health status, but only to point out the increasingly apparent imbalance in our research efforts aimed at improving health. "The shortcomings in our knowledge of human biology and medical practice are matched or exceeded by our ignorance of environmental and behavioral influences on health and factors relating to health services delivery."[20]

The potential to intervene in this situation at the state and local levels is extremely limited. We can attempt to control the widespread use of new and unproven technology, but the real challenge is to develop a national

research policy based on a realistic balance of resources devoted to all the major determinants of health.

Methods of Payment

The health care marketplace differs significantly from other sectors of the economy. In the health care sector, the buyer (consumer) has little influence over what he buys or the prices paid. The provider (physician) makes the significant purchasing decisions though the consumer may be consulted. To complicate the situation further, the consumer frequently does not directly pay the provider for his goods or services. Instead, a "third party," either private health insurance or government, pays the provider on behalf of the consumer.

In the area of hospital care, there are four participants; the physician, the hospital, the consumer and the third party, but the physician makes the essential expense generating decisions for all of them. He decides the types and amounts of medical goods and services that will be purchased.

Third parties have become the dominant financing method in the health sector to the extent that they pay for more than two-thirds of all personal health care and more than 90% of all hospital care.[21] The Council on Wage and Price Stability reports that "there has been considerable analysis of the impact of widespread insurance coverage upon demand and prices in the health sector; the consensus is that the prevalence of third-party payments is a significant factor affecting decision making by consumers and providers."[22] The widespread use of "first dollar" coverage

where all expenses for hospital care and surgical fees are covered up to a predetermined ceiling is a major factor affecting consumers' decisions. Under such coverage, there is literally no relationship between cost and the consumer's decision to seek care, nor the physician's decision to prescribe care.

In this system, consumers are effectively insulated from the costs of the care they consume. Likewise, the provider is insulated from cost considerations since he commands effectively unlimited resources (the third parties) on behalf of the consumer. It is little wonder than that many consumers and providers have become insensitive to the high costs related to their transactions.

The prevailing method of paying for private health insurance coverage further compounds the consumer's insulation from financial responsibility for personal health care. Nearly 80% of health insurance premiums are paid through employment related group plans.[23] Moreover, the employer pays an average of 67% of the total premium under such plans and in 41% of the policies, the employer pays the total premium.[24]

Another major factor in escalating cost in the third-party system is the method of reimbursing providers. Frequently, these payments are made retrospectively, actual costs incurred by the provider. The effect of this type payment system combined with first-dollar coverage is that the provider has limited incentives to be cost conscious or to practice efficient management.

Finally, the patterns of insurance coverage have been shown to strongly encourage the unnecessary utilization of the most expensive forms of service.[25] Both private insurance and government programs have promoted the use of high cost inpatient service with first-dollar coverage, lower-cost ambulatory services are either not covered or are subject to high deductibles or shared payments. This extensive coverage for complex and expensive medical services has understandably promoted the availability of complex facilities and services, regardless of the potential for more economical alternatives.

Certainly we can begin to provide better information to both providers and consumers on how they can alter their behavior to contain costs. We can also act to correct the imbalance in the patterns of coverage with a new emphasis on paying for less costly, yet safe, services and less emphasis on high cost inpatient services.

Perhaps most directly we can intervene to introduce greater incentives for management efficiency and financial accountability in the health sector, primarily in hospitals. Methods for changing the reimbursement system and improving public accountability of hospitals seem essential.

Overutilization of Services

In creases in the quantity of medical care services have traditionally been assumed to increase the quality of care provided. Research is beginning to question this "more is better" thesis and indicate that some part of the increasing utilization of services is unnecessary. A

comprehensive study on the problem of excess hospital capacity, found that "studies of current hospital utilization show a substantial number of admissions and patient days represent unnecessary or cost-ineffective use."[26] The fact that health maintenance organizations experience hospital utilization rates 30% to 50% lower than traditional fee-for-service arrangements supports the contention that hospital utilization can be safely reduced.[27]

The recent national concern over malpractice claims may indicate a new factor affecting utilization, so called defensive medicine, i.e., the practice by physicians of ordering unnecessary tests or procedures to offset the potential for malpractice suits. Though there is little data documenting the extent of this phenomenon, there appears to be general acceptance that it is widespread. An effective quality of care and utilization review program should not only identify such unnecessary services but should offer physicians protection from frivolous malpractice claims by establishing norms and standards for quality care.

Other factors such as the pattern of health insurance coverage and the availability of hospital services have been shown to affect utilization and are addressed elsewhere in this analysis, but the need for effective professional review of all hospital services for quality and appropriate utilization remains.

Excess Supply of Acute Care Hospital Beds and Services

There is considerable evidence of an excessive supply of hospital beds

and services. The Institute of Medicine, in a major study of the problem in 1976, concluded:

> "The evidence clearly indicates that significant surpluses of short-term general hospital beds exist or are developing in many areas of the United States and that these are contributing significantly to rising hospital costs..."[28]

The Institute's conclusion is corroborated in another comprehensive study which observed that the current national ratio of 4.4 beds per thousand population could be safely reduced by at least 10%.[29]

The oversupply of hospitals and beds generates excessive costs in two ways: either the productive capacity is underutilized, thereby generating unnecessary fixed operating costs, or the productive capacity is overutilized for care that is not medically necessary or cost effective. In the first case, estimates of the cost of maintaining an empty bed vary from one-half to three-quarters of the cost of an occupied bed.[29] In the latter case, there is strong evidence suggesting that "beds beget patients." In short, the availability of empty beds creates strong pressures on hospitals and physicians to use them, even where lower cost outpatient alternatives are available. Add to this the incentive of assured payment by third parties for inpatient care and the incentive structure to overutilize excess beds is complete.[31]

There is further evidence that even where bed increases are limited, the assets and labor expended per bed (service intensity) continue to increase.[32]

This phenomena is the result of availability of new technology and the tendency of hospitals to compete on the basis of size, technological advances and "prestige." Again, the third-party financing system provides little check on such added costs.

While the technical potential to constrain or reduce the supply of hospital facilities, beds and services is far from fully developed, it is adequate to begin. However, there appears to be little popular support for the concept. One study indicates that "hospital capacity reduction is even more a socio-political problem than a technical problem." The study further indicates that "the chief barrier to reduction is the absence of any climate of public support." [33] The situation in Kansas appears to be no different. A recent statewide public opinion poll on health policy issues revealed that only 26% of Kansans express approval of stronger government controls over hospital construction or expansion. [34] In comparison, 62% of the respondents in the same poll thought medical care costs were relatively high but only 48% approved of the general concept of government regulation of medical and hospital costs.

The lack of public support for efforts to reduce the number of hospitals is not surprising when we recognize that the community hospital is viewed as a symbol of both community pride and modern medical care. Kansans, like other Americans, have come to accept high-cost inpatient care as a necessary component of quality care. Moreover, like other Americans, they are insulated by third parties from the direct impact of high medical

care costs. Notwithstanding the obvious difficulties, there exists feasible approaches to this problem in the areas of government regulation, improved public education and cooperative planning between Kansas hospitals.

Lack of Price Competition

Price competition in the medical care section is extremely limited. Since the third-party system removes price as a consideration in the decision to seek or prescribe medical care, hospitals have tended to compete by "increasing in size, technological sophistication or in "prestige."[35] The lack of effective price competition reduces incentives for management efficiency and increases incentives for additional expenditures. Effective price competition in the medical care sector would introduce significant new incentives for improved management efficiency and market influence on available services. Pre-paid alternative delivery systems are feasible methods of intervention in this factor.

SUMMARY OF PROBLEM ANALYSIS

If the vast amounts we are spending for health care were yielding commensurate increments of improved health status, we might consider it money well spent. Unfortunately, though, the evidence is not conclusive, it suggests that we may not be receiving the maximum return in improved health that we are paying for.[36] The Statewide Health Coordinating Council believes that any long-term approach to containing health care costs must involve a new balance between the resources we commit to curing illness and the resources we commit to positive efforts to promote health and prevent

illness. Further, the short-term approach must advance the recognition that the goals of economy and quality are not incompatible, but rather are mutually rooted in a long tradition of Kansas progress.

The analysis of the problem of health care costs suggests a number of basic policy guidelines for efforts to constrain rising health care costs.

* The huge increase in government expenditures for health care after 1966 has been a primary source of inflationary pressure in the health system. Further expansion of government spending must be preceded by improved planning and cost controls.
* Demand for health care services for the elderly population is high and will increase as the elderly population continues to grow.
* The health implications of individual life-styles are dramatic. Changes in health related behavior patterns offer strong potential for improving health and reducing demand for costly medical care services among younger population groups.
* Heavy financial support of bio-medical research has led to emphasis on technological medicine. We must seek a new balance of research resources devoted to all the determinants of health.
* The system of third-party reimbursement has created a health care market where neither providers nor consumers bear sufficient responsibility for the prices of the services they provide or consume. The financing system replaces management incentives for efficiency with incentives to increase the costs and supply of services beyond defined need.

* The supply of hospital beds apparently exceeds the need, though the exact quantity of excess is undertermined. Lacking normal market controls, new measures to control capitalization in the hospital industry must be developed.
* Hospital services are overutilized in preference to other, lower-cost alternatives. New professional efforts to determine the appropriateness of hospital utilization must be implemented. Alternatives to costly institutional care should be encouraged.
* Normal price competition in the health care market is extremely limited. Prepayment financing alternatives should be developed to improve the climate for price competition.

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for

The Problem of Health Care Costs

Presented by: E. A. "Al" Jarvis

and

Cost Containment Proposals

Presented by: State Department of Health and Environment

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COST CONTAINMENT PROPOSALS

Presented to

Kansas Commission on Health Costs

October 5, 1977

By: State Department of Health and Environment

Atch. E

Recommendations

1. Implement rate review for all short-stay hospitals:

   Alternative #1: Non-profit corporation with state oversight

   Alternative #2: Independent rate commission.

2. Determine feasibility of rate review for non-hospital services.

3. Require all group insurance plans to offer:

   a) alternatives to institutional care coverage

   b) "first dollar" deductibles or shared payment provisions

4. Education program for:

   a) consumers

   b) providers

5. Encourage alternative delivery system development.

6. State employee coverage should include dual choice.

7. PSRO should be expanded to cover all patients in short-stay institutions.

8. Develop state policies quantifying the need for hospital facilities and services.

9. Modify Certificate of Need Law to improve effectiveness

   a) capital equipment provision should apply to ambulatory settings

   b) appeal process should be modified

10. Kansas hospitals should act to expand cooperative planning efforts.

11. Develop a state program to monitor costs:

   a) total health expenditures

   b) medical price index

   c) capital expenditures survey

12. Develop a program to assist people in maintaining their own health.

Health and health care are major concerns of the people of Kansas and will continue to constitute a major sector of the Kansas economy. The recommendations which follow are oriented to controlling those costs and expenditures that are wasteful or unnecessary, thereby restraining further unnecessary increases in the health care expenditures of Kansans.

Recommendation: By 1980, implement a State Rate Review Program for all short-stay hospitals in the state based on prospectively negotiated budgets and rates.

The methodology for rate setting and the essential data base are gradually improving. What is lacking, however, is not a specific methodology, but a political and structural framework that will permit the industry and government to work together toward solution of the problem..."[37] It is clear that buyers and sellers of hospital services, as well as government, each have a direct stake in determining rates for hospital services and must be effectively involved in any rate setting process. One method of achieving this involvement is to establish rates as the product of negotiations between buyers and sellers, with those negotiations conducted under the supervision of state government.

Alternative #1:

a. Establish a private non-profit corporation representing the major third parties to prospectively negotiate budgets and rates with hospitals. The members of this corporation should be appointed by the Governor and confirmed by the Senate.

b. Establish a state oversight agency in an existing unit of state government such as the Department of Administration or the Corporation Commission.

Alternative #2:

Establish an independent state commission composed of members appointed by the Governor and confirmed by the Senate, with sufficient professional staff and resources to prospectively negotiate and set budgets and rates.

Alternative #1 is the approach of choice.

This approach will provide for valid "arms-length" negotiations, without creating a major new state agency as would be required for the second alternative. Moreover, a private/public organization for rate setting can build on the existing capacity in both sectors to develop a political and structural framework for a cooperative and effective approach to the problem.

The rate setting methodology should be based on the following guidelines:

a. A uniform system for cost accounting and reporting:

b. Consideration of utilization factors such as occupancy rates, patient days and length of stay, as well as other budget and price factors;

c. Rewards for efficiency and penalties for inefficiency;

d. Effective linkages with the existing Health Planning and Certificate of Need Programs to assure a consistent and effective regulatory approach.

The primary financing mechanism for the rate setting program should be an assessed fee to each hospital based on a percentage of the hospital's annual operating budget. Under the recommended alternative, this method should be

used to fund the rate negotiating corporation, with funding for the state oversight agency included in the state budget.

A new tax on health insurance premiums is an alternative method of financing the rate setting program. However, a major disadvantage of this approach is that the burden of such a tax would fall on private health insurance premiums since government programs could not be taxed.

Recommendation: By 1980, determine the feasibility of programs to prospectively establish rates for health care services other than hospital services.

The feasibility of extending prospective rate setting to other sectors of the health care industry is not established. The state health planning program should undertake a study of the feasibility of such programs in conjunction with the implementation of the Hospital Rate Review Program.

Recommendation: By 1980, require all group health policies sold in Kansas to offer:

a. Coverage for specified services as alternatives to inpatient care.

b. "First dollar" deductibles and/or shared payment provisions for inpatient benefits.

The Kansas Insurance Commissioner should have responsibility for specifying alternative services to be covered and standards for deductibles and shared payment provisions. The State of Kansas should pass legislation to require

these features for all group health policies sold in Kansas.

Recommendation: By 1979, implement an education program on group health insurance and health care costs for major purchasers and statewide business groups.

The Kansas Insurance Commissioner should develop and implement an education program for major purchasers to inform them about health cost issues related to group health plans. The program should also be used to promote cost consciousness with statewide business groups such as the Chamber of Commerce and the Kansas Association of Business and Industry.

The State of Kansas should provide basic funding for this program in the state budget, with additional resources to be provided by third parties.

Recommendation: By 1979, implement education programs for consumers and providers concerning health care costs and actions to support cost containment.

Consumer Education

The Kansas Department of Health and Environment will design and implement a public education program to include information on:

1. Life-style and health
2. Causes of increasing health care costs
3. How to use health care services effectively
4. Individual action to promote cost containment

Physician Education

The Kansas University School of Medicine should evaluate its curricula for undergraduate, resident, and continuing professional education and revise them as appropriate to integrate cost considerations with professional judgments on methods of treatment and appropriate use of services.

Medical education has traditionally emphasized new and complex modes of treatment frequently without regard to cost.[38] We can begin to train medical students to understand the cost implications of their activities and to exercise cost consciousness. The National Fund for Medical Education has estimated that by 1990, more than one-third of the M.D. population would be affected if training started now.[39]

Recommendation: By 1978, the State of Kansas should amend its policies governing the state employee group health insurance plan to include a "dual choice" option in the contract provisions.

Alternative delivery systems such as prepaid group practices offer the potential for market price competition with traditional fee-for-service systems. They also tend to utilize significantly fewer inpatient days of hospital care for their enrollees. Thus, prepaid group practices are one approach to introducing price competition in the medical market and to decreasing costly overutilization of hospitals.

The concentration of state employees in the Topeka metropolitan area offers an excellent target population for an effective prepaid group practice

organization. The state government has the opportunity to directly encourage the development of such an organization by giving state employees the option of traditional health insurance coverage or prepaid group practice coverage if it is available.

Recommendation: By 1979, Kansas Blue Cross/Blue Shield should renew and expand efforts to promote the development of prepaid group practices.

Kansas Blue Cross/Blue Shield initiated a program to encourage the development of prepaid group practices several years ago, but the program has not received priority attention in recent years. Kansas Blue Cross/Blue Shield should convene appropriate professional and trade associations and state government agencies to develop a coordinated approach to promoting prepaid group practices in the state.

Congress has established a national program for quality control and utilization review called the Professional Standards Review Organization (PSRO) and the Kansas Medical Foundation has been designated as the PSRO for Kansas. Within a few years, all hospitals in the state should have the opportunity to participate in the program. As currently defined, however, the program applies only to those services paid for by one of the federal reimbursement programs.

Professional performance review agencies are necessarily complex political and structural organizations. Duplication of such activities to review services paid for by different third parties would be unnecessarily expensive

and inefficient. The American Hospital Association has issued guidelines for hospital relationships with PSROs that call for "quality of care review to encompass all services provided to all patients, regardless of source of payment"[40]

Recommendation: By 1982, extend Professional Standards Review Organization review to all patients regardless of source of payment.

The Kansas Medical Foundation, Kansas hospitals, and third parties should plan to extend PSRO coverage to all patients, regardless of payment, as soon as practical. All third-party payers should share the cost of extending PSRO coverage.

Recommendation: By 1978, develop a statewide public policy quantifying the need for hospital facilities, beds and services.

As indicated in the problem analysis, there is considerable evidence that an excess supply of hospital beds and services exists nationally. There is, however, no comprehensive study specifying the amount of excess beds and services in Kansas. Part Two of the State Plan, the "State Medical Facilities Plan," will constitute such a comprehensive study when completed. This plan will be based in part, upon plans developed by the four Health Systems Agencies in Kansas. The State Medical Facilities Plan is to be developed under guidelines not yet issued by the Secretary of the Department of Health, Education and Welfare, but should be completed by July, 1978.

The State Medical Facilities Plan will establish target goals specifying the number of hospital beds per thousand population for the state and each health service area. It will further establish optimal occupancy rates and numbers of patient days per thousand population for the state and each health service area.

Recommendation: By 1978, make revisions in the Certificate of Need Program to improve its effectiveness for appropriately limiting new capitalization.

The authorizing legislation for the Certificate of Need Program (K.S.A. 65-4801 et seq., 1976 Supp.) should be changed to require a certificate of need for capital equipment costing in excess of $150,000 purchased for use in ambulatory care settings. The current statute requires a certificate of need for such purchases only in institutional settings. However, such equipment generates significant expenditures regardless of the setting in which it is used. This "loophole" has the potential of extremely limiting the effectiveness of the law.

There are other technical changes which should be made in the statute to facilitate administration of the program and to bring it into full compliance with federal requirements. The Department of Health and Environment will present recommendations for these revisions prior to the 1978 Session of the Kansas Legislature.

The application of utilization and need criteria to a single hospital when that hospital applies for a certificate of need is ineffective and unrealistic since there are few instances where a single facility serves all the needs of a service area population. A more feasible approach would be to develop

groupings of hospitals by service or planning areas so that an application for a certificate of need could be considered in light of the needs of a defined population and all the facilities and services available to meet those needs. The Kansas Department of Health and Environment has begun research to define such hospital service/planning areas and will convene appropriate representatives of the hospital industry and public agencies to cooperatively pursue the project. In the interim Health Systems Agency subareas should be used as a basis for local planning.

Recommendation: The Kansas Hospital Association should act to expand cooperative planning and cost control efforts within the Kansas hospital industry.

The Kansas Hospital Association has provided leadership for planning and cost containment in the Kansas hospital industry through the efforts of its Committee on Shared Services and Council on Planning. These efforts have made some notable progress and should be expanded, particularly at the local level. The previous recommendation to develop hospital service/planning areas will offer the opportunity for local hospitals to begin joint planning efforts on behalf of their service area population. Such local cooperative planning on the part of hospitals should facilitate new shared service agreements, appropriate mergers and consolidations and other measures to coordinate and improve services and constrain costs. Such planning efforts within the hospital industry can and should become important adjuncts to the planning being carried out by Health Systems Agencies and the State Health Planning and Development Agency.

During 1978, the Kansas Department of Health and Environment, in cooperation with the Health Systems Agencies, will plan and implement a program to review the appropriateness of all institutional health facilities in the state. Although there is no authority to decertify unnecessary facilities costs, such strong regulatory action may become necessary if voluntary compliance is unsatisfactory.

State and local data on health care costs are presently inadequate to measure the impact of public policy decisions. Some information concerning specific types of expenditures and costs is currently available but is not adequate to permit adequate monitering. Four basic indicators necessary to monitor health care costs are: total health care expenditures, medical price index, capital asset base and service utilization. Some service utilization data is currently available. In contrast, little attention has been given to the design and implementation of the other three basic indicators.

Recommendation: By 1978, design and implement a state program to produce an analysis of total health expenditures; a medical price index; and a health facilities capital assets inventory.

The Kansas Department of Health and Environment will initiate methodological design work on the three cited indicators utilizing appropriate technical resources. The Department will involve interested agencies in the design and implementation of this program.

Recommendation: Programs should be developed to support individuals to assume more responsibility for their own health.

F

THE CERTIFICATE OF NEED PROGRAM

Testimony to the

Health Care Cost Commission

October 5, 1977

Prepared by: The Department of
Health and Environment

Atch. F

State of Kansas . . . ROBERT F. BENNETT, *Governor*

DEPARTMENT OF HEALTH AND ENVIRONMENT

DWIGHT F. METZLER, *Secretary*

Topeka, Kansas 66620

CERTIFICATE OF NEED PROGRAM

Kansas' first Certificate of Need Law was passed in 1972 soon after the enactment of P.L. 89-749 which required the establishment of Comprehensive Health Planning Regions for local decision making on health care projects and federal funding. Areawide Health Planning Councils were appointed from local provider and consumer citizens to serve a review and approval function for projects developed within their region. Sixteen such planning regions were established in Kansas and approved by the state planning agency (Kansas Department of Health and Environment). Only two of the 16 Areawide Health Planning Councils had paid staff.

A state Coordinating Council for Health Planning was established, according to state law, to perform the function of statewide health planning and coordination.

A Certificate of Need was required if a proposed project exceeded $350,000 or 5% of operating expense or increased the bed capacity. A Certificate of Need was approved or denied by one of the 16 Areawide Health Planning Councils.

The passage of P.L. 93-641 (Health Planning and Resources Development Act) required several changes in the Kansas Certificate of Need Law. The new Kansas law, effective July 1, 1976, requires a Certificate of Need before certain licenses may be granted and certain construction may be undertaken. The law requires a determination of sufficient need to be made by the Secretary of the Department of Health and Environment based upon a State Health Plan or interim criteria approved by a Statewide Health Coordinating Council (copy attached).

For regional planning purposes, the Federal law required the designation of health service areas and each has developed a not-for-profit agency (Health Systems Agency) with members selected from providers and consumers for the purposes of fulfilling the requirements of the Federal law. The Health Systems Agencies (HSA's) are required to review and comment on Certificate of Need applications in their area and make a recommendation to the Department of Health and Environment as to whether the Certificate of Need should be granted or not granted. If the HSA, applicant for a Certificate of Need, or a medical facility in the area does not agree with the decision of the Secretary of the Department of Health and Environment, they may appeal to the Statewide Health Coordinating Council (SHCC). The decision of the SHCC is final, unless the case is taken to court. The following is a summary of the Certificate of Need Decisions issued by the Secretary of the Department of Health and Environment from July 1, 1976 to October 1, 1977.

Certificate of Need Decisions

(July 1, 1976 to October 1, 1977)

HSA #1 - Health Planning Association of Western Kansas:

		Hospitals		Adult Care Homes		Other
Approved	4	($3,462,000)	5	($1,940,000)		-
Disapproved	-	-	1	($ 400,000)*		-
TOTAL	4	($3,462,000)	6	($2,340,000)		-

HSA #2 - Northeast Kansas Health Systems Agency:

		Hospitals		Adult Care Homes		Other
Approved	2	($5,725,000)	4	($1,190,000)	1	($1,479,821)
Disapproved	-	-	-	-	-	-
TOTAL	2	($5,725,000)	4	($1,190,000)	-	($1,479,821)

HSA #3 - Health Systems Agency of Southeast Kansas:

		Hospitals		Adult Care Homes		Other
Approved	2	($23,500,000)	3	($2,065,000)	1	(No Cost)
Disapproved	-	-	-	-	-	-
TOTAL	2	($23,500,000)	3	($2,065,000)	1	(No Cost)

HSA #4 - Mid-America Health Systems Agency:

		Hospitals		Adult Care Homes		Other
Approved	2	($1,220,000)	1	($435,000)	-	-
Disapproved	3	($8,812,000)*	-	-	1	($600,000)*
TOTAL	5	($10,032,000)	1	($435,000)	1	($600,000)

TOTALS

		Hospitals		Adult Care Homes		Other
Approved	10	($33,907,000)	13	($5,630,000)	2	($1,479,821)
Disapproved	3	($ 8,812,000)	1	($ 400,000)	1	($ 600,000)
TOTAL	13	($42,719,000)	14	($6,030,000)	3	($2,079,821)

* Appealed to the Kansas Statewide Health Coordinating Council

KANSAS CERTIFICATE OF NEED PROGRAM

- INTERIM CRITERIA -

To be used in conjunction with criteria specified by Section 1532(c) of PL 93-641 (attached) in reviewing all applications:

I. COMMUNITY NEED: The project must be needed or projected to be necessary to meet a specific health need of a defined population.

II. PHYSICAL RESOURCES: The project must make available adequate facilities and equipment for meeting specific programs.

III. MANPOWER RESOURCES: The project must have adequate personnel available to staff the operation when complete.

IV. COMMUNITY RESOURCES: The project must have adequate community support and be in concurrence with defined community needs.

V. FINANCIAL RESOURCES: The project must have adequate financial backing and support to complete and sustain continuous operation and be economically feasible.

Additional criteria for review may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed.

BMDH 11/10/76

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THE HILL-BURTON PROGRAM

Testimony to the

Health Care Cost Commission

October 5, 1977

Prepared by: The Department of
Health and Environment

Atch. G

State of Kansas . . . ROBERT F. BENNETT, *Governor*

DEPARTMENT OF HEALTH AND ENVIRONMENT

DWIGHT F. METZLER, *Secretary*

Topeka, Kansas 66620

HILL-BURTON PROGRAM

The Hill-Burton Program was initiated in Kansas by the Department of Health in 1946. The purpose of the program was to encourage the construction of medical facilities through the process of the Federal Government providing grants to cover a portion of the construction cost.

Over the years that the Hill-Burton Program has been operating in Kansas, approximately 50 million dollars has been allocated to pay a portion of the construction costs for medical facilities.

The Hill-Burton Law was passed in 1946. The medical facilities that accepted grants agreed to furnish a community service and furnish below cost or without charge a reasonable volume of services to persons unable to pay. The terms community service and reasonable volume of free care were not defined until the question was raised in a district court. As a result of the district court decision the Federal Government published rules and regulations defining these terms in 1972 and 1973.

Community Service Regulations:

1. You must serve the general public.
2. You may limit services only on the basis of age, medical indigency, or type or kind of medical or mental disability.
3. If otherwise eligible to do so:
   a. Arrange to accept beneficiaries of state and local governmental third-party payors providing they reimburse you at not less than actual cost as determined by accepted cost accounting principles.
   b. Arrange to accept beneficiaries of federal governmental programs such as Medicare and Medicaid to the extent you are entitled to reimbursement at "reasonable cost."
4. Take whatever steps may be necessary to ensure that admission to the services of your institution is available (without discrimination or preference) to beneficiaries of governmental programs that meet the above criteria.

Uncompensated Care Regulations:

Medical facilities which have received Hill-Burton funds have certain options they may select to fulfill their uncompensated care requirements. Presumptive compliance may be met by one of the following three options or the alternative:

1. A medical facility will not deny admission to, and services at, that facility to any person unable to pay.

2. A medical facility will provide a level of uncompensated patient care equal to ten percent annually of all Hill-Burton assistance.
3. A medical facility will provide a level of uncompensated patient care equal to the sum obtained by subtracting Medicare and Medicaid reimbursement from the facility's operating cost and then taking three percent of the remainder.
4. If a medical facility determines that selection of one of the above three options would result in undue hardship, it may propose a lower level of uncompensated patient care within 120 days after the close of it's fiscal year. The Medical Facilities Licensure Section will have 60 days to review the hospital's financial statement, consider the needs of the area, and either agree or disagree with the medical facility's proposal.

Of the 72 medical facilities in Kansas that are required to provide uncompensated care, 67 have selected option 1, 2 option 2, and 3 option 3.

The medical facilities that participate in the Hill-Burton Program are required to post the following notice.

NOTICE OF HILL-BURTON OBLIGATION

This hospital (or other facility) is required by law to give a reasonable amount of service at no cost or less than full cost to people who cannot pay. If you think that you are eligible for these services, please contact our business office (give office location) and ask for assistance. If you are not satisfied with the results, you may contact the Kansas Department of Health and Environment, Topeka, Kansas 66620.

The medical facilities are also required to submit an annual fiscal report to the Department of Health and Environment. Our latest report concerning uncompensated care is as follows:

Option 1 - (Open Door)

62 Hospitals	$1,335,822
2 Nursing Homes	19,877
3 Public Health Centers	227,512
TOTAL	$1,583,221

Option 2 - (10% of Hill-Burton Grant)

1 Hospital	$ 140,789
1 Nursing Home	12,500
TOTAL	$ 153,298

Option 3 - (3% Operating Costs)

3 Nursing Homes	$ 39,325

The medical facilities in Kansas that received Hill-Burton funds are in compliance with the Federal rules and regulations which govern the Hill-Burton Program.

Attachment 4

SERVICES COVERED UNDER MEDICAID

For individuals receiving aid or assistance under any plan of the State approved under Titles I, X, XIV, XVI, or Part A of Title IV, or with respect to whom Supplemental Security Income benefits are being paid under Title XVI, the following services are covered under the Medicaid Program.

Required Services

1. Inpatient hospital services (other than services in an institution for tuberculosis or mental diseases).

2. Outpatient hospital services.

3. Other laboratory and X-ray services.

4. Skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older.

5. Effective July 1, 1969, early and periodic screening and diagnosis of individuals under the age of 21 who are eligible under the plan.

6. Family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age who are eligible under the State Plan and who desire such services and supplies.

7. Physician's services furnished by a physician, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

Optional Services

1. Medical care, or any other type of remedial care recognized under State law and furnished by licensed practitioners within the scope of their practice as defined by State law.

2. Home health care services.

3. Private duty nursing services.

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4. Clinic services.

5. Dental services.

6. Physical therapy and related services.

7. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

8. Other diagnostic, screening, preventive, and rehabilitative services.

9. Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.

10. Intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined to be in need of such care.

11. Effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21.

12. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

NOTE: THE KANSAS MEDICAID PROGRAM COVERS ALL OF THE OPTIONAL SERVICES LISTED ABOVE EXCEPT FOR NUMBER 8.

SUMMARY OF

TITLE XIX DATA

FISCAL YEAR 1976

REGION VII

MEDICAL SERVICES DIVISION
SOCIAL AND REHABILITATION SERVICE
KANSAS CITY REGIONAL OFFICE

SUMMARY OF TITLE XIX DATA

IN REGION VII

FISCAL YEAR 1976

Prepared by:

Medical Services Division

Social and Rehabilitation Service

Kansas City Regional Office

SUMMARY OF TITLE XIX DATA

IN REGION VII

FISCAL YEAR 1976

TABLE OF CONTENTS

INTRODUCTION

The Medical Services Division of the Social and Rehabilitation Service Kansas City Regional Office is responsible for the overall administration of the Title XIX Program in Region VII. Region VII includes the States of Iowa, Kansas, Missouri, and Nebraska. The purpose of this report is to provide a statistical summary of Title XIX data in these four States for the period July 1, 1975, to June 30, 1976. The primary sources of reference used in the preparation of this report are listed below.

SRS-NCSS-2078.3	SRS-OA-41
SRS-NCSS-119	SRS-NCSS-120

In addition to the sources shown above, certain data was specifically requested by the Kansas City Regional Office.

This report is presented in seven sections. Each section deals with a major aspect of the Title XIX program; however, it should be noted that this report is not intended to provide a comprehensive indication of all Title XIX activity in Region VII and any conclusions drawn from the following material should be considered in this light. At the beginning of each section is a list of the tables included in that section and a brief explanation of each table.

Highlights

A. During fiscal year 1976, the four States in Region VII paid out a total of $443,136,628 in Title XIX benefits as reported on the SRS-NCSS-120. The totals for the individual States during this period were as follows: Missouri - $132,196,091; Kansas - $127,885,042; Iowa - $124,092,332; Nebraska - $58,963,163.

B. In fiscal year 1976, the four States in Region VII reported screening a total of 88,686 children under the Early and Periodic Screening, Diagnosis, and Treatment Program at a cost of $1,534,835. Of those screened, 29,329 were found to have referable conditions, and of this number, 18,134 were referred for treatment. These figures do not include data for Missouri for the months of November and December 1975 as it was not reported by the State.

C. There were a total of 3,704 people sterilized under the Title XIX Family Planning Program in fiscal year 1976 at a cost of $933,902.

The totals by State were as follows: Iowa - 1,870; Missouri - 835; Kansas -813; Nebraska - 186. These figures do not include data for Missouri for the first nine months of fiscal year 1976, nor do they include cost data for Kansas for March 1976. In addition, no data was available for June 1976 for Nebraska at the time this report was prepared.

D. On a regional basis, the average number of people receiving a medical service that was reimbursed under the Title XIX Program during any one month in fiscal year 1976 was 341,438. The average program payment to medical vendors during any one month in fiscal year 1976 was $35,820,937. This calculates to an average monthly benefit per recipient of $104.91.

E. The average annual benefit per recipient in fiscal year 1976 is shown below by State.

Kansas	$1,764	Iowa	$1,634
Nebraska	$1,755	Missouri	$767

F. The four States in Region VII completed investigations on 98 suspected fraud cases in fiscal year 1976. Of these, nine were referred to law officials for further action.

G. The four States in Region VII expended a total of $25,495,776 in the administration of the Title XIX Program in fiscal year 1976. The individual totals for each State were as follows: Nebraska - $7,282,268; Missouri - $4,986,996; Iowa - $6,894,073; Kansas - $6,332,439. These figures do not include training costs reported by the States.

H. The four States in Region VII processed a total of 10,247,025 Medicaid claims in fiscal year 1976. The individual totals for each State were as follows: Iowa - 1,725,545; Kansas - 3,097,847 Missouri - 4,014,471; Nebraska - 1,409,162.

I. BENEFIT PAYMENTS

A. TOTAL ASSISTANCE PAYMENTS

Total benefit payments made under the Title XIX program and claimed for Federal matching apportioned by Federal and State costs.

B. MATCHABLE MEDICAL ASSISTANCE PAYMENTS

Total benefit payments made under the Title XIX program and claimed for Federal matching broken down by calendar quarter.

C. TOTAL TITLE XIX BENEFITS PAID

Total vendor payments, EPSDT payments, and Medicare buy-in payments by quarter and State. These totals differ from those shown in tables A and B above because different sources were used in the compilation of these tables involving different reporting requirements.

D. EPSDT PAYMENTS

A breakdown by calendar quarter of the benefit payments made in connection with the early and periodic screening, diagnosis, and treatment program (EPSDT).

E. SSA BUY-IN PAYMENTS

A breakdown by calendar quarter of the program payments made in connection with the Social Security Administration (SSA) Medicare buy-in program.

F. VENDOR PAYMENTS BY QUARTER

A breakdown by calendar quarter of the benefit payments made to participating medical vendors.

G. VENDOR PAYMENTS BY TYPE OF VENDOR

A breakdown of the benefit payments made to participating medical vendors by type of vendor. The "other" category includes dental services, outpatient services, clinic services, home health services, family planning services, and laboratory and radiological services.

H. VENDOR PAYMENTS BY TYPE OF ELIGIBILITY

Breakdown of Title XIX benefit payments into eligibility categories.

I. TITLE XIX VENDOR PAYMENTS BY MONTH

Monthly breakdown of program payments to participating vendors.

A. TOTAL ASSISTANCE PAYMENTS

	Matchable	Non-Matchable	Total
Iowa	$123,899,778	$ 233,703	$124,133,481
Kansas	124,119,971	5,197,724	129,317,695
Missouri	127,368,053	4,280,320	131,648,373
Nebraska	58,924,662	-0-	58,924,662
Total	$434,312,464	$9,711,747	$444,024,211

Source: OA Form 41

B. MATCHABLE MEDICAL ASSISTANCE PAYMENTS

	Federal Share	State Share	Total
Iowa	$ 70,548,135	$ 53,351,643	$123,899,778
Kansas	60,799,872	63,320,099	124,119,971
Missouri	72,876,885	54,491,168	127,368,053
Nebraska	32,815,852	26,108,810	58,924,662
Total	$237,040,744	$197,271,720	$434,312,464

Source: OA Form 41

C. TOTAL TITLE XIX BENEFITS PAID

Quarter	Iowa	Kansas	Missouri	Nebraska*	Total
July - Sept.	$ 25,948,070	$ 25,520,593	$ 30,230,358	$12,636,184	$ 94,335,205
Oct. - Dec.	28,566,530	31,334,158	31,453,666	15,009,736	106,364,090
Jan. - March	34,034,925	32,910,016	32,588,184	15,683,415	115,216,540
Apr. - June	35,542,807	38,120,275	37,923,883	15,633,828	127,220,793
Total	$124,092,332	$127,885,042	$132,196,091	$58,963,163	$443,136,628

Source: SRS-NCSS-120
*Excludes retroactive adjustments

D. EPSDT PAYMENTS

Quarter	Iowa	Kansas	Missouri*	Nebraska	Total
July - Sept.	$ 87,163	$ 90,833	$128,210	$ 45,278	$ 351,484
Oct. - Dec.	103,360	76,450	168,419	55,982	404,211
Jan. - March	89,792	94,796	146,518	48,713	379,819
Apr. - June	74,804	98,234	182,278	44,005	399,321
Total	$355,119	$360,313	$625,425	$193,978	$1,534,835

Source: SRS-NCSS-120

*November and December data missing for Missouri

E. SSA BUY-IN PAYMENTS

Quarter	Iowa	Kansas	Missouri	Nebraska	Total
July - Sept.	$ 634,850	$ 419,393	$ 1,715,993	$ 168,594	$ 2,938,830
Oct. - Dec.	675,538	458,535	1,659,063	160,523	2,953,659
Jan. - March	643,261	456,360	1,677,809	156,485	2,933,915
Apr. - June	668,485	483,658	1,615,774	156,223	2,924,140
Total	$ 2,622,134	$ 1,817,946	$ 6,668,639	$ 641,825	$ 11,750,544

Source: SRS-NCSS-120

F. VENDOR PAYMENTS BY QUARTER

Quarter	Iowa	Kansas	Missouri	Nebraska	Total
July - Sept.	$ 25,226,057	$ 25,010,367	$ 28,386,155	$ 12,422,312	$ 91,044,891
Oct. - Dec.	27,787,632	30,799,173	29,626,184	14,793,231	103,006,220
Jan. - March	33,301,872	32,358,860	30,763,857	15,478,217	111,902,806
Apr. - June	34,799,518	37,538,383	36,125,831	15,433,600	123,897,332
Total	$ 121,115,079	$ 125,706,783	$ 124,902,027	$ 58,127,360	$ 429,851,249

Source: SRS-NCSS-120

G. VENDOR PAYMENTS BY TYPE OF VENDOR

Vendor	Iowa	Kansas	Missouri	Nebraska	Total
Inpatient	$ 21,611,882	$ 35,762,869	$ 46,049,088	$ 10,561,528	$ 113,985,367
SNF	584,557	3,387,282	8,219,487	1,965,003	14,156,329
ICF	66,733,872	46,377,393	24,454,720	29,548,568	167,114,553
Physicians	11,350,983	13,294,017	18,546,295	4,812,647	48,003,942
Drugs	8,547,082	10,072,412	15,991,498	5,495,778	40,106,770
Other	12,286,703	16,812,810	11,640,939	5,743,836	46,484,288
Total	$ 121,115,079	$ 125,706,783	$ 124,902,027	$ 58,127,360	$ 429,851,249

Source: SRS-NCSS-120, Part I

PERCENT

Vendor	Iowa	Kansas	Missouri	Nebraska	Total
Inpatient	17.8 %	28.4 %	36.9 %	18.2 %	26.5 %
SNF	0.5	2.7	6.6	3.4	3.3
ICF	55.1	36.9	19.6	50.8	38.9
Physicians	9.4	10.6	14.8	8.3	11.2
Drugs	7.1	8.0	12.8	9.5	9.3
Other	10.1	13.4	9.3	9.8	10.8
Total	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

H. VENDOR PAYMENTS BY TYPE OF ELIGIBILITY

Eligibility	Iowa	Kansas	Missouri*	Nebraska	Total
65 or Over	$ 59,827,304	$ 36,506,012	$ 42,441,708	$ 26,650,062	$ 165,425,086
Blind	1,220,212	684,953	1,611,236	490,302	4,006,703
Disability	24,123,898	30,138,075	22,694,698	17,893,772	94,850,443
AFDC Adults	19,676,926	32,455,726	23,294,228	6,988,735	129,609,780
AFDC Children	14,375,581	NA***	26,878,916	5,939,668	NA
Other	1,891,158	25,954,503	7,981,241	164,821	35,991,723
Total	$ 121,115,079	$ 125,739,269**	$ 124,902,027	$ 58,127,360	$ 429,883,735

Source: SRS-NCSS-120, Part II

PERCENT

Eligibility	Iowa	Kansas	Missouri	Nebraska	Total
65 or Over	49.4 %	29.0 %	34.0 %	45.8 %	38.5 %
Blind	1.0	0.5	1.3	0.8	0.9
Disability	19.9	24.0	18.2	30.8	22.1
AFDC Adults	16.2	25.8	18.7	12.0	30.1
AFDC Children	11.9	NA	21.5	10.2	NA
Other	1.6	20.7	6.3	0.4	8.4
Total	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

*August data extrapolated.
**Disagrees with F and G totals due to discrepancy in March 1976 report.
***AFDC benefits not separately identified for adults and children.

I. TITLE XIX VENDOR PAYMENTS BY MONTH

Month	Iowa	Kansas	Missouri	Nebraska	Total
July 1975	$ 9,249,275	$ 5,324,529	$ 7,703,711	$ 4,099,332	$ 26,376,847
August 1975	7,713,993	10,318,986	9,586,639	4,071,429	31,691,047
September 1975	8,262,789	9,366,852	11,095,805	4,251,551	32,976,997
October 1975	9,878,298	9,038,664	10,075,309	5,278,385	34,270,656
November 1975	9,749,672	4,361,896	8,449,133	5,177,267	27,737,968
December 1975	8,159,662	17,398,613	11,101,742	4,337,579	40,997,596
January 1976	9,883,435	9,498,881	9,394,278	4,785,576	33,562,170
February 1976	10,286,359	12,770,247	10,026,942	5,148,578	38,232,126
March 1976	13,132,078	10,089,732	11,342,637	5,544,063	40,108,510
April	11,756,280	12,536,632	12,163,083	5,309,288	41,765,283
May 1976	11,956,613	13,915,771	11,177,063	4,941,765	41,991,212
June 1976	11,086,625	11,085,980	12,785,685	5,182,547	40,140,837
Total	$ 121,115,079	$ 125,706,783	$ 124,902,027	$ 58,127,360	$ 429,851,249
Monthly Average	$ 10,092,923	$ 10,475,565	$ 10,408,502	$ 4,843,947	$ 35,820,937

Source: SRS-NCSS-120

II. EPSDT, STERILIZATIONS, AND FAMILY PLANNING

A. EPSDT DATA

The number of children screened and referred for treatment under the Early and Periodic Screening, Diagnosis, and Treatment Program, as well as the costs of providing these services.

B. PERCENT OF AFDC RECIPIENTS SCREENED

The number of children receiving AFDC benefits as of February 1976 and the number of persons screened under the EPSDT Program in fiscal year 1976. While this table is designed to furnish an indication as to the effectiveness of a State's program in reaching eligible children, it must be recognized these figures may not provide an accurate measure of a State's performance due to the transient nature of the eligible population.

C. STERILIZATIONS

The number and costs of non-therapeutic sterilizations paid for under the Title XIX Program.

D. FAMILY PLANNING COSTS

The total costs of family planning services claimed by the States at the 90 percent Federal matching rate.

A. EPSDT DATA

	Iowa	Kansas	Missouri*	Nebraska	Total
Number Screened	24,948	18,090	34,924	10,724	88,686
Number Nonreferable	18,548	11,330	20,940	7,498	58,316
Number Referable	6,400	6,760	12,943	3,226	29,329
Percent Referable	26%	37%	37%	30%	33%
Number Referred	6,400	6,740	2,547	2,447	18,134
Percent Referred	100%	99%	20%	76%	62%
Screening Costs	$355,119	$360,313	$625,425	$193,978	$1,534,835
Cost Per Screen	$ 14.23	$ 19.92	$ 14.85**	$ 18.09	$ 16.10

Source: SRS-NCSS-120, Part III
*November and December data missing except for costs
**Excludes November and December costs

B. PERCENT OF AFDC RECIPIENTS SCREENED

	AFDC Children As of February 1976	Number Screened Fiscal Year '76	Percent Screened
Iowa	65,580	24,948	38.0%
Kansas	56,846	18,090	31.8%
Missouri	197,687	34,924	17.8%
Nebraska	26,011	10,724	41.2%
TOTAL	346,124	88,686	25.6%

Source: SRS-NCSS-2078.3 and 120, Part III

C. STERILIZATIONS

	Iowa	Kansas	Missouri**	Nebraska	Total
Vasectomies	63	87	7	2	159
Tubal Ligations	671	726	743	184	2,324
Hysterectomies	589	0	0	0	589
Other	547	0	85	0	632
TOTAL	1,870	813	835	186	3,704
COST	$425,988	$115,467*	$363,850	$28,597	$933,902

Source: SRS-NCSS-120, Part IV
*No Cost Data Reported For March 1976.
**No Data Reports For July - March Period For Missouri

D. FAMILY PLANNING COSTS

	Total	FFP
Iowa	$ 890,179	$ 801,162
Kansas	850,498	765,449
Missouri	1,385,472	1,240,360
Nebraska *	173,303	155,973
TOTAL	$3,299,452	$2,962,944

Source: OA Form 41
*No Family Planning Costs Reported For The April - June 1976 Quarter Due To Computer Problems

III. ADMINISTRATIVE COSTS

A. TITLE XIX REPORTED ADMINISTRATIVE COSTS

The costs incurred in the administration of the Title XIX program as reported by each State broken down by Federal and State shares. These figures do not include training costs.

B. QUARTERLY REPORTED ADMINISTRATIVE COSTS

The costs incurred in the administration of the Title XIX program by quarter as reported by each State. These figures do not include training costs.

C. FFP BREAKDOWN OF ADMINISTRATIVE COSTS

The Federal share of the administrative costs reported by each State broken down into the four Federal financial participation rates available to the States under the Title XIX program.

D. TRAINING COSTS

The total training costs reported by each State under the Title XIX program and the Federal share of these costs.

E. RATIO OF ADMINISTRATIVE COSTS TO BENEFITS PAID

The Title XIX administrative costs reported by the State divided by the total Title XIX benefits paid during the same period. This provides one measure of cost effectiveness.

A. TITLE XIX REPORTED ADMINISTRATIVE COSTS

	Federal Share	State Share	Total
Iowa	$ 3,917,002	$ 2,977,071	$ 6,894,073
Kansas	3,416,701	2,915,738	6,332,439
Missouri	2,813,415	2,173,581	4,986,996
Nebraska	4,086,885	3,195,383	7,282,268
Total	$14,234,003	$ 11,261,773	$ 25,495,776

Source: Form 41

B. QUARTERLY REPORTED ADMINISTRATIVE COSTS

	Iowa	Kansas	Missouri	Nebraska	Total
July - Sept.	$ 1,434,624	$ 1,041,140	$ 1,015,451	$ 1,748,979	$ 5,240,194
Oct. - Dec.	1,820,458	1,477,941	1,281,036	1,823,688	6,403,123
Jan. - March	1,921,375	1,347,318	1,256,637	1,827,420	6,352,750
Apr. - June	1,717,616	2,466,040	1,433,872	1,882,181	7,499,709
Total	$ 6,894,073	$ 6,332,439	$ 4,986,996	$ 7,282,268	$ 25,495,776

Source: Form 41

C. FFP BREAKDOWN OF ADMINISTRATIVE COSTS*

	50%	75%	90%	100%	Total
Iowa	2,778,327	$ 596,233	$ -0-	$ 542,442	$ 3,917,002
Kansas	2,805,428	330,938	-0-	280,335	3,416,701
Missouri	2,031,827	385,796	118,414	277,378	2,813,415
Nebraska	3,043,721	298,281	470,154	274,729	4,086,885
Total	$10,659,303	$1,611,248	$588,568	$1,374,884	$14,234,003

Source: Form 41
*Federal Share only

D. TRAINING COSTS

	Total	Federal Share
Iowa	$33,696	$25,272
Kansas	-0-	-0-
Missouri	-0-	-0-
Nebraska	6,853	4,533
Total	$40,549	$29,805

Source: Form 41

E. RATIO OF ADMINISTRATIVE COSTS TO BENEFITS PAID

	Title XIX Benefits Paid	Administrative Costs	Percent
Iowa	$ 124,092,332	$ 6,894,073	5.6 %
Kansas	127,885,042	6,332,439	5.0
Missouri	132,196,091	4,986,996	3.8
Nebraska	60,287,981	7,282,268	12.1
Total	$ 444,461,446	$ 25,495,776	5.7 %

Source: SRS-NCSS-120 and OA Form 41

IV. RECIPIENTS

A. MONTHLY AVERAGE NUMBER OF RECIPIENTS RECEIVING A TITLE XIX SERVICE

The average number of eligibles who actually received one or more services for which program reimbursement was made during any one month of fiscal year 1976. It does not necessarily correlate to the number of services provided or to the total number of persons who received covered services during this period.

B. AVERAGE ANNUAL BENEFIT PER RECIPIENT BY CATEGORY

The total fiscal year 1976 vendor payments divided by the monthly average number of recipients. This data is shown for recipients in six eligibility categories.

C. AVERAGE QUARTERLY BENEFIT PER RECIPIENT--ALL CATEGORIES

The total State vendor payments made in a calendar quarter divided by the monthly average number of recipients for that quarter.

D. NUMBER OF RECIPIENTS RECEIVING A TITLE XIX SERVICE BY MONTH

Monthly breakdown of the number of eligibles who actually received one or more services for which program reimbursement was made.

E. AVERAGE NUMBER OF MEDICAID ELIGIBLES PER MONTH

The average (mean) number of individuals who were eligible to receive Title XIX benefits during any month in fiscal year 1976.

F. PERCENT OF ELIGIBLES RECEIVING ONE OR MORE COVERED SERVICES

The average percentage of those people eligible for Title XIX services during any month in fiscal year 1976 who acutally received one or more medical services which were reimbursed under the Medicaid program.

A. MONTHLY AVERAGE NUMBER OF RECIPIENTS RECEIVING A TITLE XIX SERVICE

	Iowa	Kansas	Missouri	Nebraska	Total
65 or Over	20,055	16,105	49,911	10,931	97,002
Blind	670	350	1,948	171	3,139
Disability	7,441	9,152	17,889	5,641	40,123
AFDC Adults	18,750	13,328	37,381	6,660	76,119
AFDC Children	25,280	20,448	48,757	9,590	104,075
Other	1,914	11,915	7,016	135	20,980
Total	74,110	71,298	162,902	33,128	341,438

Source: SRS-NCSS-120, Part II

PERCENT

	Iowa	Kansas	Missouri	Nebraska	Total
65 or Over	27.1 %	22.6 %	30.6 %	33.0 %	28.4 %
Blind	0.9	0.5	1.2	0.5	0.9
Disability	10.0	12.8	11.0	17.0	11.8
AFDC Adults	25.3	18.7	22.9	20.1	22.3
AFDC Children	34.1	28.7	29.9	28.9	30.5
Other	2.6	16.7	4.4	0.5	6.1
Total	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

B. AVERAGE ANNUAL BENEFIT PER RECIPIENT BY CATEGORY

Category	Iowa	Kansas	Missouri	Nebraska	Total
65 or Over	$ 2,983	$ 2,267	$ 850	$ 2,438	$ 1,705
Blind	1,821	1,957	827	2,867	1,276
Disability	3,242	3,293	1,269	3,172	2,364
AFDC Adults	1,049	961	623	1,049	719
AFDC Children	569	NA*	551	619	NA
Other	988	2,178	1,138	1,221	1,716
Total	$ 1,634	$ 1,764	$ 767	$ 1,755	$ 1,259

Source: Tables I.H. and IV.A. of this report.

*AFDC benefits not separately identified for adults and children.

C. AVERAGE QUARTERLY BENEFIT PER RECIPIENT - ALL CATEGORIES

	Iowa	Kansas	Missouri	Nebraska	Total
July - Sept.	$ 378	$ 384	$ 123	$ 407	$ 293
Oct. - Dec.	363	486	188	439	311
Jan. - March	437	407	193	450	320
Apr. - June	452	487	202	455	338
July - June	$ 1,634	$ 1,764	$ 767	$ 1,755	$ 1,259

Source: SRS-NCSS-120

D. NUMBER OF RECIPIENTS RECEIVING A TITLE XIX SERVICE BY MONTH

Month	Iowa	Kansas	Missouri	Nebraska	Total
July 1975	72,579	50,133	136,641	30,576	289,929
August 1975	62,154	77,232	*	30,495	169,881
September 1975	65,313	68,180	168,567	30,416	332,476
October 1975	76,107	71,090	158,943	36,061	342,201
November 1975	74,076	16,061	147,377	32,401	269,915
December 1975	79,246	102,935	166,022	32,573	380,776
January 1976	67,020	71,066	147,129	32,278	317,493
February 1976	75,481	86,631	156,264	33,767	352,143
March 1976	86,359	81,194	174,826	37,229	379,608
April 1976	79,118	88,720	180,292	35,145	383,275
May 1976	78,768	82,481	171,138	31,661	364,048
June 1976	73,098	59,850	184,709	34,932	352,589
Total	889,319	855,573	1,791,908	397,534	3,934,334
Monthly Average	74,110	71,298	162,902	33,128	341,438

Source: SRS-NCSS-120

*August 1975 data not reported for Missouri.

E. AVERAGE NUMBER OF MEDICAID ELIGIBLES PER MONTH

Category	Iowa	Kansas	Missouri**	Nebraska	Total
Aged	40,091*	20,385	69,442	12,238	192,389
Blind	-	483	3,180	245	-
Disabled	-	12,217	27,002	7,106	-
AFDC	94,642	82,172	296,949	35,510	509,273
Other	4,293	23,227	13,196	1,396	42,112
Total	139,026	138,484	409,769	56,495	743,774

Source: Requested by Regional Office
*Includes Blind and Disabled
**Data only for March-May 1976

F. PERCENT OF ELIGIBLES RECEIVING ONE OR MORE COVERED SERVICES

Category	Iowa	Kansas	Missouri	Nebraska	Total
Aged	70.3%	79.0%	71.9%	89.3%	72.9%
Blind	-	72.5	61.3	69.8	-
Disabled	-	74.9	66.3	79.4	-
AFDC	46.5	41.1	29.0	45.8	35.4
Other	44.6	51.3	53.2	9.7	49.8
Total	53.3%	51.5%	39.8%	58.6%	45.9%

Source: Tables IV. A. and E. of this Report

V. CLAIMS

A. NUMBER OF MEDICAID CLAIMS PROCESSED

Total number of Medicaid claims processed by each State in fiscal years 1975 and 1976 and the change between these two years.

B. AVERAGE BENEFIT PER CLAIM--FY 1976

Fiscal year 1976 vendor payments divided by claims processed for 10 vendor categories.

C. NUMBER OF MEDICAID CLAIMS PROCESSED--IOWA

The number of Medicaid claims processed in the State of Iowa in fiscal years 1975 and 1976 broken down into 10 vendor categories.

D. AVERAGE BENEFIT PER CLAIM--IOWA

A comparison of the average Title XIX benefit payment per claim in fiscal year 1975 to fiscal year 1976 for each of ten vendor categories.

E. NUMBER OF MEDICAID CLAIMS PROCESSED--KANSAS

Refer to C above.

F. AVERAGE BENEFIT PER CLAIM--KANSAS

Refer to D above.

G. NUMBER OF MEDICAID CLAIMS PROCESSED--MISSOURI

Refer to C above.

H. AVERAGE BENEFIT PER CLAIM--MISSOURI

Refer to D above.

I. NUMBER OF MEDICAID CLAIMS PROCESSED--NEBRASKA

Refer to C above.

J. AVERAGE BENEFIT PER CLAIM--NEBRASKA

Refer to D above.

A. NUMBER OF MEDICAID CLAIMS PROCESSED

	FY 75	FY 76	Increase	Percent
Iowa	1,393,729	1,725,545	331,816	23.8 %
Kansas	2,797,604	3,097,847	300,243	10.7
Missouri	3,953,298	4,014,471	61,173	1.5
Nebraska	1,321,505	1,409,162	87,657	6.6
Total	9,466,136	10,247,025	780,889	8.2 %

Source: Special State Reports

B. AVERAGE BENEFIT PER CLAIM - FY 1976

	Iowa	Kansas	Missouri	Nebraska
Inpatient	$ 530.33	$ 641.98	$438.85	$ 621.48
Outpatient	27.99	30.56	12.59	28.61
Lab and X-Ray	8.06	NA	NA	14.80
Physician	24.14	28.50	19.31	23.56
Long-term Care	265.65	302.27	335.20	308.90
Dental	55.44	46.74	39.73	66.26
Optometric	35.25	36.29	18.86	23.61
Clinic	14.86	NA	NA	19.83
Drugs	14.38	5.14	7.00	5.97
Other	19.78	51.73	48.80	26.14
Total	$ 66.46	$ 40.10	$ 31.27	$ 40.08

Source: Special State Reports

C. NUMBER OF MEDICAID CLAIMS PROCESSED - IOWA

	FY 75	FY 76	Increase	Percent
Inpatient	34,833	41,500	6,667	19.1 %
Outpatient	91,044	117,518	26,474	29.1
Lab and X-Ray	6,189	8,023	1,834	29.6
Physician	413,605	491,445	77,840	18.8
Long-term Care	187,723	227,826	40,103	21.4
Dental	66,858	86,598	19,740	29.5
Optometric	28,222	35,649	7,427	26.3
Clinic	3,156	6,449	3,293	104.3
Drugs	494,657	608,530	113,873	23.0
Other	67,442	102,007	34,565	51.3
Total	1,393,729	1,725,545	331,816	23.8 %

Source: July 28, 1976, Special Report from State

D. AVERAGE BENEFIT PER CLAIM - IOWA

	FY 75	FY 76	Increase	Percent
Inpatient	$ 434.22	$ 530.33	$ 96.11	22.1 %
Outpatient	24.49	27.99	3.50	10.1
Lab and X-Ray	7.26	8.06	.80	11.0
Physician	22.09	24.14	2.05	9.3
Long-term care	228.95	265.65	36.70	16.0
Dental	51.54	55.44	3.90	7.6
Optometric	33.89	35.25	1.36	4.0
Clinic	12.71	14.86	2.15	16.9
Drugs	13.69	14.38	.69	5.0
Other	19.69	19.78	.09	0.5
Total	$ 58.86	$ 66.46	$ 7.60	12.9 %

Source: July 28, 1976, Special Report form State

E. NUMBER OF MEDICAID CLAIMS PROCESSED - KANSAS

	FY 75	FY 76	Increase	Percent
Inpatient	50,852	56,081	5,229	10.3%
Outpatient	109,751	134,888	25,137	22.9
Lab and X-Ray	NA	NA	NA	NA
Physician	535,098	626,771	91,673	17.1
Long-term Care	122,641	128,044	5,403	4.4
Dental	83,748	99,443	15,695	18.7
Optometric	32,734	38,024	5,290	16.2
Clinic	NA	NA	NA	NA
Drugs	1,850,890	2,000,274	149,384	8.1
Other	11,890	14,322	2,432	20.5
Total	2,797,604	3,097,847	300,243	10.7%

Source: August 13, 1976, Special Report from the State.

F. AVERAGE BENEFIT PER CLAIM - KANSAS

	FY 75	FY 76	Increase	Percent
Inpatient	$ 568.51	$ 641.98	$ 73.47	12.9 %
Outpatient	27.63	30.56	2.93	10.6
Lab and X-Ray	NA	NA	NA	NA
Physician	25.80	28.50	2.70	10.5
Long-term Care	268.16	302.27	34.11	12.7
Dental	40.57	46.74	6.17	15.2
Optometric	33.03	36.29	3.26	9.9
Clinic	NA	NA	NA	NA
Drugs	4.60	5.14	.54	11.7
Other	45.32	51.73	6.41	14.1
Total	$ 35.86	$ 40.10	$ 4.24	11.8 %

Source: August 13, 1976, Special Report from the State.

G. NUMBER OF MEDICAID CLAIMS PROCESSED - MISSOURI

	FY 75	FY 76	Increase	Percent
Inpatient	110,590	104,932	(5,658)	(5.1) %
Outpatient	321,469	370,472	49,003	15.2
Lab and X-Ray	NA	NA	NA	NA
Physician	1,121,833	964,654	(157,179)	(14.0)
Long-term Care	67,528	97,498	29,970	44.4
Dental	122,265	110,930	(11,335)	9.3
Optometric	15,347	27,778	12,431	81.0
Clinic	NA	NA	NA	NA
Drugs	2,162,278	2,284,799	122,521	5.7
Other	31,988	52,958	20,970	65.6
Total	3,953,298	4,014,021	60,723	1.5 %

Source: August 13, 1976, Special Report from the State.

H. AVERAGE BENEFIT PER CLAIM - MISSOURI

	FY 75	FY 76	Increase	Percent
Inpatient	$ 365.99	$ 438.85	$ 72.86	19.9 %
Outpatient	12.97	12.59	(.38)	2.9
Lab and X-Ray	NA	NA	NA	NA
Physician	14.88	19.31	4.43	29.8
Long-term Care	302.24	335.20	32.96	10.9
Dental	24.99	39.73	14.74	59.0
Optometric	17.55	18.86	1.31	7.5
Clinic	NA	NA	NA	NA
Drugs	5.98	7.00	1.02	17.1
Other	52.53	48.80	(3.73)	(7.1)
Total	$ 25.21	$ 31.27	$ 6.06	24.0 %

Source: August 13, 1976, Special Report from the State.

I. NUMBER OF MEDICAID CLAIMS PROCESSED - NEBRASKA

	FY 75	FY 76	Increase	Percent
Inpatient	16,751	15,905	(846)	(5.1) %
Outpatient	50,696	53,007	2,311	4.6
Lab and X-Ray	60,328	44,336	(15,992)	(26.5)
Physician	164,352	174,272	9,920	6.0
Long-term Care	109,589	101,981	(7,608)	(6.9)
Dental	20,703	22,512	1,809	8.7
Optometric	14,909	15,322	413	2.8
Clinic	2,885	23,856	20,971	726.9
Drugs	848,596	920,231	71,635	8.4
Other	32,696	37,740	5,044	15.4
Total	1,321,505	1,409,162	87,657	6.6 %

Source: August 5, 1976, Special Report from State.

J. AVERAGE BENEFIT PER CLAIM - NEBRASKA

	FY 75	FY 76	Increase	Percent
Inpatient	$ 537.72	$ 621.48	$ 83.76	15.6 %
Outpatient	24.08	28.61	4.53	18.8
Lab and X-Ray	14.45	14.80	.35	2.4
Physician	23.00	23.56	.56	2.4
Long-term Care	279.57	308.90	29.33	10.5
Dental	70.40	66.26	(4.14)	(5.9)
Optometric	21.33	23.61	2.28	10.7
Clinic	12.60	19.83	7.23	57.4
Drugs	3.20	5.97	2.77	86.6
Other	26.50	26.14	(.36)	(1.4)
Total	$ 38.53	$ 40.08	$ 1.55	4.0 %

Source: August 5, 1976, Special Report from State.

VI. SUSPECTED FRAUD ACTIVITY

A. TITLE XIX SUSPECTED FRAUD ACTIVITIES BY STATE

The number of administrative and legal actions on allegations of suspected Title XIX fraud, to include new cases, completed cases, and cases referred to law officials.

B. TITLE XIX SUSPECTED FRAUD ACTIVITIES - REGION VII

A breakdown of the information referred to in A above by calendar quarter.

C. TITLE XIX SUSPECTED FRAUD ACTIVITIES - IOWA

Refer to B above.

D. TITLE XIX SUSPECTED FRAUD ACTIVITIES - KANSAS

Refer to B above.

E. TITLE XIX SUSPECTED FRAUD ACTIVITIES - MISSOURI

Refer to B above.

F. TITLE XIX SUSPECTED FRAUD ACTIVITIES - NEBRASKA

Refer to B above.

A. TITLE XIX SUSPECTED FRAUD ACTIVITIES BY STATE

	Iowa	Kansas	Missouri	Nebraska	Total
New Cases Added	39	62	46	5	152
Cases Completed	33	54	6	5	98
Referred to Officials	1	0	3	5	9
Not Referred	32	54	3	0	89

Source: SRS-NCSS-119.1

B. TITLE XIX SUSPECTED FRAUD ACTIVITIES - REGION VII

	July-Sept.	Oct.-Dec.	Jan.-March	Apr.-June	Total
New Cases Added	25	51	43	33	152
Cases Completed	24	19	33	22	98
Referred to Officials	1	4	1	3	9
Not Referred	23	15	32	19	89

Source: SRS-NCSS-119.1

C. TITLE XIX SUSPECTED FRAUD ACTIVITIES - IOWA

	July-Sept.	Oct.-Dec.	Jan.-March	Apr.-June	Total
New Cases Added	15	9	9	6	39
Cases Completed	11	11	10	1	33
Referred to Officials	0	1	0	0	1
Not Referred	11	10	10	1	32

Source: SRS-NCSS-119.1

D. TITLE XIX SUSPECTED FRAUD ACTIVITIES - KANSAS

	July-Sept.	Oct.-Dec.	Jan.-March	Apr.-June	Total
New Cases Added	10	8	23	21	62
Cases Completed	11	5	20	18	54
Referred to Officials	0	0	0	0	0
Not Referred	11	5	20	18	54

Source: SRS-NCSS-119.1

E. TITLE XIX SUSPECTED FRAUD ACTIVITIES - MISSOURI

	July-Sept.	Oct.-Dec.	Jan.-March	Apr.-June	Total
New Cases Added	0	31	10	5	46
Cases Completed	2	0	2	2	6
Referred to Officials	1	0	0	2	3
Not Referred	1	0	2	0	3

Source: SRS-NCSS-119.1

F. TITLE XIX SUSPECTED FRAUD ACTIVITIES - NEBRASKA

	July-Sept.	Oct.-Dec.	Jan.-March	Apr.-June	Total
New Cases Added	0	3	1	1	5
Cases Completed	0	3	1	1	5
Referred to Officials	0	3	1	1	5
Not Referred	0	0	0	0	0

Source: SRS-NCSS-119.1

VII. CHARTS

A. TITLE XIX PAYMENTS BY VENDOR CATEGORY

Pie graph breakdown of Title XIX benefit payments into five vendor categories: (1) inpatient hospital services, (2) intermediate care facility services, (3) physician services, (4) drug costs, (5) skilled nursing facility services, and (6) all other covered services (dental, outpatient, clinic, home health, family planning, laboratory, and radiological). Data source was the SRS-NCSS-120.

B. TITLE XIX PAYMENTS BY ELIGIBILITY CATEGORY

Pie graph breakdown of Title XIX benefit payments into five eligibility categories of recipients. Data source was the SRS-NCSS-120.

C. TITLE XIX BENEFITS PAID BY QUARTER

Bar graph comparison of quarterly benefit payments. Data source was the OA-41.

D. TITLE XIX RECIPIENTS BY ELIGIBILITY CATEGORY

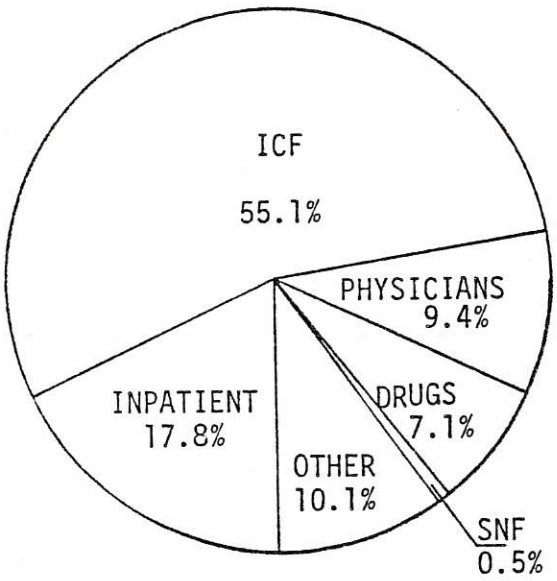
Pie graph breakdown of those persons who actually received one or more services under the Title XIX Program into five eligibility categories. Data source was the SRS-NCSS-120.

E. TITLE XIX ADMINISTRATIVE COSTS BY QUARTER

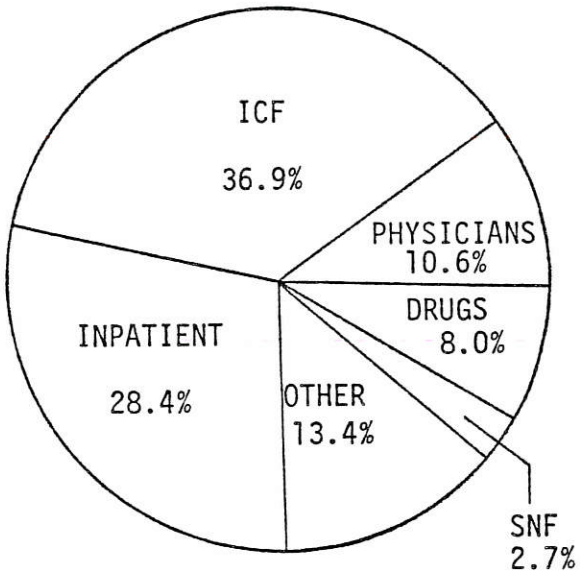
Bar graph comparison of Title XIX administrative costs (excluding training costs) by quarter as reported by the States. Data source was the OA-41.

F. BENEFIT PAYMENTS PER CAPITA

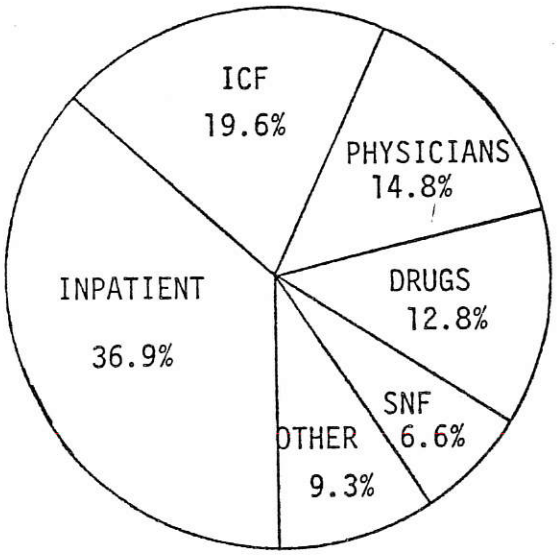
Bar graph comparison of Title XIX benefit payments divided by the State population as of July 1, 1973. Data sources were the SRS-NCSS-120 for benefit payments and the 1974 Statistical Abstract of the United States for population. More recent population data was not available at the time this report was prepared.



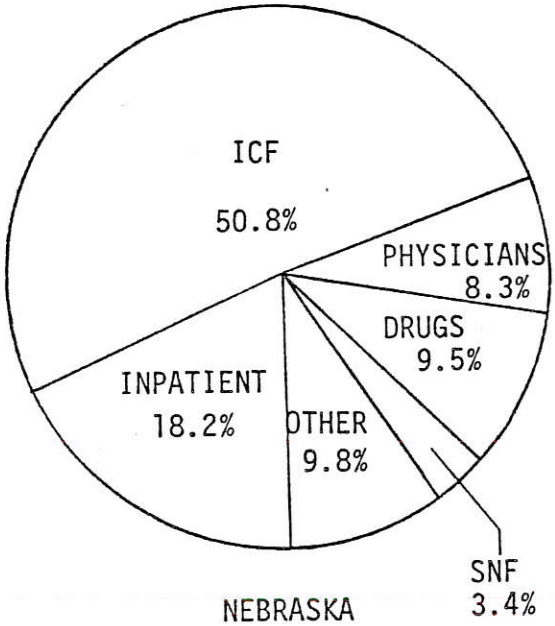
IOWA



KANSAS



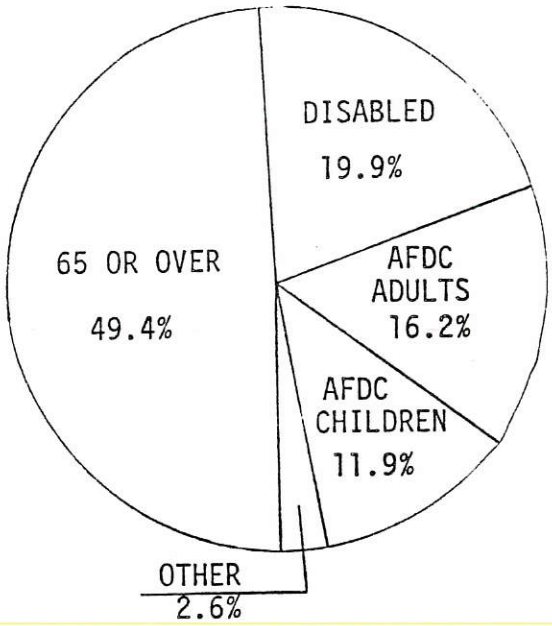
MISSOURI



NEBRASKA

A. TITLE XIX PAYMENTS BY VENDOR CATEGORY

FISCAL YEAR 1976



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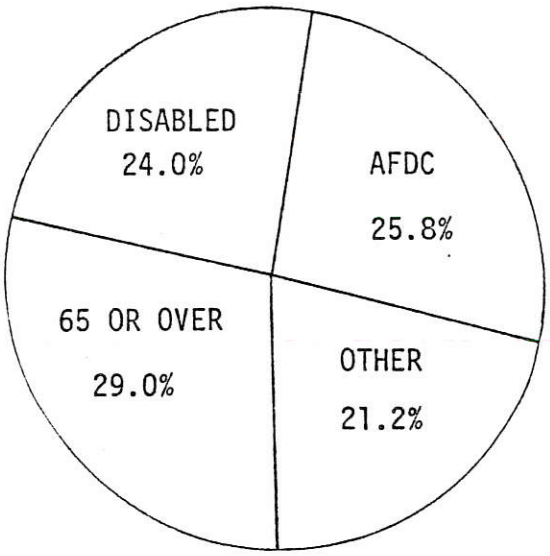
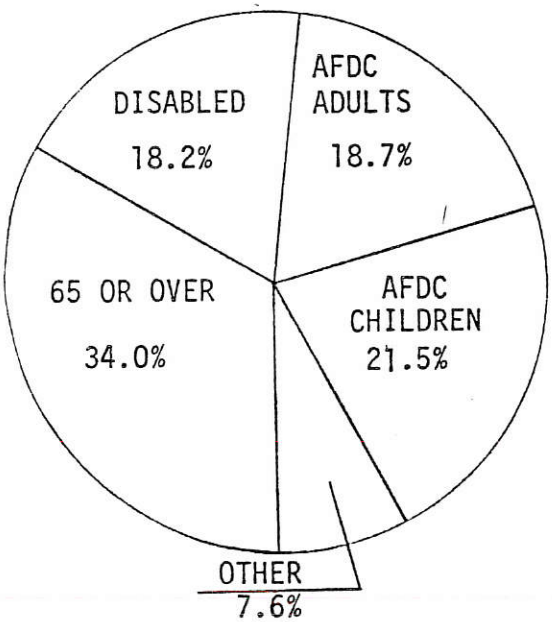
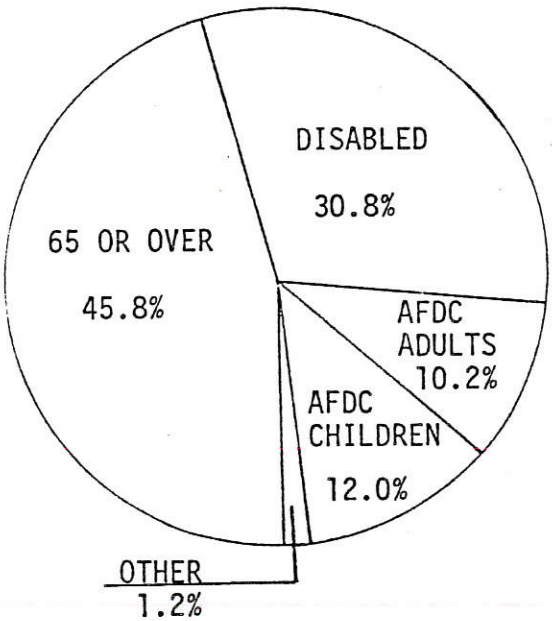


KANSAS



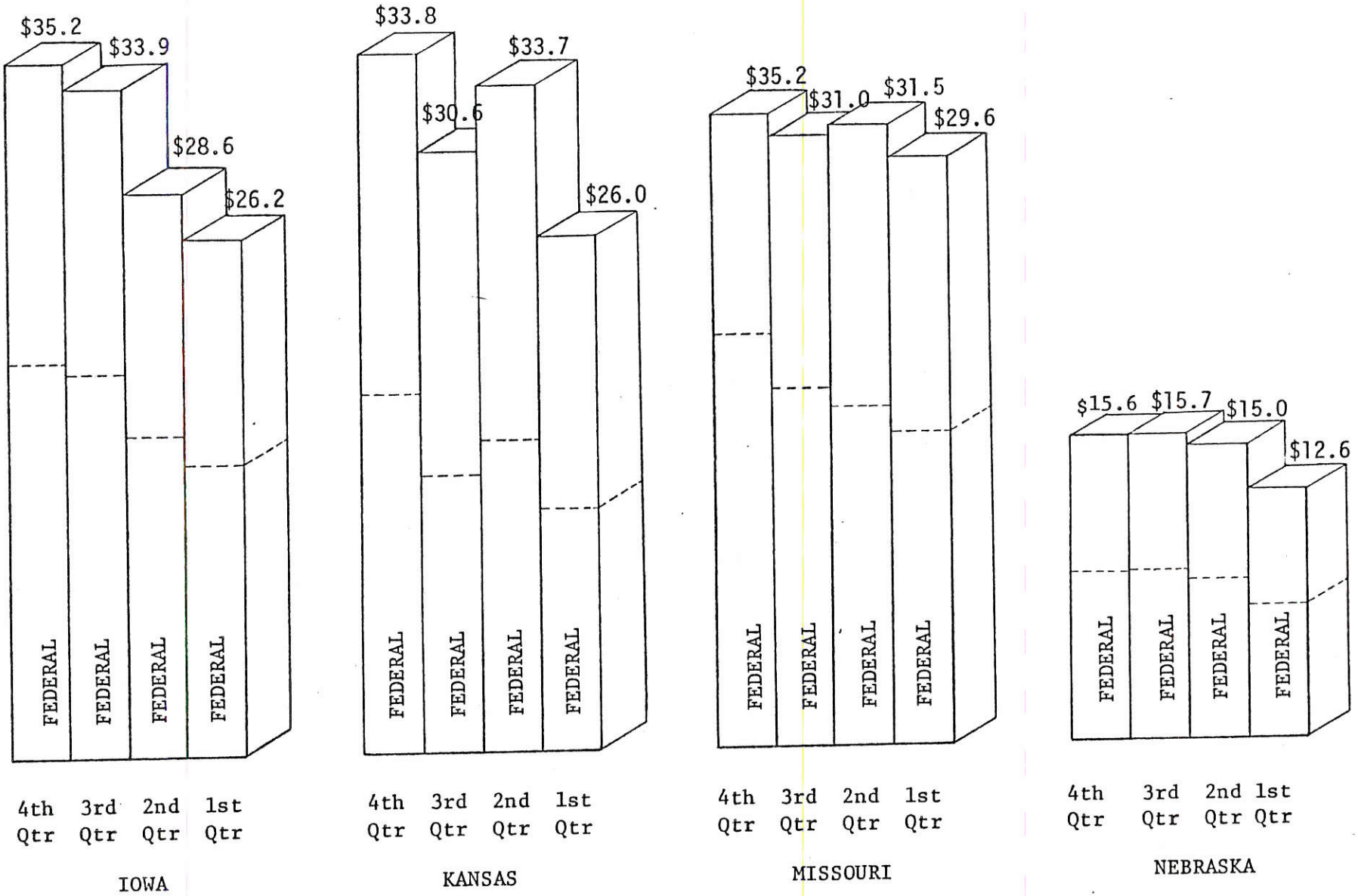
MISSOURI



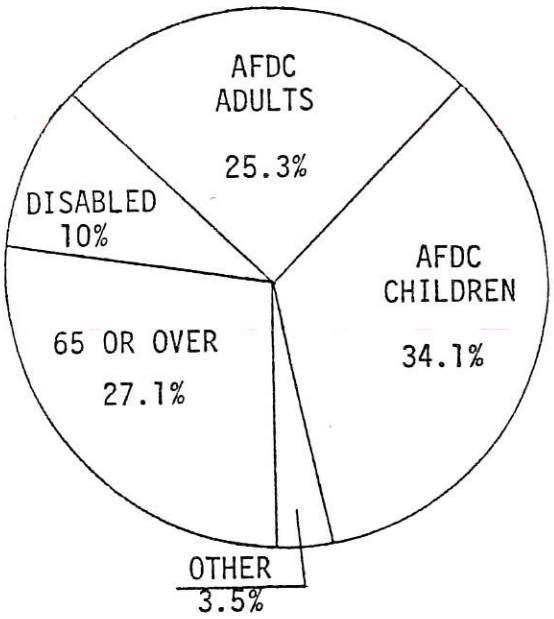
NEBRASKA

B. TITLE XIX PAYMENTS BY ELIGIBILITY CATEGORY

FISCAL YEAR 1976



C. TITLE XIX BENEFITS PAID BY QUARTER
FISCAL YEAR 1976
(In millions)



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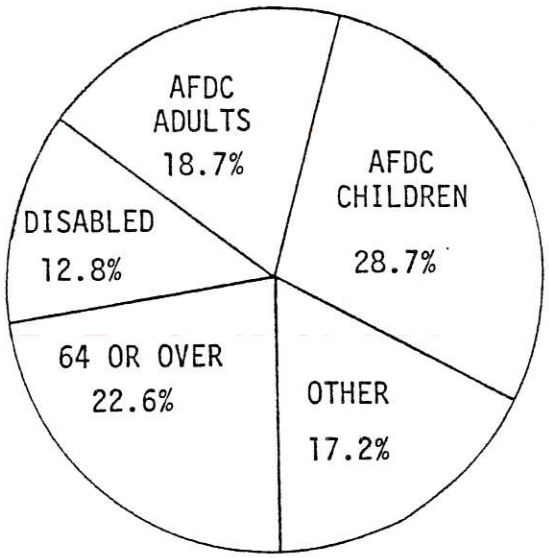
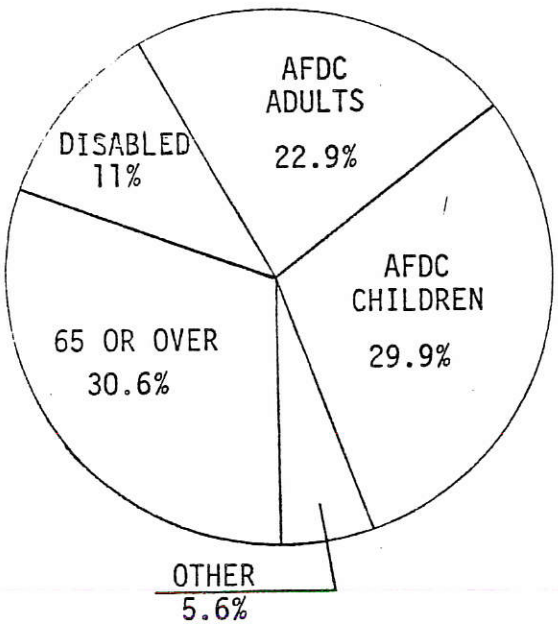
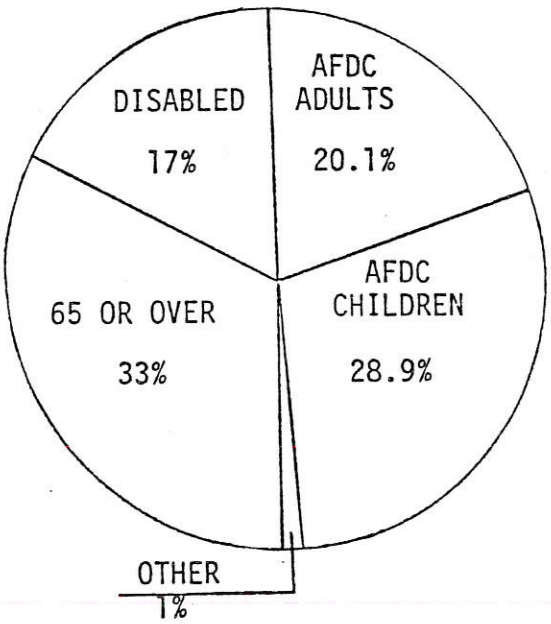


KANSAS



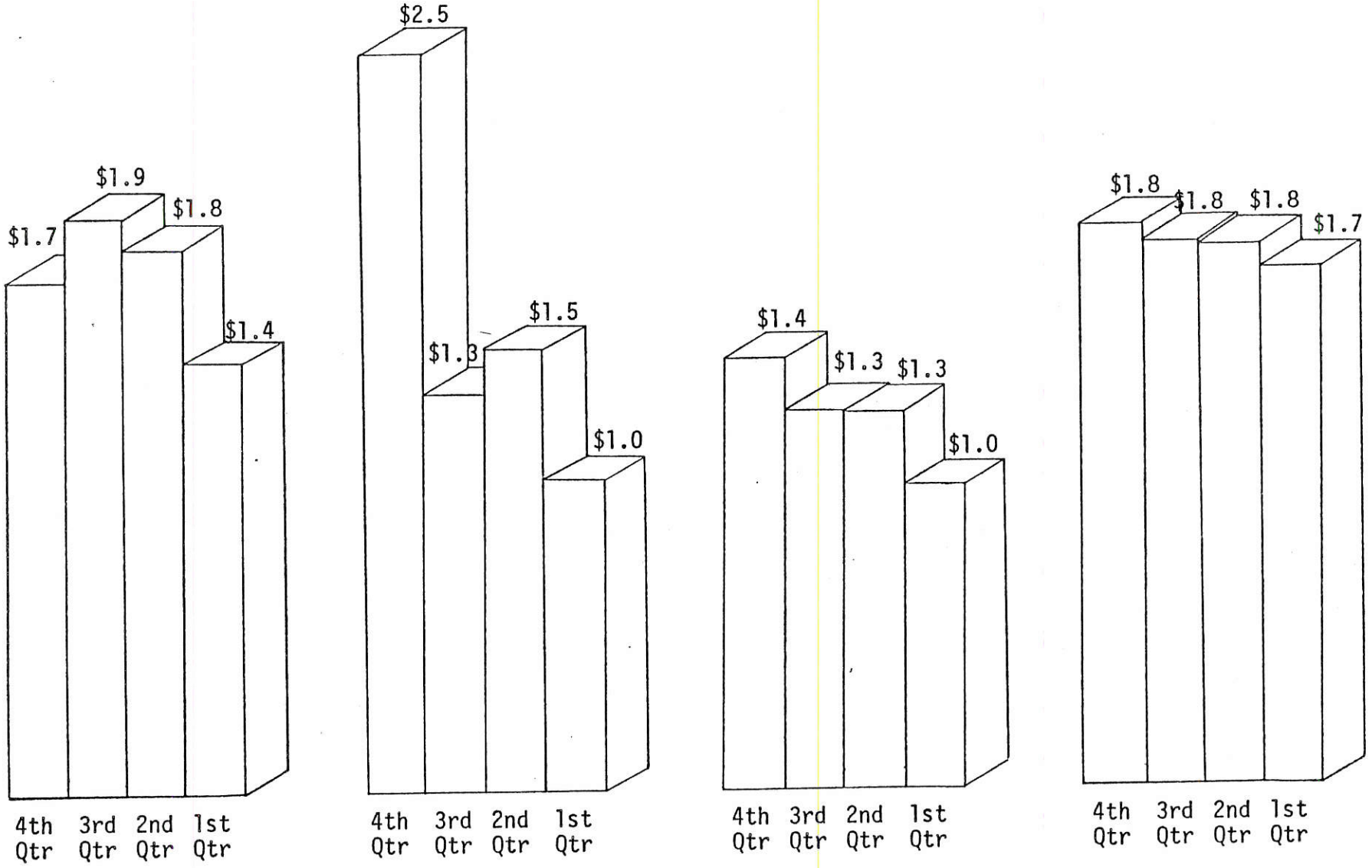
MISSOURI



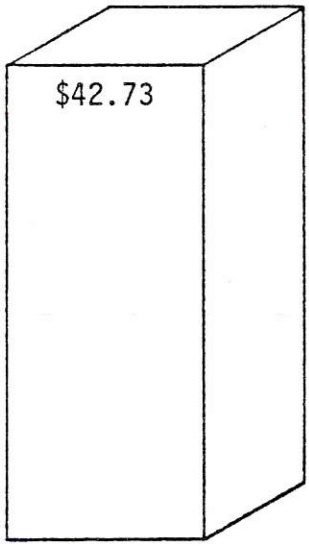
NEBRASKA

D. TITLE XIX RECIPIENTS BY ELIGIBILITY CATEGORY

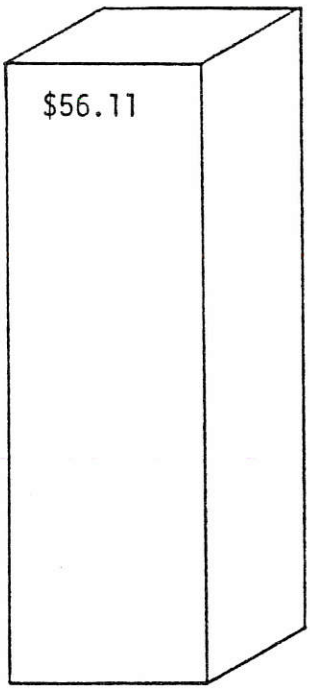
FISCAL YEAR 1976



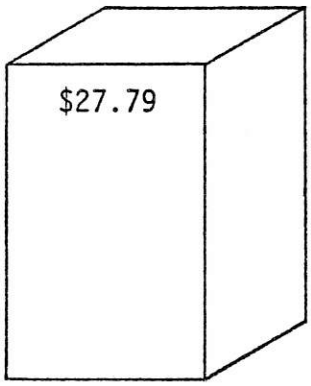
E. TITLE XIX ADMINISTRATIVE COSTS BY QUARTER
FISCAL YEAR 1976
(In millions)



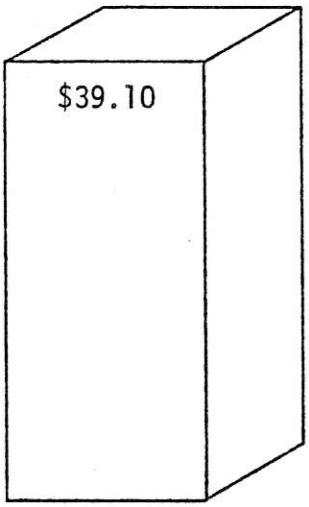
IOWA



KANSAS



MISSOURI



NEBRASKA

F. BENEFIT PAYMENTS PER CAPITA

(Based on July 1, 1973, State Population)

EDUCATION, AND WELFARE
Washington, D.C. 20201

Offi siness

Postage and Fees Paid
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HEW-392

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Social and Rehabilitation Service
Medical Services Administration

(SRS) 75-24001
Revised January 1975

TITLE XIX

Grants to States for Medical Assistance Programs

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS[1] AND RELATED PROVISIONS OF P.L. 92–603, P.L. 93–66, and P.L. 93–233

Appropriation

Sec. 1901.[2] For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals,[3] whose income and re-

[1] This title is administered by the Social and Rehabilitation Services Administration, Department of Health, Education, and Welfare. Regulations of the Secretary of Health, Education, and Welfare relating to this title are contained in chapter II, title 45, Code of Federal Regulations.

See footnote to sec. 1 of title I for provisions of the Civil Rights Act of 1964 affecting federally assisted programs.

P.L. 90–248, sec. 234(c), provides:

"(c) Notwithstanding any other provisions of law, after June 30, 1968, no Federal funds shall be paid to any State as Federal matching under title I, X, XIV, XVI, or XIX of the Social Security Act for payments made to any nursing home for or on account of any nursing home services provided by such nursing home for any period during which such nursing home is determined not to meet fully all requirements of the State for licensure as a nursing home, except that the Secretary may prescribe a reasonable period or periods of time during which a nursing home which has formerly met such requirements will be eligible for payments which include Federal participation if during such period or periods such home promptly takes all necessary steps to again meet such requirements."

P.L. 92–603, sec. 402, provides:

"In order for a State to be eligible for any payments pursuant to title IV, V, XVI, or XIX of the Social Security Act with respect to expenditures for any quarter in the fiscal year ending June 30, 1975, and for the purpose of providing an orderly transition from State to Federal administration of the Supplemental Security Income Program, such State shall enter into an agreement with the Secretary of Health, Education, and Welfare under which the State agencies responsible for administering or for supervising the administration of the plans approved under titles I, X, XIV, and XVI of the Social Security Act will, on behalf of the Secretary, administer all or such part or parts of the program established by section 301 of this Act, during such portion of the fiscal year ending June 30, 1975, as may be provided in such agreement."

[2] P.L. 93–233, section 13(d) made changes in section 1901 and 1902 effective with respect to payments under Section 1903 of the Act for calendar quarters commencing after December 31, 1973.

[3] P.L. 93–233, section 13(a)(1) struck "permanently and totally" which preceded "disabled" in the first sentence of section 1901 to reflect establishment of the Supplemental Security Income Program and conformance with the title XVI definition of disability.

ices, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

State Plans for Medical Assistance

Sec. 1902.[1] (a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 percentum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the plan approved under title I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI, or by the agency or agencies administering the Supplemental Security Income Program established under title XVI or the State plan approved under part A of title IV if the State is not eligible to participate in the State plan program established under title XVI;[1]

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportu-

[1] P.L. 93–233, section 13(d) made changes in sections 1901 and 1902 effective with respect to payments under section 1903 of the Act for calendar quarters commencing after December 31, 1973.

[1] P.L. 93–233, section 13(a)(2)(B) amended 1902(a)(5) to take account of the Supplemental Security Income Program. Under the old public assistance titles of the Act, Medicaid eligibility determinations had to be made by the same agency administering the State's cash assistance program for the aged. Since the State plan programs now exist only in Guam, Puerto Rico and the Virgin Islands, all States—pursuant an amendment by P.L. 93–233, section 13(a)(2)(A)—have flexibility in designating an appropriate agency or agencies to make eligibility determinations.

reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purposes specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions;[1]

(10) provide—[2]

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI;[3]

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause (A); and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the Supplemental Security Income Program under title XVI, as the case may

[1] P.L. 92-603, section 239(a) revised section 1902(a)(9) in its entirety. Effective January 1, 1973 (or earlier if the State plan so provides). Previously, section 1902 (a) (9) read: "(9) provide for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services;".

[2] P.L. 93-233, Section 13 made the necessary technical changes in 1902(a)(10) to take account of the Supplemental Security Income Program under which receipt of Medicaid is no longer dependent upon receipt of cash assistance.

[3] States which do not elect to return to their 1972 medical assistance eligibility standards are required to provide Medicaid coverage to individuals receiving Federal Supplemental Security Income benefits.

scribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them Supplemental Security Income benefits under title XVI, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State

paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);[2]

(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan; and (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments for part or all of the cost of plans or projects under title V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under title V and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made

[1] States have the option to provide coverage for categories of individuals receiving or eligible to receive State supplementary payments.

[2] P.L. 92-603, as amended by P.L. 93-66, provides persons eligible for receiving cash under the public assistance titles of the Social Security Act for the month of August 1972 are grandfathered into continued Medicaid coverage to July 1975 if they are terminated from cash assistance as a result of the 20 percent Social Security benefit increase provided by P.L. 92-336. See Section 249E (as amended by Section 233 of P.L. 93-66) of P.L. 92-603 in addendum.

P.L. 93-233 requires States to continue Medicaid eligibility for individuals receiving mandatory State supplementary payments. See Section 13(c) of P.L. 93-233 in addendum.

P.L. 93-66 provides that any individual eligible for medical assistance in December 1973 as an essential person continues to be eligible as long as the individual with whom such person is living continues to meet the criteria in effect for December 1973 for aid or assistance under a State plan and the essential spouse relationship is maintained according to the December 1973 State plan. See Section 230 of P.L. 93-66 in addendum.

P.L. 93-66, as amended by P.L. 93-233, provides for continued Medicaid eligibility for those blind and disabled persons who were in December 1973 eligible for medical assistance on the basis of their blindness or disability but who do not meet the new title XVI definitions of blindness or disability provided they meet the other eligibility conditions of the current plan. See Section 232 of P.L. 93-66 in addendum.

P.L. 93-66, as amended by P.L. 93-233, provides that individuals in medical institutions in December 1973 who would have been eligible for assistance under a State plan approved under title I, X, XIV, or XVI, except for the fact that they were inpatients (or whose special needs as inpatients make them eligible for assistance) will retain their Medicaid eligibility as long as there is a continuing need for care for the condition or conditions for which they were institutionalized and continuing eligibility for financial assistance under the approved State plan under title I, X, XIV or XVI in effect in December 1973. See Section 231 of P.L. 93-66 in addendum.

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) (i) for the inclusion of some institutional and some non-institutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing home services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and[1]

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1905(a) or

(ii) (I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home, and

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122,[2] which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of

[1] P.L. 93-233, section 13(a)(4) made the necessary technical change in 1902(a)(13)(B) to take account of the Supplemental Security Income Program.

[2] P.L. 92-603, section 221(c)(5), inserted ", consistent with section 1122,". Effective October 30, 1972.

standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII;[1] and

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost-related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary;[2]

(14) effective January 1, 1973, provide that—

(A) in case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI, or who meet the income and resources requirements of the appropriate State plan, or the Supplemental Security Income Program under title XVI, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10) (A)—[3]

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in clauses (1) through (5) and (7) of section 1905(a), will be imposed under the plan, and

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount

[1] P.L. 92-603, section 232(a), revised section 1902(a) (13) (D) in its entirety. Effective July 1, 1972, or earlier if the State plan so provides. Previously, section 1902(a) (13)(D) read: "(D) for payment of the reasonable cost (as determined in accordance with standards, approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan:".

[2] P.L. 92-603, section 249(a), added section 1902(a) (13) (E).

[3] P.L. 93-233, section 13(a) (5) made the necessary technical change in 1902(a) (14) (A) to take account of the Supplemental Security Income Program.

proved by the Secretary and included in the plan), and

(B) with respect to individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10) (A)) who are not receiving aid or assistance under any such State plan and with respect to whom Supplemental Security Income benefits are not being paid under title XVI and who do not meet the income and resources requirements of the appropriate State plan, or the Supplemental Security Income Program under title XVI, as the case may be,[1]

(i)[2] there may be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and

(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal;[3]

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by title XVIII, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such title is not met, the portion thereof which is met shall be determined on a basis reasonably

[1] P.L. 93-233, section 13(a) (6) made technical changes in 1902(a) (14) (B) to take account of the Supplemental Security Income Program. States retain their option to cover the medically needy in their medical assistance programs.

[2] P.L. 93-368 changed this from "shall" to "may" thus making such fees and charges optional with State Agencies.

[3] P.L. 92-603, section 208(a), amended section 1902(a) (14) in its entirety. Effective January 1, 1973 or earlier if the State plan so provides. Previously, section 1902(a) (14) read: "(14) provides that (A) in the case of individuals receiving aid or assistance under State plans approved under titles I, X, XIV, XVI, and part A of title IV, no deduction, cost sharing, or similar charge will be imposed under the plan on the individual with respect to inpatient hospital services furnished him under the plan, and (B) any deduction, cost sharing, or similar charge imposed under the plan with respect to inpatient hospital services or any other medical assistance furnished to an individual thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, shall be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or his income and resources;".

proved by the Secretary and included in the plan) to such individual's income or his income and resources;

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom Supplemental Security Income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient, and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under a State plan approved under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him Supplemental Security Income benefits under title XVI as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program);

ards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;[1]

(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program) of any medical assistance correctly paid on behalf of such individual under the plan;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate

[1] P.L. 93-233, section 13(a)(7) amended 1902(a)(17) to take account of the Supplemental Security Income Program.

patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution;

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in 3(a) (4) (A) (i) and (ii), or section 603(a)(1)(A)(i) and (ii), or section 1603 (a)(4)(A)(i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for

erative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality; and

(23) provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization;[1]

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this Act, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this Act, and (C) to provide information needed to determine payments due under this Act on account of care and services furnished to individuals;

[1] P.L. 92-603, Section 240, added "and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization;". Paragraph (23) of section 1902(a), pursuant to P.L. 90-248, sec. 227(b), as amended by P.L. 92-603, section 271(a) effective from and after July 1, 1972, applies in the case of Puerto Rico, the Virgin Islands, and Guam only with respect to calendar quarters beginning after June 30, 1975.

tering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(26) effective July 1, 1969, provide (A) for a regular program of medical review (including medical evaluation) of each patient's need for skilled nursing facility care or (in the case of individuals who are eligible therefor under the State plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing facility; (B) for periodic inspections to be made in all skilled nursing facilities and mental institutions (if the State plan includes care in such institutions) within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) or (i) the care being provided in such nursing facilities (and mental institutions, if care therein is provided under the State plan) to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing facilities (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities (or institutions), (iii) the necessity and desirability of the continued placement of such patients in such nursing facilities (or institutions), and (iv) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections together with any recommendations to the State agency administering or supervising the administration of the State plan;

tution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency with such information, regarding any payments claimed by such persons or institution for providing services under the State plan, as the State agency may from time to time request;

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1861(j), except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this title;[1]

(29) include a State program which meets the requirements set forth in section 1908, for the licensing of administrators of nursing homes;

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4))[2] as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

(31) provide (A) for a regular program of independent professional review (including medical evaluation of each patient's need for intermediate care) and a written plan of service prior to admission or authorization of benefits in an intermediate care facility[3] as determined under regulations of the Secretary; (B) for periodic on-site inspections to be made in all such intermediate care facilities (if the State plan includes care in such institutions) within the State by one or more independent professional review teams (com-

[1] P.L. 92-603, section 246(a), revised section 1902(a)(28) in its entirety. Effective July 1, 1973.
[2] P.L. 92-603, section 237(a)(2), inserted "(including but not limited to utilization review plans as provided for in section 1903(i)(4))". Effective July 1, 1973.
[3] P.L. 92-603, section 298, deleted "which provides more than a minimum level of health care services".

ate health and social service personnel) of (i) the care being provided in such intermediate care facilities to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular intermediate care facilities to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities, (iii) the necessity and desirability of the continued placement of such patients in such facilities, and (iv) the feasibility of meeting their health care needs through alternative institutional or non-institutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections, together with any recommendations to the State agency administering or supervising the administration of the State plan;[1]

(32) provide that no payment under the plan for any care or service provided to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner, except that payment may be made (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;[2]

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of

[1] P.L. 92-223, section 4(b), added section 1902(a)(31), effective January 1, 1972.
[2] P.L. 92-603, section 236(b), added section 1902(a)(32). Effective January 1, 1973, or earlier if the State plan so provides.

pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan;[1]

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such asistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application[2] (or application was made on his behalf in the case of a deceased individual[3]) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) effective January 1, 1973, provide that any intermediate care facility receiving payments under such plan must supply to the licensing agency of the State full and complete information as to the identity (A) of each person having (directly or indirectly) an ownership interest of 10 per centum or more in such intermediate care facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such intermediate care facility or any of the property or assets of such intermediate care facility,[4] (B) in case an intermediate care facility is organized as a corporation, of each officer and director of the corporation, and (C) in case an intermediate

[1] P.L. 92-603, section 239(b), added section 1902(a)(33). Effective January 1, 1973, or earlier if the State plan so provides.
[2] P.L. 92-603, section 255(a), added section 1902(a)(34). Effective July 1, 1973.
[3] P.L. 93-233, section 18(o), added parenthetical provision, effective July 1, 1973, pursuant to section 18(Z)(4) of P.L. 93-233.
[4] P.L. 93-233, section 18(p) expanded 1902(a)(35) to include persons who own obligations secured by the assets of an institution.

care facility is organized as a partnership, of each partner, and promptly report any changes which would affect the current accuracy of the information so required to be supplied;[1] and

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization.[2]

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)).

For purposes of paragraph (9)(A), (29), (31), and (33), and of section 1903(i)(4), the term "skilled nursing facility" and "nursing home" do not include a Christian Science sanatorium

[1] P.L. 92-603, section 299A, added section 1902(a)(35).
[2] P.L. 92-603, section 299D(b), added section 1902(a)(36).

Scientist, Boston, Massachusetts.[1]

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes as a condition for eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 406(a)(2), be a dependent child under part A of subchapter IV of this chapter; or

(3) any residence requirement which excludes any individual who resides in the State; or

(4) any citizenship requirement which excludes any citizen of the United States.

(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this title, attributable to medical needs)[2] provided for eligible individuals under a plan of such State approved under title I, X, XIV, or XVI, or part A of title IV.

(d) (Repealed).[3]

(e) Notwithstanding any other provision of this title, effective January 1, 1974, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calen-

[1] P.L. 92-603, section 268(a), added the last sentence of section 1902(a). Effective as of October 30, 1972.
[2] P.L. 91-56, sec. 2(c), enacted August 9, 1969, inserted "in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this title, attributable to medical needs)" in lieu of "(other than so much of the aid or assistance as is provided for under the plan of the State approved under this title)".
[3] P.L. 92-603, sec. 231, repealed sec. 1902(d).

ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.[1]

(f) Notwithstanding any other provision of this title, except as provided in subsection (e), no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any Supplemental Security Income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom Supplemental Security Income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10)(C) of that subsection, an individual who is eligible for medical assistance

[1] P.L. 92-603, section 209(a), added section 1902(e). P.L. 93-233, section 18(q) modified the extension of Medicaid eligibility for certain AFDC recipients.

tion of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection.[1]

Payment to States

Sec. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter beginning with the quarter commencing January 1, 1966

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (h) of this section)[2] of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof);[3] plus

[1] P.L. 92-603, section 209(b)(1), added section 1902(f). Effective January 1, 1974. P.L. 93-233, section 13(a)(10) amended 1902(f) to take account of the new Supplemental Security Income Program; section 13(a)(10)(C) substituted "as defined in section 213 of the Internal Revenue Code of 1954" with "as recognized under State law;" section 13(a)(10)(D) modified the language of 1902(f) to clarify that States have the option to return to their January 1, 1972 medical assistance standard for purposes of determining Medicaid eligibility and that persons who enter the program through the spend-down are considered categorically needy in States which do not have medically needy programs.

[2] P.L. 92-603, section 207(a)(2), inserted ", subject to subsections (g) and (h) of this section". Effective July 1, 1973.

[3] P.L. 93-233, section 13(a)(11) amended section 1903(a)(1) to take account of the Supplemental Security Income Program; section 18(r)(1) amended 1903(a)(1) to limit Federal payments for expenditures related to the disabled eligible under title XVIII.

sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency; plus

(3) an amount equal to—

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed $150,000), and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operations of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan of the specific services so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments

made under the plan on account of the services; plus[1]

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this Act; plus[2]

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies,[3]

(6) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b)(1)[4] Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969,[5] shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).[6]

(2) For limitation on Federal participation for capital ex-

[1] P.L. 92-603, section 235(a), added section 1903(a)(3). Applicable to expenditures under State plans approved under title XIX made after June 30, 1971.

[2] P.L. 92-603, section 249B, added section 1903(a)(4). Effective for the period beginning October 1, 1972, and ending June 30, 1974. P.L. 93-233, section 18(s) amended 1903(a)(4) to clarify that 100 percent Federal matching is for costs incurred rather than sums expended between October 1, 1972 and June 30, 1974. This was further extended to June 30, 1977 by P.L. 93-368.

[3] P.L. 92-603, section 299E(a), added section 1903(a)(5). P.L. 93-233, section (18)(t) amended 1903(b)(5) to clarify that Federal payment for family planning expenditures is not limited to administrative costs.

[4] P.L. 92-603, section 295, repealed former section 1903(b)(1).

[5] P.L. 90-364, sec. 303(a)(1), enacted June 28, 1968, inserted "1969" in lieu of "1967".

[6] P.L. 93-233, section 18(r)(2) placed a limitation on payments to States for expenditures in relation to disabled individuals eligible for title XVIII. P.L. 93-233, section 18(z-3)(4) made the effective date of this provision July 1, 1973. P.L. 93-233, section 18(u) amended 1903(b)(2) to include an exception to the limitation on payments to States.

plan of a State or areawide planning agency, see section 1122.[1]

(c) (Repealed).[2]

(d) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(e) (Repealed).[3]

[1] P.L. 92-603, section 221(c)(6), added section 1903(b)(2).

[2] P.L. 93-233, sec. 18(y)(1)(A) repealed sec. 1903(c).

[3] P.L. 92-603, section 230, repealed section 1903(e). Former section 1903(e) read: "(e) The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by June 1, 1977, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care."

der the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133-1/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family for medical care or for any other type of remedial care recognized under State law.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan (without regard to section 408) provided for aid to such a family.

(4)[1] The limitations on payment imposed by the preceding pro-

[1] P.L. 93-233, section 13(a)(12) amended 1903(f) to take account of the Supplemental Security Income Program.

expended by a State as medical assistance for any individual—

(A) who is not receiving aid or assistance under any plan of the State approved under title I, X, XIV, XVI, or part A of title IV, or with respect to whom Supplemental Security Income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the Supplemental Security Income benefit rate established by section 1611(b)(1), at the time of the provision of the medical assistance giving rise to such expenditure.[1]

(g)(1) With respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876), the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year shall be decreased by 33-1/3 per centum thereof unless the State

[1] P.L. 93-233, section 13(a)(12) amended 1903(f)(4) to allow States the option of covering as categorically needy, institutionalized persons by deeming them in need of a supplementary payment, and therefore Medicaid, on the basis that they would need cash assistance if they were outside of the institution, if their income is within 300 percent of the Supplemental Security Income level.

showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services (including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—

(A) in each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days, and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

(B) in each such case, such services were furnished under a plan established and periodically reviewed and evaluated by a physician;

(C) such State has in effect a continuous program of review of utilization pursuant to section 1902(a)(30) whereby the necessity for admission and the continued stay of each patient in such institution is periodically reviewed and evaluated (with such frequency as may be prescribed in regulations of the Secretary) by medical and other professional personnel who are not themselves directly responsible for the care of the patient or financially interested in any such institution or, except in the case of hospitals, employed by the institution;[1] and

(D) such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to section 1902(a)(26) and (31) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams.

[1] P.L. 93-233, section 18(v) amended 1903(g)(1)(C) to exempt hospitals from the requirement that review of the utilization of institutional care be performed by individuals not employed by the institution involved.

ceived services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.[1]

(h)(1) If the Secretary determines for any calendar quarter beginning after June 30, 1973, with respect to any State that there does not exist a reasonable cost differential between the statewide average cost of skilled nursing facility services and the statewide average cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expenditures under the State plan by any amount which in his judgment is a reasonable equivalent of the difference between the amount of the expenditures by such State for intermediate care facility services and the amount that would have been expended by such State for such services if there had been a reasonable cost differential between the cost of skilled nursing facility services and the cost of intermediate care facility services.

(2) In determining whether any such cost differential in any State is reasonable the Secretary shall take into consideration the range of such cost differentials in all States.

(3) For the purposes of this subsection, the term "cost differential" for any State for any quarter means, as determined by the Secretary on the basis of the data for the most recent calendar quarter for which satisfactory data are available, the excess of—

(A) the average amount paid in such State (regardless of the source of payment) per inpatient day for skilled nursing facility services, over

(B) the average amount paid in such State (regardless of the source of payment) per inpatient day for intermediate care facility services.

(4) For purposes of this subsection, the term "cost" shall mean amounts reimbursable by the State under a State plan approved

[1] P.L. 92-603, section 207(a)(1), added section 1903(g). Effective July 1, 1973.

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1842(b)(3); or[2]

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2); or[3]

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or[4]

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility unless such hospital or skilled nursing home has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing facility has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this para-

[2] P.L. 92-603, section 224(c), added section 1903(i)(1).
[3] P.L. 92-603, section 229(c), added section 1903(i)(2).
[4] P.L. 92-603, section 233(c), added section 1903(i)(3). Applicable to services furnished by hospitals in accounting periods beginning after December 31, 1972.

it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).[1]

(j)[2](1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any institution during any period that an order for suspension of payment (as authorized by this subsection) is effective with respect to such institution.

(2) The Secretary may issue a suspension of payment order with respect to any institution if—

(A) such institution (i) does not (at the time such order is issued) have in effect an agreement with the Secretary which is entered into pursuant to section 1866; and (ii) did (prior to the time such order is issued) have in effect such an agreement; and

(B)(i) The Secretary has been unable to collect (or make satisfactory arrangement for the collection of) amounts due on account of overpayments made to such institution under title XVIII; or

(ii) the Secretary has been unable to obtain from such institution the data and information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII.

(3) Whenever the Secretary issues any order for suspension of payment under this subsection with respect to any institution, he shall submit a notice of such order to the single State agency (referred to in section 1902(a)(5) of each State which he has reason to believe does or may utilize the services of such institution in providing medical assistance under a plan approved under this title.

(4) Any order for suspension of payment issued with respect to any institution under this subsection shall become effective, in the case of any State plan approved under this title, on the 60th day after the date the State agency (referred to in section 1902(a)(5)) administering or supervising the administration of such plan re-

[1] P.L. 92-603, section 237(a)(1), added section 1903(i)(4).

[2] P.L. 92-603, section 225 added another section 1903(j) which limited the allowable increase in average per diem payments for skilled nursing facility and intermediate care facility services, and which was repealed by P.L. 93-66, Section 234(a). Effective for skilled nursing services and for intermediate care facility services furnished in calendar quarters which begin after December 31, 1972, as per P.L. 93-66, section 234(b).

Any such order shall cease to be effective at such time as the Secretary is satisfied that the institution is participating in substantial negotiations which seek to remedy the conditions which gave rise to his order of suspension of payments, or that the amounts (referred to in paragraph (2) are no longer due from such institution or that a satisfactory arrangement has been made for the payment by such institution of any such amounts. Upon the determination of the Secretary that any such order with respect to any such institution shall cease to be effective, he shall forthwith notify each State agency to which he has theretofore submitted notice under paragraph (3) with respect to such institution.

(5) Whenever any order which has been issued by the Secretary under the preceding provisions of this subsection with respect to an institution ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such institution shall be made to such State for the month in which such order ceases to be effective.[1]

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any health maintenance organization which meets the requirements of section 1876 for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.[2]

Operation of State Plans

Sec. 1904. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments

[1] P.L. 92-603, section 290, added a second section 1903(j).

[2] P.L. 92-603, section 226(e), added section 1903(k). Applicable to services provided on or after June 1, 1973.

will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

Definitions

Sec. 1905.[1] For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom Supplemental Security Income benefits are not being paid under title XVI, who are

(i) under the age of 21,[2]

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child, except for section 406(a)(2), is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

[1] P.L. 93-233, section 13(a)(13) amended 1905(a) to take account of the Supplemental Security Income Program.

[2] The 1965 Amendments to the Social Security Act broadened the Kerr-Mills program to make eligible for medical assistance, all needy children under 21 regardless of their categorical relatedness.

of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,[1] or

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) outpatient hospital services;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older; (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;[2]

(5) physicians' services furnished by a physician (as defined in section 1861(r)(1))[3], whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

[1] See Section 230 of P.L. 93-66 in addendum.

[2] P.L. 92-603, sec. 299E(b), added sec. 1905(a)(4)(C).

[3] P.L. 92-603, sec. 280, inserted "furnished by a physician (as defined in section 1861(r)(1))".

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;[1]

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;[2]

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h); and

(17) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16)[3], such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases,

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well being of such individual.

[1] P.L. 92-603, sec. 297(a), revised sec. 1905(a)(14) in its entirety. Applicable to services furnished after December 31, 1972. Previously, sec. 1905(a)(14) read: "(14) inpatient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;".

[2] P.L. 92-223, sec. 4(a)(1), added sec. 1905(a)(15). Effective January 1, 1972.

[3] P.L. 92-603, section 299B(c) inserted "except as otherwise provided in paragraph (16)," in lieu of "except that".

State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1110(a)(8).

(c) For purposes of this title the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, and (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing homes under State law. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to institutional services deemed appropriate by the State. The term "intermediate care facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of clauses (2) and (3) of this subsection and providing the care and services required under clause (1). With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d), any public institution or distinct part thereof

(d) The term "intermediate care facility services" may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions if—

(1) The primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and which meet such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and

(3) the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.[2]

(e) In the case of any State the State plan of which (as approved under this title)—

(1) does not provide for the payment of services (other than services covered under section 1902(a)(12)) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term "physicians' services" (as used in subsection (a)(5)) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to

[1] P.L. 92-223, sec. 4(a)(2), added sec. 1905(c) except the next to the last sentence. Effective January 1, 1972. P.L. 92-603, section 299L(a), added the next to the last sentence of section 1905(c).

[2] P.L. 92-223, sec. 4(a)(2), added sec. 1905(d). Effective January 1, 1972. P.L. 92-603, section 299, revised section 1905(d)(3) in its entirety. Previously, section 1905(d)(3) read: "(3) the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures with respect to patients in such institution (or distinct part thereof) will not be reduced because of payments made under this title."

or an optometrist.[1]

(f) For purposes of this title, the term "skilled nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis.[2]

(g) If the State plan includes provision of chiropractors' services, such services include only—

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1861(r)(5); and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.[3]

(h)(1) For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—

(A) inpatient services which are provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary,[4] and (ii) a team, consisting of physicians and other personnel qualified to make determination with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (A) the date such individual attains age

[1] P.L. 92-603, section 212(a), added section 1905(e). Applicable to services performed after October 30, 1972.

[2] P.L. 92-603, section 247(b), added section 1905(f). Applicable to services furnished after December 31, 1972.

[3] P.L. 92-603, section 275(a), added section 1905(g). Applicable to services furnished after June 30, 1973.

[4] P.L. 93-233, section 18(w) amended 1905(h)(1)(B) to give the Secretary authority under title XIX to establish standards for the active treatment of mental illness.

services in the period immediately preceding the date on which he attained age 21, (i) the date such individual no longer requires such services, or (ii) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State and the political subdivisions thereof, from non-Federal funds for such services.[1]

(i) For purposes of this title, the term "skilled nursing facility" also includes any institution which is located in a State on an Indian reservation and is certified by the Secretary as being a qualified skilled nursing facility by meeting the requirements of section 1861(j).[2]

(j) The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving Supplemental Security Income benefits under title XVI or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Secretary), but only to the extent that such payments are made with respect to an individual with respect to whom Supplemental Security Income benefits are payable under title XVI, or would but for his income be payable under that title.[3]

(k) Increased Supplemental Security Income benefits payable pursuant to section 211 of P.L. 93–66 shall not be considered Supplemental Security Income benefits payable under title XVI.[4]

Sec. 1906. [Repealed.][5]

[1] P.L. 92-603, section 299B(b), added section 1905(h).
[2] P.L. 92-603, section 299L(b), added a second section 1905(h) which P.L. 93-233 redesignated as subsection (i).
[3] P.L. 93-233, section 13(a)(18) added subsection (j) to 1905.
[4] P.L. 93-233, section 13(a)(18) added subsection (k) to 1905.
[5] P.L. 92-603, section 287(a), repealed section 1906. Effective January 1, 1973.

Sec. 1907. Nothing in this title shall be construed to require any State which has a plan approved under this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

State Programs for Licensing of Administrators of Nursing Homes

Sec. 1908. (a) For purposes of section 1902(a)(29), a "State program for licensing of administrators of nursing homes" is a program which provides that no nursing home within the State may operate except under the supervision of an administrator licensed in the manner provided in this section.

(b) Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of chronically ill and infirm aged patients and established to carry out the purpose of this section.

(c) It shall be the function and duty of such agency or board to—

(1) develop, impose, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator, which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators;

(2) develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

(3) issue licenses to individuals determined, after the application of such techniques, to meet such standards, and re-

any case where the individual holding any such license is determined substantially to have failed to conform to the requirements of such standards;

(4) establish and carry out procedures designed to insure that individuals licensed as nursing home administrators will, during any period that they serve as such, comply with the requirements of such standards;

(5) receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the board to the effect that any individual licensed as a nursing home administrator has failed to comply with the requirements of such standards; and

(6) conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of the standards imposed for the licensing of such administrators and of procedures and methods for the enforcement of such standards with respect to administrators of nursing homes who have been licensed as such.

(d)[1] No State shall be considered to have failed to comply with the provisions of section 1902(a)(29) because the agency or board of such State (established pursuant to subsection (b)) shall have granted any waiver, with respect to any individual who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in section 1902 (a)(29) are first met by the State, has served as a nursing home administrator, of any of the standards developed, imposed, and enforced by such agency or board pursuant to subsection (c).[2]

(e) As used in this section, the term—

(1) "nursing home" means any institution or facility defined as such for licensing purposes under State law, or, if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary, but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts[3]; and

(2) "nursing home administrator" means any individual

[1] P.L. 92-603, section 269, inserted the first sentence of section 1908(d).
[2] P.L. 93-233, section 18(y)(3) deleted obsolete provisions following the first sentence of 1908(d) and redesignated subsection (g) as subsection (e).
[3] P.L. 92-603, section 268(b), inserted, "but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts". Effective on October 30, 1972.

home whether or not such individual has an ownership interest in such home and whether or not his functions and duties are shared with one or more other individuals.

Penalties[1]

Sec. 1909. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes items or services to an individual for which payment is or may be made in whole or in part out of Federal funds under a State plan approved under this title and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

[1] P.L. 92-603, section 242(c), added section 1909. Does not apply to any acts, statements, or representations made or committed before October 30, 1972.

dividual to another person for the furnishing of such items or services

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than 6 months or both.

Certification and Approval of Skilled Nursing Facilities[1]

Sec. 1910. (a) Whenever the Secretary certifies an institution in a State to be qualified as a skilled nursing facility under title XVIII, such institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1902(a)(28).

(b) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any institution which has applied for certification by him as a qualified skilled nursing facility.

[1] P.L. 92-603, section 249(a), added section 1910. Applicable to agreements filed with the Secretary under section 1866 by skilled nursing facilities before, on, or after October 30, 1972, but accepted by him after that date.

Section 1108 of the Act (Limitation on Payments to Puerto Rico, the Virgin Islands, and Guam) as amended by Section 271 of Public Law 92–603)

Public Law 92–603

Sec. 249E Determining Eligibility for Assistance under Title XIX for Certain Individuals (as amended by Section 233 of P.L. 93–66)

Sec. 221
Limitation on Federal Participation for Capital Expenditures

Sec. 249C
Disclosure of Information Concerning the Performance of Carriers, Intermediaries, State Agencies, and Providers of Services Under Medicare and Medicaid

Sec. 249D
Limitation on Institutional Care

Sec. 299E
Family Planning Services Mandatory Under Medicaid

Sec. 299F
Penalty for Failure to Provide Child Health Screening Services Under Medicaid

Public Law 93–66

Sec. 230
Coverage of Essential Persons Under Medicaid

Sec. 231 (as amended by section 13(b)(1) of P.L. 93–233)
Persons in Medical Institutions

Sec. 232 (as amended by section 13(b)(2) of P.L. 93–233)

Public Law 93–233

Sec. 13C
Medical Eligibility for Persons Receiving Mandatory State Supplementary Payments

Section 1108 Limitation on Payments to Puerto Rico, the Virgin Islands, and Guam (as amended by Section 271 of P.L. 92–603, which provided an increase in the limitation on Payments to Puerto Rico and the Virgin Islands for Medical Assistance.)

Sec. 1108. (a) The total amount certified by the Secretary of Health, Education, and Welfare under title I, X, XIV, and XVI, and under part A of title IV (exclusive of any amounts on account of services and items to which subsection (b) applies)—

(1) for payment to Puerto Rico shall not exceed—

(A) $12,500,000 with respect to the fiscal year 1968,

(B) $15,000,000 with respect to the fiscal year 1969,

(C) $18,000,000 with respect to the fiscal year 1970,

(D) $21,000,000 with respect to the fiscal year 1971,

or

(E) $24,000,000 with respect to the fiscal year 1972 and each fiscal year thereafter:

(2) for payment to the Virgin Islands shall not exceed—

(A) $425,000 with respect to the fiscal year 1968,

(B) $500,000 with respect to the fiscal year 1969,

(C) $600,000 with respect to the fiscal year 1970,

(D) $700,000 with respect to the fiscal year 1971, or

(E) $800,000 with respect to the fiscal year 1972 and each fiscal year thereafter: and

(3) for payment to Guam shall not exceed—

(A) $575,000 with respect to the fiscal year 1968,

(B) $690,000 with respect to the fiscal year 1969,

(C) $825,000 with respect to the fiscal year 1970,

(D) $960,000 with respect to the fiscal year 1971, or

(E) $1,100,000 with respect to the fiscal year 1972 and each fiscal year thereafter.

(b) The total amount certified by the Secretary under part A of title IV, on account of family planning services and services provided under section 402(a)(19) with respect to any fiscal year—

(1) for payment to Puerto Rico shall not exceed $2,000,000,

(2) for payment to the Virgin Islands shall not exceed $65,000, and

(3) for payment to Guam shall not exceed $90,000.

with respect to any fiscal year—

(1) for payment to Puerto Rico shall not exceed $30,000,000,

(2) for payment to the Virgin Islands shall not exceed $1,000,000, and

(3) for payment to Guam shall not exceed $900,000.

(d) Notwithstanding the provisions of section 502(a) and 512(a) of this Act, and the provisions of sections 421, 503(1), and 504(1) of this Act as amended by the Social Security Amendments of 1967, and until such time as the Congress may by appropriation or other law otherwise provide, the Secretary shall, in lieu of the initial allotment specified in such sections, allot such smaller amounts to Guam, American Samoa, and the Trust Territory of the Pacific Islands as he may deem appropriate.

Excerpt From the Social Security Amendments of 1972 as modified by Public Law 93–66 (Section 233)

DETERMINING ELIGIBILITY FOR ASSISTANCE UNDER TITLE XIX FOR CERTAIN INDIVIDUALS

Sec. 249E. For purposes of section 1902(a)(10) of the Social Security Act any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act and who for such month was entitled to monthly insurance benefits under title II of such Act shall be deemed to be eligible for such aid or assistance for any month thereafter prior to July 1975 if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under title II of such Act resulting from enactment of Public Law 92–336 not been applicable to such individual.

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Section 221(a) Title X. of the Social Security Act is amended by adding at the end thereof the following new section.

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

"SEC. 1122. (a) The purpose of this section is to assure that Federal funds appropriated under titles V, XVIII, and XIX are not used to support unnecessary capital expenditures made by or on behalf of health care facilities or health maintenance organizations which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.

(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least half of whose members represent consumer interests) will—

"(1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility or health maintenance organization in such State within the field of its responsibilities,

(2) receive from other agencies described in clause (ii) of subsection (d)(1)(B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proposed by or on behalf of health care facilities or health maintenance organizations in such State within the fields of their respective responsibilities, and

"(3) establish and maintain procedures pursuant to which a person proposing any such capital expenditure may appeal a recommendation by the designated agency and will be granted an opportunity for a fair hearing by such agency or person other than the designated agency as the Governor (or other chief executive officer) may designate to hold such hearings, whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

"(c) The Secretary shall pay any such State from the Federal Hospital Insurance Trust Fund, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

"(d)(1) Except as provided in paragraph (2), if the Secretary determines that—

in subsection (b) nor an agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to obligation for such expenditure; or

"(B) (i) the planning agency so designated or an agency so described had received such timely notice of the intention to make such capital expenditure and had, within a reasonable period after receiving such notice and prior to obligation for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency had responsibility, and

"(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b)—

"(I) consulted with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314(a) and 604(a) of the Public Health Service Act (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act and covering the area in which the health care facility or health maintenance organization proposing such capital expenditure is located (where such agency is not the agency designated in the agreement), or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with criteria included in regulations, similar functions, and

"(II) granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings;

then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure. With respect to any organization which is reimbursed on a per capita basis, in determining the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita basis.

"(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility or health maintenance organization would discourage the operation or expansion of such facility or organization, or of any facility of such organization, which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration

graph (1).

"(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

"(f) Any person dissatisfied with a determination by the Secretary under this section may within six months following notification of such determination request the Secretary to reconsider such determination. A determination by the Secretary under this section shall not be subject to administrative or judicial review.

"(g) For the purpose of this section, a 'capital expenditure' is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $100,000, (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000.

"(h) The provisions of this section shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

"(i) (1) The Secretary shall establish a national advisory council, or designate an appropriate existing national advisory council, to advise and assist him in the preparation of general regulations to carry out the purposes of this section and on policy matters arising in the administration of this section, including the coordination of activities under this section with those under other parts of this Act or under other Federal or federally assisted health programs.

"(2) The Secretary shall make appropriate provision for consultation between and coordination of the work of the advisory council established or designated under paragraph (1) and the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this section and the coordination of activities under this section with related Federal health programs.

"(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise in the regular full-time employ of the United States, and who shall be appointed by the Secretary without regard to the civil service laws from among leaders in the fields of the fundamental sciences, the medical sciences, and the organization, delivery, and financing of health care, and persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council, while attending meet-

entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS–18 in section 5332 of title 5, United States Code, including traveltime, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of such title 5 for persons in the Government service employed intermittently."

(b) The amendment made by subsection (a) shall apply only with respect to a capital expenditure the obligation for which is incurred by or on behalf of a health care facility or health maintenance organization subsequent to whichever of the following is earlier: (A) December 31, 1972, or (B) with respect to any State or any part thereof specified by such State, the last day of the calendar quarter in which the State requests that the amendment made by subsection (a) of this section apply in such State or such part thereof.

(c)(1) Section 505(a)(6) of such Act (as amended by section 232(b) of this Act) is further amended by inserting ", consistent wth section 1122," after "standards" where it first appears.

(2) Section 506 of such Act (as amended by sections 224(d), 229(d), 233(d), and 237(b) of this Act, is further amended by adding at the end thereof the following new subsection:

"(g) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122."

(3) Clause (2) of the second sentence of section 509(a) of such Act is amended by inserting ", consistent with section 1122," after "standards".

(4) Section 1861(v) of such Act is amended by adding at the end thereof the following new paragraph:

"(5) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122."

(5) Section 1902(a)(13)(D) of such Act (as amended by section 232(a) of this Act) is further amended by inserting ", consistent with section 1122," after "standards" where it first appears.

(6) Section 1903(b) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122."

(d) In the case of a health care facility providing health care services as of December 18, 1970, which on such date is committed to a formal plan of expansion or replacement, the amendments made by the preceding provisions of this section shall not apply with respect to such expenditures as may be made or obligations incurred for capital items included in such plan where preliminary expenditures toward the plan of expansion or replacement (including payments for studies, surveys, designs, plans, working drawings, specifications, and site acquisition, essential to the acquisition, improvement, expansion, or replacement of the health care facility or equipment concerned) of $100,000 or more, had been made during the three-year period ended December 17, 1970.

DISCLOSURE OF INFORMATION CONCERNING THE PERFORMANCE OF CARRIERS, INTERMEDIARIES, STATE AGENCIES, AND PROVIDERS OF SERVICES UNDER MEDICARE AND MEDICAID

SEC. 249C. (a) Section 1106 of the Social Security Act is amended by adding at the end thereof the following new subsections:

"(d) Notwithstanding any other provision of this section the Secretary shall make available to each State agency operating a program under title XIX and shall, subject to the limitations contained in subsection (e), make available for public inspection in readily accessible form and fashion, the following official reports (not including, however, references to any internal tolerance rules and practices that may be contained therein, internal working papers or other informal memoranda) dealing with the operation of the health programs established by titles XVIII and XIX—

"(1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews;

"(2) comparative evaluations of the performance of such contractors, including comparisons of either overall performance or of any particular aspect of contractor operation; and

"(3) program validation survey reports and other formal evaluations of the performance of providers of services, including the reports of follow-up reviews, except that such reports shall not identify individual patients, individual health care practitioners, or other individuals.

"(e) No report described in subsection (d) shall be made public by the Secretary or the State title XIX agency until the contractor or provider of services whose performance is being evaluated has had a reasonable opportunity (not exceeding 60 days) to review such report and to offer comments pertinent parts of which may be incorporated in the public report; nor shall the Secretary be required to include in any such report information with respect to any deficiency (or improper practice or procedures) which is known by the Secretary to have been fully corrected, within 60 days of the date such deficiency was first brought to the attention of such contractor or provider of services, as the case may be."

(b) The provisions of subsection (a) shall apply with respect to reports which are completed by the Secretary after the third calendar month following the enactment of this Act.

LIMITATION ON INSTITUTIONAL CARE

SEC. 249D. Section 121(b) of the Social Security Amendments of 1965 is amended by adding at the end thereof the following new sentence: "After the date of enactment of the Social Security Amendments of 1972, Federal matching shall not be available for any portion of any payment by any State under title I, X, XIV, or XVI, or part A of title IV, of the Social Security Act for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under title XIX of such Act, if such care is (or could be) provided under a State plan approved under title XIX of such Act by an institution certified under such title XIX.".

(This provision in effect for State plans under titles, I, X, XIV and Part A of title IV. Section 14 of P.L. 93–233 parallels this provision for aged, blind and disabled persons where the Supplemental Security Income Program is in effect.)

FAMILY PLANNING SERVICES MANDATORY UNDER MEDICAID

SEC. 299E. (a) Section 1903(a) of the Social Security Act, as amended by sections 235 and 249B of this Act, is further amended by redesignating paragraph (5) as paragraph (6), and by inserting after paragraph (4) the following new paragraph:

"(5) an amount equal to 90 per centum of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the plan) which are attributable to the offering, arranging and furnishing (directly or on a contract basis) of family planning services and supplies;".

(b) Section 1905(a)(4) of the Social Security Act is amended by adding after clause (B) the following: "and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;".

(c) Section 402(a)(15)(B) of such Act is amended, effective January 1, 1973, (1) by adding after "in all appropriate cases" the following: "(including minors who can be considered to be sexually active)", and (2) by adding after "family planning services are offered them" the following: "and are provided promptly (directly or under arrangements with others) to all individuals voluntarily requesting such services".

(d) Section 403 of such Act is amended by adding at the end thereof the following new sections:

"(e) Notwithstanding any other provision of subsection (a), with respect to expenditures during any calendar quarter beginning after December 31, 1972 (as found necessary by the Secretary for the proper and efficient administration of the plan) which are attributable to the offering, arranging, and furnishing, directly or on a contract basis, of family planning services and supplies, the amount payable to any State under this part shall be 90 per centum of such expenditures.

"(f) Notwithstanding any other provision of this section, the amount payable to any State under this part for quarters in a fiscal year shall with respect to quarters in fiscal years beginning after June 30, 1973, be reduced by 1 per centum (calculated without regard to any reduction under section 403(g)) of such amount if such State—

"(1) in the immediately preceding fiscal year failed to carry out the provisions of section 402(a)(15)(B) as pertain to requiring the offering and arrangement for provision of family planning services; or

"(2) in the immediately preceding fiscal year (but, in the case of the fiscal year beginning July 1, 1972, only considering the third and fourth quarters thereof), failed to carry out the provisions of section 402(a)(15)(B) of the Social Security Act with respect to any individual who, within such period or periods as the Secretary may prescribe, has been an applicant for or recipient of aid to families with dependent children under the plan of the State approved under this part."

PENALTY FOR FAILURE TO PROVIDE CHILD HEALTH SCREENING SERVICES UNDER MEDICAID

SEC. 299F. Section 403 of the Social Security Act is amended by adding at the end thereof the following:

"(g) Notwithstanding any other provision of this section, the amount payable to any State under this part for quarters in a fiscal year shall with respect to quarters in fiscal years beginning after June 30, 1974, be reduced by 1 per centum (calculated without regard to any reduction under section 403(f) of such amount if such State fails to—

"(1) inform all families in the State receiving aid to families with dependent children under the plan of the State approved under this part of the availability of child health screening services under the plan of such State approved under title XIX,

"(2) provide or arrange for the provision of such screening services in all cases where they are requested, or

"(3) arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services."

* * * * *

COVERAGE OF ESSENTIAL PERSONS UNDER MEDICAID

SEC. 230. In the case of any State plan (approved under title XIX of the Social Security Act) which for December 1973 provided medical assistance to persons described in section 1905(a)(vi) of such Act, there is hereby imposed the requirement (and such State plan shall be deemed to require) that medical assistance under such plan be provided to each such person (who for December 1973 was eligible for medical assistance under such plan) for each month (after December 1973) that—

(1) the individual (referred to in the last sentence of section 1905(a) of such Act) with whom such person is living continues to meet the criteria (as in effect for December 1973) for aid or assistance under a State plan (referred to in such sentence), and

(2) such person continues to have the relationship with such individual described in such sentence and meets the other criteria (referred to in such sentence) with respect to a State plan (so referred to) as such plan was in effect for December 1973.

Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals eligible for such assistance under this section.

* * * * *

Section 231 (As amended by section 13(b)(1) of P.L. 93-233)

PERSONS IN MEDICAL INSTITUTIONS

SEC. 231. For purposes of section 1902(a)(10) of the Social Security Act, any individual who, for all (or any part of) the month of December 1973—

(1) was an inpatient in an institution qualified for reimbursement under title XIX of the Social Security Act, and

(2)(A) received or would (except for his being an inpatient in such institution) have been eligible to receive aid or assistance under a State plan approved under title I, X, XIV, or XVI of such Act, and

(B) on the basis of his status as described in subparagraph (A), was included as an individual eligible for medical assistance under a State plan approved under title XIX of such Act (whether or not such individual actually received aid or assistance under a State plan referred to in subparagraph (a)),

shall be deemed to be receiving such aid or assistance for such month and for each succeeding month in a continuous period of months if, for each month in such period—

(3) such individual continues to be (for all of such month an inpatient in such an institution and would (except for his being an inpatient in such institution) continue to meet the conditions of eligibility to receive aid or assistance under such plan (as such plan was in effect for December 1973), and

(4) such individual is determined (under the utilization review and other professional audit procedures applicable to State plans approved under title XIX of the Social Security Act) to be in need of care in such an institution.

Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals eligible for such assistance under this section.

Section 232 (As amended by section 13(b)(2) of P.L. 93-233)

BLIND AND DISABLED MEDICALLY INDIGENT PERSONS

SEC. 232. For purposes of section 1902(a)(10) of the Social Security Act, any individual who, for the month of December 1973 was eligible for medical assistance by reason of his having been determined to meet the criteria for blindness or disability (established by a State plan approved under title I, X, XIV, or XVI of such Act), shall be deemed for purposes of title XIX to be an individual who is blind or disabled within the meaning of section 1614(a) of the Social Security Act for each month in a continuous period of months (beginning with the month of January 1974), if, for each month in such period, such individual continues to meet the criteria for blindness or disability so established by such a State plan and the other conditions of eligibility contained in the plan of the State approved under title XIX (as it was in effect in December 1973). Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals eligible for such assistance under this section.

MEDICAID ELIGIBILITY FOR INDIVIDUALS RECEIVING MANDATORY STATE SUPPLEMENTARY PAYMENTS

(c) In addition to other requirements imposed by law as conditions for the approval of any State plan under title XIX of the Social Security Act, there is hereby imposed (effective January 1, 1974) the requirement (and each such State plan shall be deemed to require) that medical assistance under such plan shall be provided to any individual—

(1) for any month for which there (A) is payable with respect to such individual a supplementary payment pursuant to an agreement entered into between the State and the Secretary of Health, Education, and Welfare under section 212(a) of Public Law 93–66, and (B) would be payable with respect to such individual such a supplementary payment, if the amount of the supplementary payments payable pursuant to such agreement were established without regard to paragraph (3)(A)(ii) of such section 212(a), and

(2) in like manner, and subject to the same terms and conditions, as medical assistance is provided under such plan to individuals with respect to whom benefits are payable for such month under the Supplementary Security Income Program established by title XVI of the Social Security Act.

Federal matching under title XIX of the Social Security Act shall be available for the medical assistance furnished to individuals who are eligible for such assistance under this subsection.

PAYMENTS TO SUBSTANDARD FACILITIES UNDER MEDICAID

SEC. 14. Section 1616 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(e) Payments made under this title with respect to an individual shall be reduced by an amount equal to the amount of any supplementary payment (as described in subsection (a)) or other payment made by a State (or political subdivision thereof) which is made for or on account of any medical or any other type of remedial care provided by an institution to such individual as an inpatient of such institution in the case of any State which has a plan approved under title XIX of this Act if such care is (or could be) provided under a State plan approved under title XIX of this Act by an institution certified under such title XIX.".

☆ U.S. GOVERNMENT PRINTING OFFICE: 1975 O—567-052

NATIONAL GUIDELINES FOR HEALTH PLANNING

Public Health Service

Federal Register
September 23, 1977

TITLE	GUIDELINES
I. General Hospitals—Bed-population Ratio	There should be less than four non-Federal, short-term hospital beds per 1000 persons in a health service area, except under extraordinary circumstances.
II. General Hospitals—Occupancy Rate	There should be an average annual occupancy rate of at least 80 percent for all non-Federal, general short-term hospitals in a health service area, except under extraordinary circumstances.
III. Obstetrical Services A.	There should be at least 2000 deliveries annually in an obstetrical unit located in an SMSA with a population of 100,000 or more. There should be at least 500 deliveries annually in any obstetrical unit not located in an SMSA with a population of 100,00 or more.
B.	There should be an average annual occupancy rate of at least 75 percent in each obstetrical unit.
IV. Pediatric Inpatient Services—Number of Beds	There should be a minimum of 20 beds in a pediatric unit.
V. Pediatric Inpatient Services—Occupancy Rates	Pediatric units should maintain average annual occupancy rates related to number of pediatric beds (exclusive of neonatal instensive care units) in the facility. For a facility with 20-39 pediatric beds, the average annual occupancy rate should be at least 65 percent; for a facility with 40-79 pediatric beds, the average annual occupancy rate should be at least 75 percent; for facilities with 80 or more pediatric beds, the average annual occupancy rate should be at least 80 percent.

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VI. Neonatal Intensive Care Units

A. The total number of neonatal intensive care beds should not exceed four per thousand live births per year in a defined neonatal service area.

B. A single neonatal intensive care unit should contain a minimum of 20 beds.

VII. Open Heart Surgery

A. There should be a minimum of 200 procedures performed annually in any institution in which open heart surgery is performed.

B. There should be no new open heart units opened unless each existing or previously approved unit in the health service area (or areas) to be served is operating and is expected to continue to operate at a minimum of 350 open heart surgery cases per year.

VIII. Cardiac Catheterization Unit Services

A. There should be a minimum of 300 procedures (intracardiac and/or coronary artery catheterization) performed annually in any adult cardiac catheterization unit.

B. There should be a minimum of 150 cardiac catheterizations performed annually in any pediatric cardiac catheterization unit.

C. There should be no new cardiac catheterization units opened in any facility not performing open heart surgery.

D. There should be no new adult cardiac catheterization units opened unless the projected number of studies per year is greater than 500 based on the current number of procedures, existing capacity, estimated need and referral patterns in the health service area(s) to be served and as determined by the Health Systems Agency(ies).

IX. Radiation Therapy

A. A megavoltage radiation therapy unit should serve a population of at least 150,000 persons or at least 450 new cancer cases per year.

B. There should be now new megavoltage units opened unless each existing or approved megavoltage unit in the health service area(s) is performing and is expected to continue to perform at least 7,500 treatments per year.

X. Computed Tomographic Scanners

A. Each computed tomographic (CT) scanner (head and body) should operate at a minimum of 2,500patient procedures per year.

B. There should be no CT scanners approved unless each existing or approved CT scanner in the service area is performing at a rate greater than 4,000 patient procedures per year.

C. Charges for existing or proposed CT scanner are to be calculated on the basis of 2,500, the projected or actual number of patient procedures per year, whichever is greater.

D. There should be no new computer tomographic (CT) scanners approved unless the owners or operators of the proposed equipment will set in place, with operation of the equipment, a data collection system.

XI. End-Stage Renal Disease (ESRD)

The Health Systems Plans established by health systems agencies should be consistent with standards and procedures contained in the DHEW regulations governing conditions for coverage of suppliers of end-stage renal disease services, 20 CFR Part 405, Subpart U.

FISCAL AGENT CONTRACT

Since 1967 Blue Cross-Blue Shield has served as fiscal agent for the Kansas Medicaid Program. We are reimbursed for our services on a negotiated rate for each type of claim paid or our actual cost of administration if less than our annual reimbursement through contract rates.

On an annual basis we pay more than 3,000,000 claims including professional, hospital, pharmaceutical and other covered health care services. Our average cost per all types of claims paid is approximately $.75. Our average cost for processing a physician's claim is approximately $1.50. This is about half the average cost for processing Medicare Part B physician claims.

Why? Different environment -- concentration on costs in Title XIX, more freedom for innovation -- no checks to providers in Title XIX. More rules and regulations and paper work for Medicare.

We work very closely with Dr. Harder and his staff in carrying out our Medicaid responsibilities. We have a joint staff meeting every two weeks to review problems, make decisions and assign operations priorities. In addition we provide office space for several State staff members to promote more efficient program coordination on day-to-day problems.

Generally, our contractual responsibilities are as follows:

Contract Responsibilities:

1. Receive and process claims from all Medicaid health care providers, except nursing homes.

   a. check eligibility of recipient
   b. determine coverage and medical necessity, edit for duplicates
   c. determine level of payment (50th percentile for prof. 1975)
   d. prepare magnetic tape for state to issue checks and remittance letters to providers.
   e. Furnish state claims inventory and performance information

2. Develop and maintain Provider Manuals and ongoing provider educational programs.

   a. Newsletters, workshops
   b. On site visits

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3. Answer inquiries from providers.

   a. we utilize CRT's to gain instant access to paid history and suspended claims data. We have installed a unit in State SRS offices.

4. Develop and distribute claim forms.

5. Advise and assist State in matters relating to Policies.

6. Assist State in liason with various provider groups with respect to present and future program policy.

7. Assist providers in the development of procedures related to utilization practices.

8. Provide State with necessary statistical data through routine or special requests.

Our agreement does not delegate authority to us to:

1. Change existing State rules and regulations.

2. Determine recipient eligibility.

3. Write checks or issue remittance letters.

4. Audit hospital costs.

We are proud of our record as the State's fiscal agent for the Kansas Medicaid program and welcome your questions.

FACILITY LICENSING AND CERTIFICATION PROGRAM

Testimony to The

Health Care Cost Commission

October 6, 1977

Prepared by: The Department
of Health and Environment

Atch. K

State of Kansas . . . ROBERT F. BENNETT, *Governor*

DEPARTMENT OF HEALTH AND ENVIRONMENT

DWIGHT F. METZLER, *Secretary*

Topeka, Kansas 66620

FACILITY LICENSING AND CERTIFICATION PROGRAM

I. Adult Care Homes

A. Background: The Department of Health and Environment is responsible for the licensing of adult care homes in Kansas under a 1961 law--K.S.A. 39-923. The Department has the authority to adopt rules and regulations under this statute. Over the intervening 16 years the Department of Health and Environment and its predecessor, the Department of Health, have worked to improve the standards in adult care homes. This was well under way before the federal programs began in 1967.

Further steps for upgrading care in nursing homes were taken with implementation of fire safety requirements--requirements to meet the life safety code--in 1972, and licensure of nursing home administrators in 1970.

The federal program began in 1967 when the federal government established standards for nursing home patients receiving assistance under Title XVIII or Title XIX of the Social Security Act.

The regulations of the federal government have become progressively more stringent, most specifically those of January 15, 1974, dealing with homes providing intermediate care. Kansas has carried out an aggressive program both under the state statute and under the federal rules and regulations. The net effect has been to decrease the number of facilities licensed. More modern homes have been built in response to the need and the number of beds have been increased.

B. Responsibilities of the Department of Health and Environment:

1. Licensure of Adult Care Homes: The Department of Health and Environment is responsible for the licensure of Adult Care Homes. In order to be licensed, an Adult Care Home must meet the requirements of K.S.A. 39-923 and the rules and regulations adopted by the Department of Health and Environment. As of June 30, 1977 there were:

	Number	Bed Capacity
Skilled Nursing Homes	50	5,231
Intermediate Care Homes	259	16,696
Personal Care Homes	46	2,218
	355	24,145
One-Bed Homes	57	57
Two-Bed Homes	146	292

2. Certification of Homes: The Department of Health and Environment has the additional responsibility to certify that facilities which wish to do so are qualified to participate in the Federal Skilled Nursing Facility Program, the Intermediate Care Facility Program, or the Intermediate Care Facility for the Mentally Retarded.

	Number	Bed Capacity
Certified Skilled Nursing Facility	52	4,263
Certified Intermediate Care Facility	315	20,475
Certified Intermediate Care Facility for the Mentally Retarded	8	1,886

II. Medical Care Facilities

A. Background: The Department of Health and Environment is responsible for the licensure of medical care facilities in Kansas under a 1946 law. This law has been amended several times over the years, as have the rules and regulations which govern the licensure program.

The Medicare Law (P.L. 89-384) was passed in 1966. The Department of Health and Environment, under provisions of a contract with the Secretary of Health, Education, and Welfare, assists in the administration of the Medicare Program through conducting surveys to determine if the providers of the various services meet the requirements of the Medicare Law. Under this law, each provider is surveyed once a year and this is followed by a revisit within 90 days. Deficiencies of a serious nature must be corrected, or positive corrective action taken, before a provider can be certified.

B. Responsibilities of the Department of Health and Environment:

1. Licensure of Medical Care Facilities: The Department of Health and Environment is responsible for the licensure of Medical Care Facilities. In order to be licensed a Medical Care Facility must meet the requirements of K.S.A. 65-425 and the rules and regulations adopted by the Department of Health and Environment. As of June 30, 1977 there were:

	Number	Bed Capacity
General Hospitals	151	14,528
Special Hospitals (Mental)	6	2,799
Ambulatory Surgical Centers	2	-
Recuperation Centers	3	394
	162	17,721

2. Certification of Facilities: The Department of Health and Environment has the responsibility to recommend certification for the facilities which wish to participate in the Medicare Program. The facilities must meet federal requirements and be certified in order that they may be reimbursed with federal funds. As of June 30, 1977 there were:

	Number	Bed Capacity
Hospitals	152	12,901
Home Health Agencies	36	-
Independent Laboratories	24	-
Renal Dialysis Centers	4	-
	216	12,901