The New Medical Assistance Program

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WE NEED ONLY to scan our daily papers to call to mind new and dramatic evidence that the poor do not as yet receive the comprehensive health care services which our society holds as essential. It is too simple an explanation to say that the inability to pay for care alone accounts for the long neglect of the health problems of the poor, but this inability has been a major barrier. The 1965 amendments to the Social Security Act have gone far to remove it. Under the Medicare provisions of the act (title XVIII), there is no reason why virtually every person over 65 cannot get the basic care provided through the hospital insurance and voluntary medical insurance programs of the Social Security system. Under the medical assistance provisions (title XIX), not only can the deductibles and voluntary insurance premiums be paid for needy older people, but comprehensive medical care can be financed for needy people in all age groups. This program is administered by the Bureau of Family Services in the Welfare Administration.

Requirements for States

Title XIX requires that States which establish a medical assistance program between January 1966 and July 1967 must provide some institutional and some noninstitutional care for all recipients. After July 1, 1967, however, any State using title XIX must provide not two, but five minimum services, namely: (*a*) inpatient hospital services, (*b*) outpatient hospital services, (*c*) physicians' services (whether provided in the physician's office, the patient's home, a hospital, a nursing home, or elsewhere), (*d*) skilled nursing home services for persons over 21, and (*e*) X-ray and other laboratory services.

The law lists the following other items of medical services which States may pay for with Federal participation: medical care or any type of remedial care recognized under State law which is provided by licensed practitioners within the scope of their practices as defined by State law, home health care services, private duty nursing services, clinic services, dental services, physical therapy and related services, dentures, prosthetic devices, prescribed drugs, and eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist (whichever the patient selects).

The policy of the Welfare Administration is to reinforce the legislation by insisting that these medical and remedial services be of high quality. Care provided through use of public funds should equal the care paid for privately.

The Welfare Administration is therefore urging States to begin at once to improve their present programs so that when they adopt the new program it will without question be of high quality. Some States can adopt the new program now; all States must be in a position to do so by 1970 if they are to continue to receive Federal funds for medical care for persons receiving public assistance.

Services Provided

Federal responsibilities for the administration of title XIX are carried by the Bureau of Family Services of the Welfare Administration. The program consists of the four following

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basic parts, which represent a step-by-step progression in the range and scope of services:

Medical care for public assistance recipients. Priority attention must be given to those receiving financial aid in the categories of Old Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to Families with Dependent Children. These categories represent coverage which the States must provide if they have a plan under title XIX.

Provisions for the medically indigent. Medical care may be provided for the medically indigent who are not receiving money payments but who would otherwise qualify for public assistance because they are blind, disabled, aged, or in families with dependent children. Their inclusion is optional with the States. Specifically, this provision means that if a State decides to pay for medical care for elderly people who are now included in the Kerr-Mills program, the State must also pay for medical care for its medically needy blind and disabled who are not receiving financial assistance and for medically indigent children and adults in families which are not receiving financial assistance but who otherwise meet the eligibility requirements of the Aid for Dependent Children program.

Medically needy children. States have the option to provide full and comprehensive medical care for all medically needy children under age 21, with substantial Federal participation. Families of these children need not be receiving public assistance. The parents can be employed full time but, if they are not earning enough to meet medical costs, they can still qualify for such aid for their children. A family's income may cover all the children's basic daily needs; if this family income is insufficient, however, to cover the cost of medical care and services, the children can be made eligible for the title XIX program. By this means, additional thousands of children of low-income families can be brought into a range of preventive, remedial, and treatment services which are essential to their future health and well-being as productive adult citizens.

Almost all of the medically indigent. Finally, by July 1, 1975, substantially all medically indigent persons must be included in a comprehensive program of medical care, with State funds providing for persons not covered by Federally aided programs. Thus, the States can move ahead in four stages to assure that people who need, but cannot afford, a broad spectrum of medical care will receive it. To summarize, the program will cover:

1. The people who depend upon federally aided public assistance programs for all or some of their basic income.
2. People in the same general categories who do not meet requirements for financial assistance for daily maintenance, but who need assistance with medical bills.
3. All children under age 21 in any family with income too low to meet medical costs.
4. Finally, any remaining medically needy persons aged 21 to 64 (the State meeting expenses for this group).

As of August 1, 1966, a total of 25 jurisdictions had indicated that they hoped in 1966 to launch medical assistance programs under title XIX. Fourteen jurisdictions have already received approval from the Department of Health, Education, and Welfare for participation in Medical Assistance, namely, California, Hawaii, Idaho, Illinois, Louisiana, Minnesota, Nebraska, North Dakota, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Utah, and Washington.

Eligibility Requirements

The determination of financial eligibility is intended, under the statute, to be a simple process. Federal policies will carry out the intention of the statute.

In addition to simplicity, the statute protects the income that a person needs for his basic support. Each State or jurisdiction must set a level for maintenance, and this level must be comparable for all groups included in the title XIX program. Persons whose incomes are below this established level and who are otherwise eligible must be included. The States are permitted considerable latitude in setting the level of maintenance, but it cannot be lower than the level now in effect for the most liberal of the State's money-payment programs. States may, of course, set their level of maintenance for the medically needy at any reasonable figure,

and this can, and should, be above the level on which eligibility for financial assistance is based.

The law sets forth several limitations on the kind of financial eligibility test the States may impose. These provisions were included in the statute because Congress was dissatisfied with tests imposed by some States under the Kerr-Mills program. Title XIX provides that only available income and resources may be taken into consideration. If the income is not certain or is irregular, only that which is actually in hand may be counted.

In determining eligibility for medical assistance, States may go back a reasonable period to help the person who does not realize he needs help until after he has incurred an obligation or is in the process of incurring one. While future income can be taken into account, the Welfare Administration contemplates setting a limit on the period in the future that income can be considered as available. It seems unreasonable to require the person with a marginal income to project into the future a living standard at or close to the assistance level of maintenance without some definite limits on that period.

Responsibility of Relatives

Another important feature of title XIX is a new concept of the financial responsibility of relatives. Such responsibility may only be taken into account for the spouse or for a child who is under the age of 21 or who is blind or permanently and totally disabled. The States may not impose an obligation on older children to support their aged parents. Of course, contributions voluntarily made may be taken into account.

Residence Requirements

States may not require a certain period of residence as a condition of eligibility for medical assistance. People passing through a State or who are there temporarily and who reside elsewhere are not an obligation of the State, but a newly arrived resident is. A State may, of course, have a more liberal policy and accept for care all persons present in the State without regard to residence.

States must also make arrangements to provide medical assistance to persons who are residents of the State but who are temporarily absent from it. This provision will require arrangements with other States to assist in the the provision of the medical assistance. It is aimed at minimizing the effect of State residence requirements for income maintenance programs.

Equal Services for All

An important requirement of the law is that the medical services provided must be equal in amounts, duration, and scope for all beneficiary groups included in the program. The services provided for one category of public assistance recipients must be the same for all the others. This requirement also applies to services provided for medically indigent persons who are not receiving money payments. Furthermore, the medically indigent cannot receive medical services above and beyond those provided for persons who are receiving financial assistance.

In their plans, States will be expected to approach the provision of medical care services with the explicit aim of making them readily available to all eligible persons. In addition, the law emphasizes simplified methods of administration so that recipients may be treated in a sympathetic and dignified manner. Furthermore, States are expected to use professional medical personnel in their programs and to assure that persons covered receive high-quality care.

In short, if States are to continue to receive Federal aid for medical care, they will be obliged to extend and improve their medical assistance programs—both by specific statutory provisions and by administrative requirements authorized by statute.

Target Dates for States

There are four target dates in this progressive effort.

1. By July 1, 1967, the scope of medical care in States with a plan under title XIX must conform to a minimum package of five specified service areas, and payment for hospital care must be made "at a reasonable cost."

2. By January 1, 1970, all States must have a

medical assistance program under title XIX or forego Federal matching funds for any payments made for medical care on behalf of assistance recipients.

3. By July 1, 1970, the non-Federal share of the program's cost must be financed entirely from State funds unless safeguards exist to assure that a local scarcity of tax funds does not impede the program's operation or thwart its objectives.

4. By July 1, 1975, it is envisaged that under the new law comprehensive care and services will be available to substantially all medically needy people throughout the nation. The law permits continued payment of Federal funds to a State only if the Secretary of Health, Education, and Welfare is satisfied that the State is making efforts toward that 1975 goal by broadening the scope of the program and liberalizing eligibility requirements.

Reasonable Cost Requirements

The 1965 amendments also contain "reasonable cost" requirements for inpatient hospital services. Under title XIX, payment on the basis of reasonable cost must be made by July 1, 1967, 1 year later than under the title XVIII program.

The Welfare Administration, Public Health Service, and Social Security Administration are currently working with the Health Insurance Benefits Advisory Council to develop principles for implementing the reasonable cost provision. These principles, which the Secretary of Health, Education, and Welfare will enunciate, are expected to be equally applicable to the Medicare insurance program and to the medical assistance program. Payment on the basis of reasonable cost does not, of course, mean a flat fixed amount for all hospitals in a State or locality. Reasonable cost will relate to each individual hospital.

Administration of Titles XVIII and XIX

The social insurance provisions for medical care and the medical assistance provisions are closely related. A close relationship is anticipated in their administration for many reasons, including the following: (*a*) the new hospitalization insurance program will immediately relieve State public welfare departments of the substantial sums they are now spending for hospital care for the aged, (*b*) the same can be said for the supplementary medical insurance provisions with respect to the costs of physician's services, and (*c*) title XVIII has provisions for payment of deductibles and co-insurance costs which would be a burden to low-income people. Thus the items of services under the two titles have many elements in common, and it is appropriate that they be administered with the same quality of services.

The law provides, as a condition of plan approval, that State title XIX agencies pay the deductibles for needy aged persons who are covered by the hospital insurance (title XVIII). This provision means that the deductible of $40 for hospital care and the $20 for outpatient diagnostic service must be paid. Obviously, with such a provision, there is no reason why a person should not receive the care he needs in a hospital even if he lacks the necessary income himself. Persons who receive money payments through Old Age Assistance would not have the money to pay these amounts, but we anticipate that the States would pay these fees also for the medically needy.

Most of the requirements under the new legislation are such that close collaboration of State agencies with hospitals and other health facilities is essential to successful program administration.

Coordination of the missions and responsibilities of the agencies within the Department of Health, Education, and Welfare which are charged with implementing the new medical assistance programs is equally important. The breadth and complexity of the new law certainly requires all of the Health, Education, and Welfare family to strive for the highest degree of cooperation.

Conclusion

This review of the new medical assistance program demonstrates that our nation is at last moving beyond piecemeal—and unsatisfactory—attacks on the health problems of the poor.

The 1965 amendments offer a powerful tool to assure for all medically indigent citizens their right to high-quality health services.