Some Major Aspects of Medical Assistance Under Title XIX

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A POTENTIALLY LARGE program of medical assistance under title XIX of the Social Security Act began on January 1, 1966, under the aegis of the Welfare Administration, Department of Health, Education, and Welfare. As in the other Federal-State assistance programs, States set their own financial eligibility standards for individuals within certain Federal rules and regulations. Based upon standards in States that have implemented title XIX, estimates indicate that perhaps 35 million persons may ultimately be protected by the new medical assistance program.

The Welfare Administration, through its Bureau of Family Services, has had considerable experience in administering medical assistance, a responsibility which began when the 1950 amendments to the Social Security Act provided for direct payments for medical care of public assistance recipients. This experience was widened by administering Medical Assistance for the Aged (MAA), beginning in 1960 with the passage of the Kerr-Mills Act, Public Law 86–778.

The MAA program during the fiscal year ending June 30, 1963, assisted about 311,000 persons at a cost of $286 million. The increase in expenditures for fiscal year 1965 to $521 million signaled an expanding program. On December 31, 1965, there were 47 jurisdictions with MAA programs in effect. As the medical assistance plan becomes effective in a State under title XIX of the Social Security Act (as amended through December 31, 1965), the MAA program is dropped in accordance with section 1905(b) under title XIX (section 121, Public Law 89–97).

Present indications are that in 24 States the public welfare agency will purchase supplementary medical insurance benefits under title XVIII for recipients of Old Age Assistance. Several other States will include $3 in the money-payment budgets of eligible recipients so that they can enroll and pay the monthly premiums themselves.

Single State Agency

The Commissioner of Welfare, in an address on March 4, 1966 (an adaptation of which appears in this issue), described progress in implementation of title XIX and reported the future plans of the States. Administrative responsibility for title XIX programs in States which have them in operation has been placed by statute or designation of the Governor under a single State agency, as required under title XIX. The Governor may designate the public health, public welfare, or other State agency as the single State agency. In States already implementing title XIX, the departments of public welfare have been so designated except that in California the State's health and welfare agency has been designated and in Maryland, the State's public health department.

If the single State agency is not the public

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welfare agency, there must be written agreements on the relationships and functions of the single State agency and the public welfare agency. The public welfare agency will still be responsible for determining eligibility for medical assistance in accordance with the standards, rules, regulations, and policies established in the State's title XIX plans.

Under section 1902(a)(5) of title XIX of the Social Security Act as amended through December 31, 1965, the single State agency is responsible for representing the State in its dealings with the Federal agency on every phase of the medical assistance plan and its operation.

The law provides for interagency relationships and collaborative activity in the setting and maintenance of standards, in promoting a high quality of medical care, and in the maximum use of alternative plans of care to the best interest of the patient. Federal policy, rules, and regulations permit the single State agency to make arrangements with other State agencies or private organizations to act as its agent in providing medical care and services under the State plan and to arrange for making payments to providers of services. State plans are to set forth " . . . the cooperative 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. . . ."

Financing

Under title XIX, immediate provision must be made for financial participation by the State equal to not less than 40 percent of the non-Federal share of expenditures under the plan. By July 1, 1970, the State's financial participation must be equal to the entire non-Federal share or provide for equalization or other procedures to insure that any lack of funds from local sources will not reduce the amount, duration, scope, or quality of medical care and services.

The amount paid by the Federal Government is determined on a formula basis with no ceiling on the total expenditures in which it will share. The Federal share varies in relation to a State's per capita income; States with average per capita income at the level of the national average are reimbursed for 55 percent of their expenditures, and States at the lowest level receive as much as 83 percent. No State, however, is to receive less than 50 percent of Federal financial participation even though its average income is above the national average.

Total expenditures for medical care under title XIX are expected to be greater than they have been under former titles of the Social Security Act because of the requirements of paying reasonable cost for inpatient hospital care after July 1, 1967, and of maintaining State financial effort; also because of the expansion of scope of services to comprehensive medical care by July 1, 1975.

Quality of Care

The legal requirements of the medical assistance program and Federal policy determine the basic administration of the program as well as the services provided. Under title XIX, States are required to include in their State plans a description of the standards and methods they will use to obtain high-quality medical or remedial care and services; they should also include a plan for continuous evaluation and surveillance.

It is not expected that the single State agency alone should administer all details of the medical assistance program. Cooperation and coordination with other agencies and use of their skills and services will be necessary for a successful venture in quality care. Agencies and organizations such as the State public health agency, the State medical society, the State hospital association, the nursing home association, pharmacists, the State vocational rehabilitation agency, and the visiting nurse service should be brought into the implementation of the program. Such an approach to medical assistance administration also requires the employment and use of professional personnel from the health and medical fields.

Interagency cooperation and coordination may be made clear by an example. If a State provides in its title XIX program for medical assistance to persons aged 65 or older who are

patients in institutions for mental disease, it must provide for agreements between the single State agency and the appropriate authorities concerned with the institutions in order to insure that there is joint planning for the care of the patient, that care and services provided are in his best interests, that there is an individual plan for care of each patient, that each patient's medical needs are periodically reviewed, and, also, that methods are established for determining the reasonable cost of care.

Another example of the need for interagency cooperation is in the provision of nursing home care. The public health agency sets the standards and certifies each nursing home after licensure. This agency might, for example, carry out followup inspections and evaluations to verify that a nursing home is clean and safe; that meals are balanced, nutritious, and adequate; that appropriate medical records are kept current which show the medication administered, physicians' orders, nurses' progress notes, and so forth; that the patient is well treated, provided nursing care, helped to attain the maximum possible degree of self-care, and provided diversion and exercise, social activity, and where possible, some contact with appropriate community functions and entertainment. Physical and occupational therapy looking to self-care and reorientation to social relationships are also part of the required quality care for patients in nursing homes. All these many phases of care should be harmoniously amalgamated with the single State agency's activity in providing the medical assistance that title XIX makes possible.

An advisory committee on medical care is to be established in each State to provide advice from professional medical representatives and other knowledgeable citizens. The advisory committees need to be broadly based and should make optimal use of subcommittees composed of specialists who will concentrate on specific problems. Several States have used this technique to good effect.

Recommendations issued by the Welfare Administration include nine points for use of the advisory committees as guidelines. Such committees are expected to make recommendations on standards, quality, and cost of services; help identify unmet needs; recommend long-range planning objectives, methods of implementing requirements, means for evaluation and for utilization review, and methods for providing drugs and medical supplies effectively and economically; advise on fiscal matters; interpret various phases of the medical assistance program to professional groups; and report to the appointing authority.

States will be encouraged to pay the fees and costs necessary to attract (*a*) a substantial number of qualified practitioners, certified by the national boards, (*b*) good-quality licensed, certified, or accredited institutions, such as hospitals and nursing homes, and (*c*) home health care agencies. Standards must be enforced and should be gradually improved. States are encouraged to apply title XVIII standards and controls to the title XIX program. Quality care and services cost money, and States will probably find it advantageous to carry over from title XVIII the principle of payment of reasonable costs for nursing home care and for other care and services in order to attain the desired quality.

Conclusion

The various provisions of title XIX are intended to insure that the patient who is medically needy has medical and remedial care available to him that is equal in scope and quality to that available in the mainstream of medical care and services for the general public. Thus, charity medicine should become past history.