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MATERIAL RELATED TO H.R. 1
MEDICARE AND MEDICAID
AMENDMENTS



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CONTENTS

Charts:	Page
1. Hospital insurance costs estimates consistently low.....	3
2. Estimates of daily hospital costs continually increased.....	5
3. Annual per capital hospital costs projections underestimated.....	7
4. Estimated daily hospital costs.....	9
5. Erroneous assumptions as to declining rates of increase in hospital costs.....	11
6. Medicare deficit, \$242 billion.....	13
7. Methods adopted in H.R. 1 to meet the hospital deficit.....	15
8. Actuarial deficit under present law and H.R. 1.....	17
9. Total vendor payments for Medicaid continue to climb.....	19
10. Mandatory Medicaid deductible for families with earnings— Case 1.....	21
11. Mandatory Medicaid deductible for families with earnings— Case 2.....	23
12. Mandatory Medicaid deductible for families with earnings— Case 3.....	25
13. Increased general revenues financing for social security.....	27
 Medicare and Medicaid amendments:	
Principal new Medicare, Medicaid provisions in H.R. 1.....	30
Medicare coverage for disabled beneficiaries.....	31
Hospital insurance for the uninsured.....	31
Part B premium charges.....	31
Increase in part B deductible.....	32
Increase in hospital copayment and lifetime reserve days.....	32
Automatic enrollment for part B.....	33
Incentives for States to undertake required institutional care review activities and to emphasize comprehensive health care under Medicaid.....	33
Cost sharing under Medicaid.....	34
Relationship between Medicare and Federal employees' benefits.....	34
Medicare benefits for border residents.....	35
Limitation on Federal payments for disapproved capital expenditure.....	35
Experiments in prospective reimbursement and peer review.....	36
Limitations on coverage of costs.....	36
Limitation on prevailing charge levels.....	37
Limits on Medicaid payments for skilled nursing home and intermediate care.....	37
Payments to health maintenance organization.....	37
Payment for physicians' services in the teaching setting.....	38
Advance approval of ECF and home health coverage.....	39
Termination of payment to suppliers of service.....	39
Mandatory Medicaid deductible for families with earnings.....	40
Elimination of requirement that States move toward comprehensive Medicaid program.....	41
Reductions in care and services under Medicaid program.....	41
Determination of reasonable hospital costs under Medicaid.....	42
Amount of payment where customary charges are less than reasonable costs.....	42
Institutional budget planning under Medicare program.....	42
Payments to States under Medicaid for installation and operation of claims processing and information retrieval systems.....	43
Prohibition against reassignment of claims to benefits.....	43
Utilization review requirements for hospitals and skilled nursing homes under Medicaid and maternal and child health programs.....	43
Notification of unnecessary hospital admission.....	44

	Page
Use of State health agency to perform certain notions under Medicaid.....	44
Relationship between Medicaid and comprehensive health programs.....	45
Program for determining qualifications for certain health care personnel.....	45
Penalties for fraudulent acts and false reporting under Medicare and Medicaid.....	45
Provider reimbursement review board.....	46
Physical therapy services and other services under Medicare.....	46
Coverage of supplies related to colostomies.....	47
Coverage of ptosis bars.....	47
Inclusion under Medicaid of care in intermediate care facilities.....	48
Prosthetic lenses furnished by optometrists under part B.....	48
Prohibition against requiring professional social workers in ECF's under Medicare.....	49
Waiver of requirement of registered professional nurse in rural skilled nursing homes under Medicaid.....	49
Licensure requirement for nursing home administrators.....	49
Increase in Medicaid matching to Puerto Rico.....	50
Study of chiropractic coverage.....	50
Major Senate amendments not included in H.R. 1:	
Establishment of professional standards review organizations.....	51
Inspector general for Medicare and Medicaid.....	51
Medicaid coverage of mentally ill children.....	52
Coverage of chiropractic services.....	52
Conform Medicare and Medicaid standards for nursing care facilities.....	52
Provide for simplified reimbursement of ECF's.....	53
Early diagnosis and screening for children.....	53
Consultants for extended care facilities.....	54
Public disclosure of information regarding deficiencies.....	54
HEW Medicaid assumptions and estimated Federal savings (section by section).....	55
Tables:	
1. Medicaid benefit cost estimates under current law and under H.R. 1.....	55
2. Estimated percent of increase in daily hospital costs over previous year.....	58
3. Social security general revenue costs.....	59
4. Total, Federal, and State Medicaid expenditures, fiscal year 1973, under current law and H.R. 1.....	60
Payments for public assistance vendor medical bills by type of service selected fiscal years 1957-69, chart.....	62

Charts

(1)

CHART ONE**Hospital Insurance Costs Estimates Consistently Low**

Hospital insurance cost estimates were made by the administration in 1965, 1967, 1969 and 1971. Except, of course, for the untested current estimate, each time the projected benefit costs were grossly understated. For example, as the chart opposite indicates, the 1965 estimates projected 1975 costs at \$4.3 billion; in 1967 the 1975 estimate was increased to \$5.8 billion; the estimated 1975 cost was again raised to \$7.6 billion in 1969. Currently, 1975 benefit costs are projected at \$11.5 billion. Even more dramatic than the changes in estimates for 1975 are those projected for the year 1990. The estimated costs for 1990 ascend upward from the original \$8.8 billion projected in 1965 to the current estimate of \$32.8 billion.

Hospital Insurance Benefit Estimates Have Risen Sharply in Six Years

(dollars in billions)

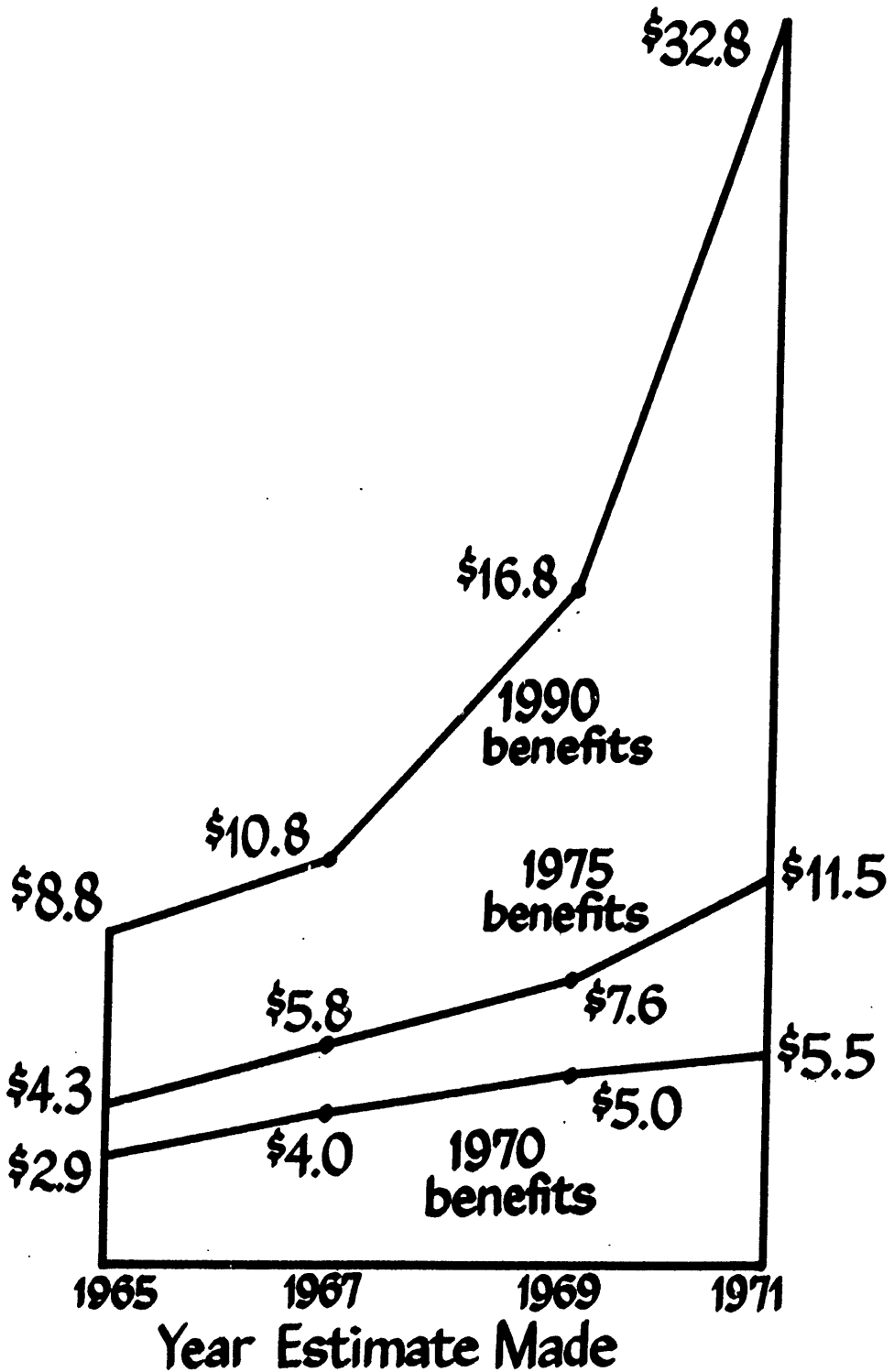


CHART TWO**Estimates of Daily Hospital Costs Continually Increased**

The actuaries preparing the various hospital costs estimates have assumed progressive increases in daily hospital costs over given periods of time—but the results of those assumptions as to projected daily hospital costs have consistently fallen far short of the mark. In 1965, daily hospital costs for the year 1975 were projected at \$62. That projection for 1975 was increased to \$73 in 1967 and \$81 in 1969. Currently, average daily hospital costs are estimated at \$110 for 1975.

Estimates of Average Daily Hospital Costs Have Continued to Rise

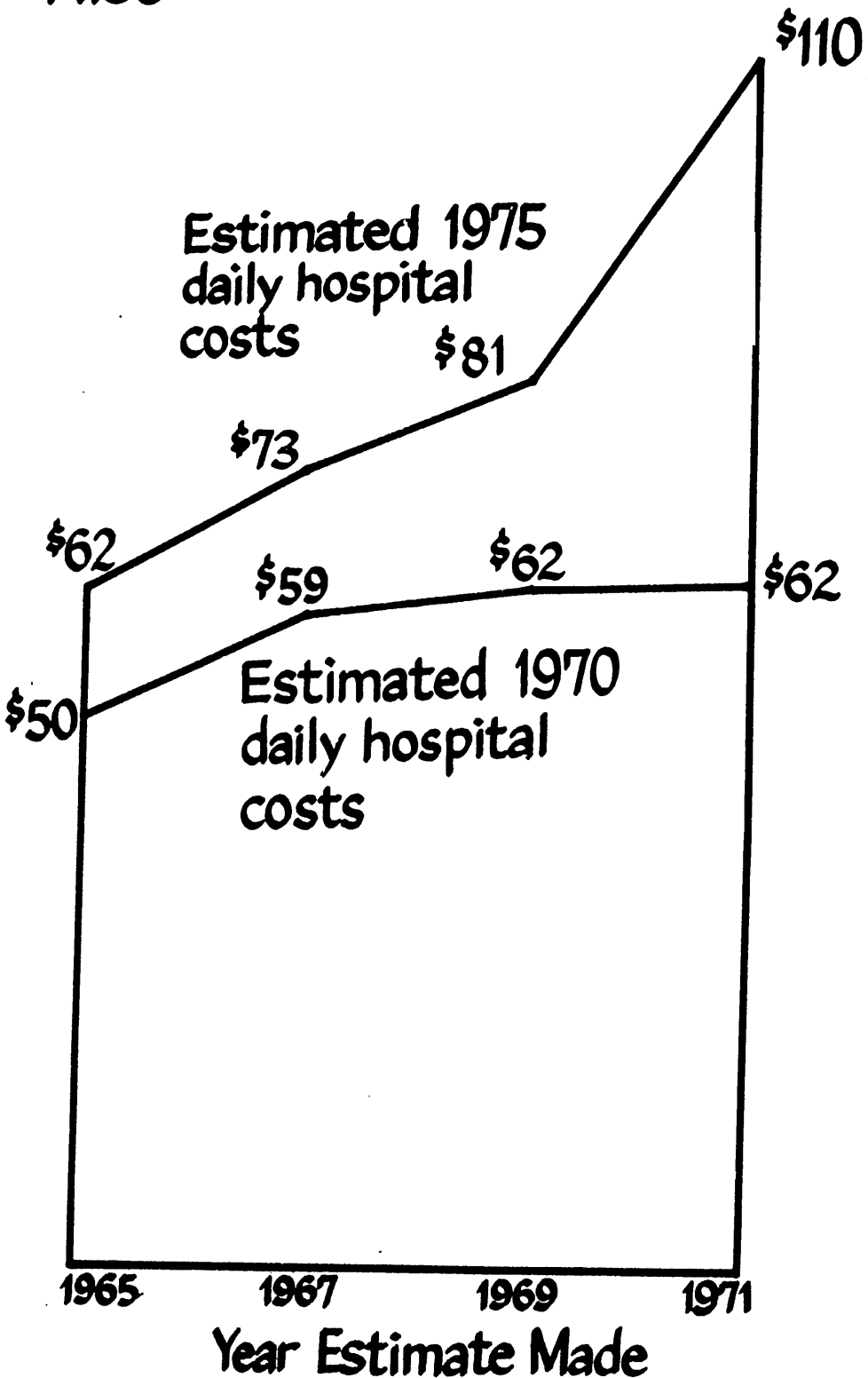


CHART THREE**Annual Per Capita Hospital Costs Projections Underestimated**

The previous charts indicating the total magnitude of the Medicare deficit can also be expressed in terms of individual beneficiaries. The initial Medicare estimate in 1965 projected annual hospital costs of \$196 per beneficiary in 1975. That 1975 estimated cost was increased to \$229 in 1967 and again raised in 1969 to \$307. Currently, 1975 average hospital costs per beneficiary are estimated at \$465.

Estimated Average Annual Hospital Cost per Beneficiary Has Continued to Rise

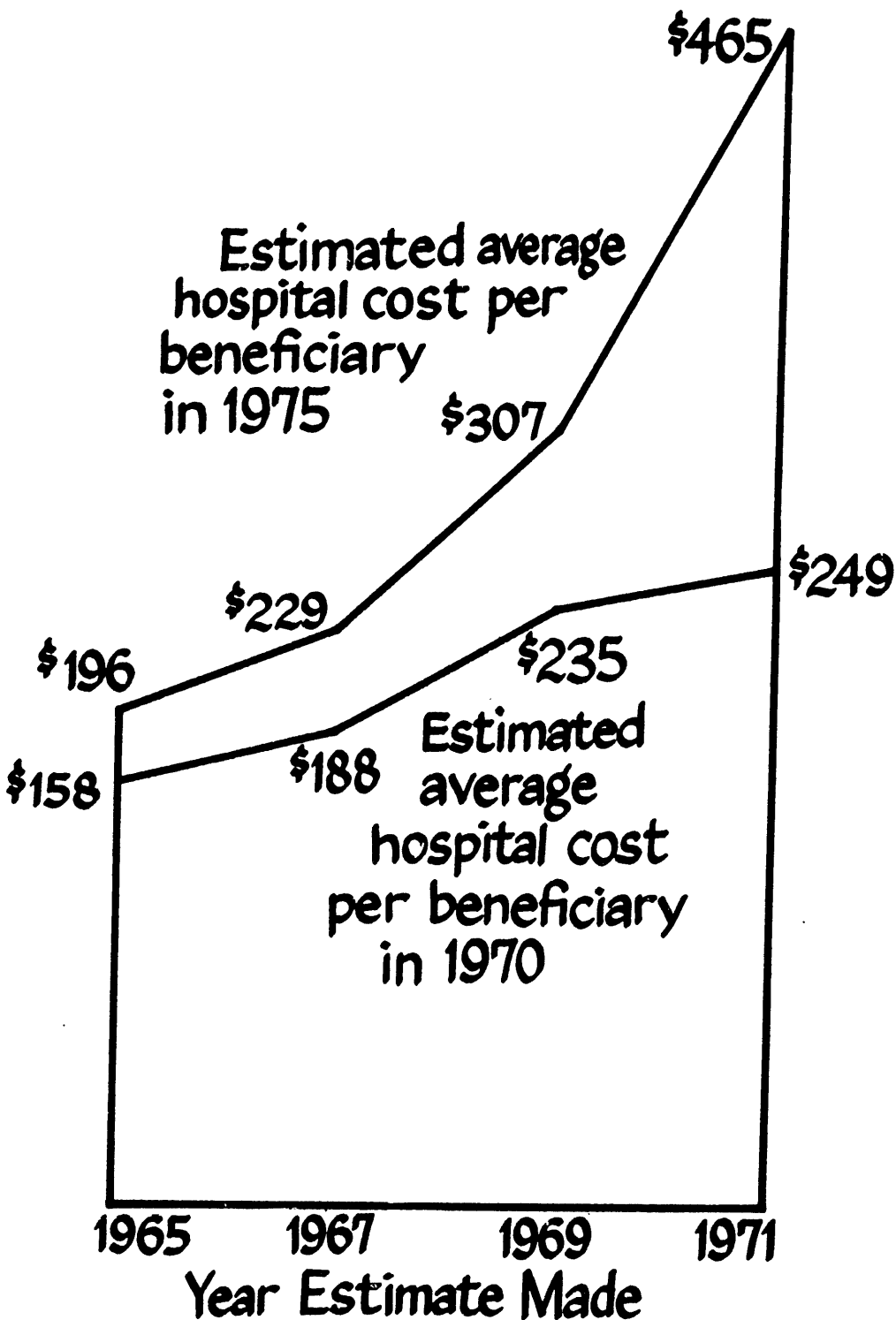


CHART FOUR**Estimated Daily Hospital Costs**

Projecting the daiiy increase in hospital costs on the basis of the actuarial assumptions in H.R. 1, the cost per hospital day will rise from \$62 in 1970 to \$162 in 1982.

Estimated Daily Hospital Rates, 1967 - 1982

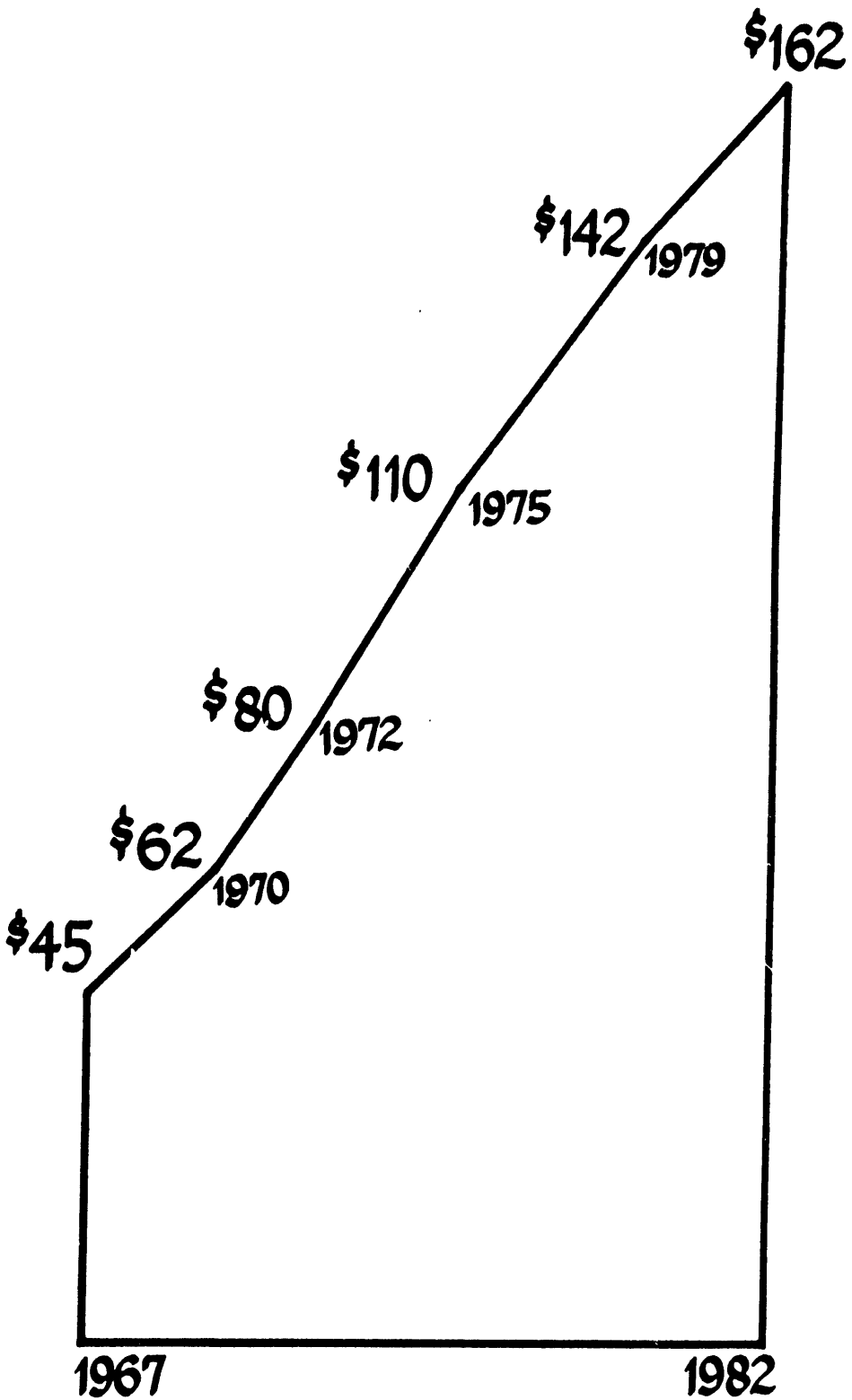


CHART FIVE**Erroneous Assumptions as to Declining Rates of Increase in Hospital Costs**

Each of the actuarial estimates prepared in 1965, 1967, and 1969 projected hospital costs increasing at fairly high rates for a few years and then tapering off to an ultimate rate of increase paralleling that of increases in wages. The key deficiency in the actuarial assumptions has been, of course, that hospital cost increases have not, in fact, tapered off, but rather have continued at high rates.

For example, for the year 1970, the 1965 estimate assumed an increase in daily hospital costs of 4.35%, in 1967 it was estimated that 1970 costs would rise by 6.0% and in 1969 the cost rise for 1970 was estimated to be 9.0%. In fact, 1970 costs rose by 14.0%.

Similar to the earlier assumptions, the current actuarial estimate for H.R. 1 assumes that 1970 was the peak year for hospital cost increases and that the rate of increase will decline subsequently. Thus, the current estimate projects a 13.5% increase in daily hospital costs in 1971 declining progressively to 9.5% in 1975 and to only 4.5% in 1980.

Estimates have assumed a declining rate of increase in hospital costs -- contrary to actual experience

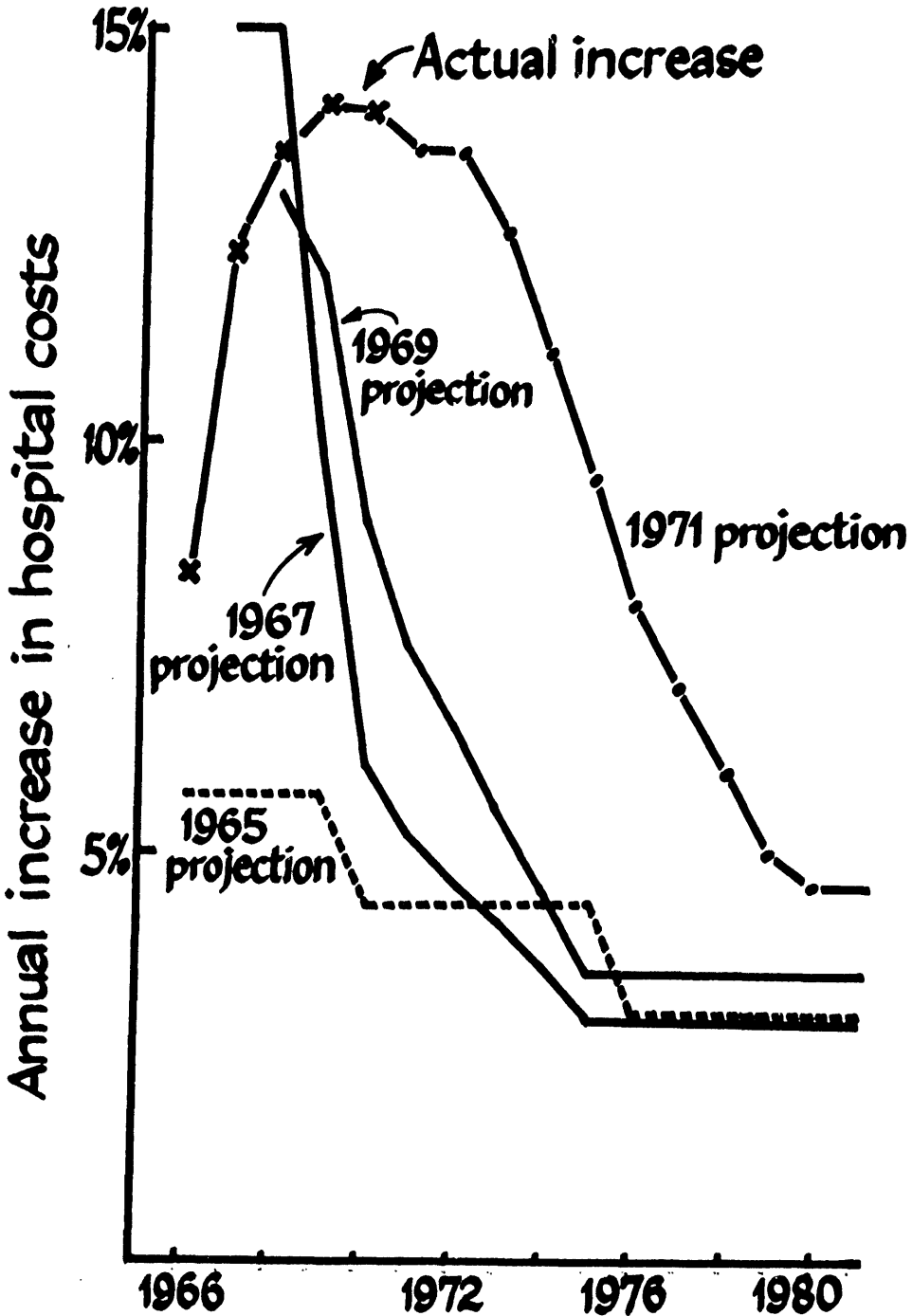


CHART SIX**Medicare Deficit—\$242 Billion**

Since Medicare's enactment in 1965 it has been necessary for Congress to increase the program's financing on two occasions. The 1967 Social Security Amendments provided for an increase in total Medicare taxes of approximately 25 percent achieved through increasing the scheduled tax rates and increasing the taxable wage base to \$7,800 from \$6,600. In early 1971, Medicare taxes were slightly increased when the taxable wage base for social security was raised to \$9,000 from \$7,800.

Despite these increases, Medicare with the financing provided by current law, is confronted with an enormous deficit over the next 25 years—amounting to \$242 billion. Included in the various financing aspects of H.R. 1 are tax increases for the hospital insurance program designed to generate the taxes necessary to meet the projected deficit. As may be noted from the chart the yearly deficit under present law increases from \$3.8 billion in 1975 to \$25.8 billion in 1995.

The Hospital Insurance Trust Fund
Has an Estimated 25-Year Deficit
of \$242 Billion Under Present Law
(dollars in billions)

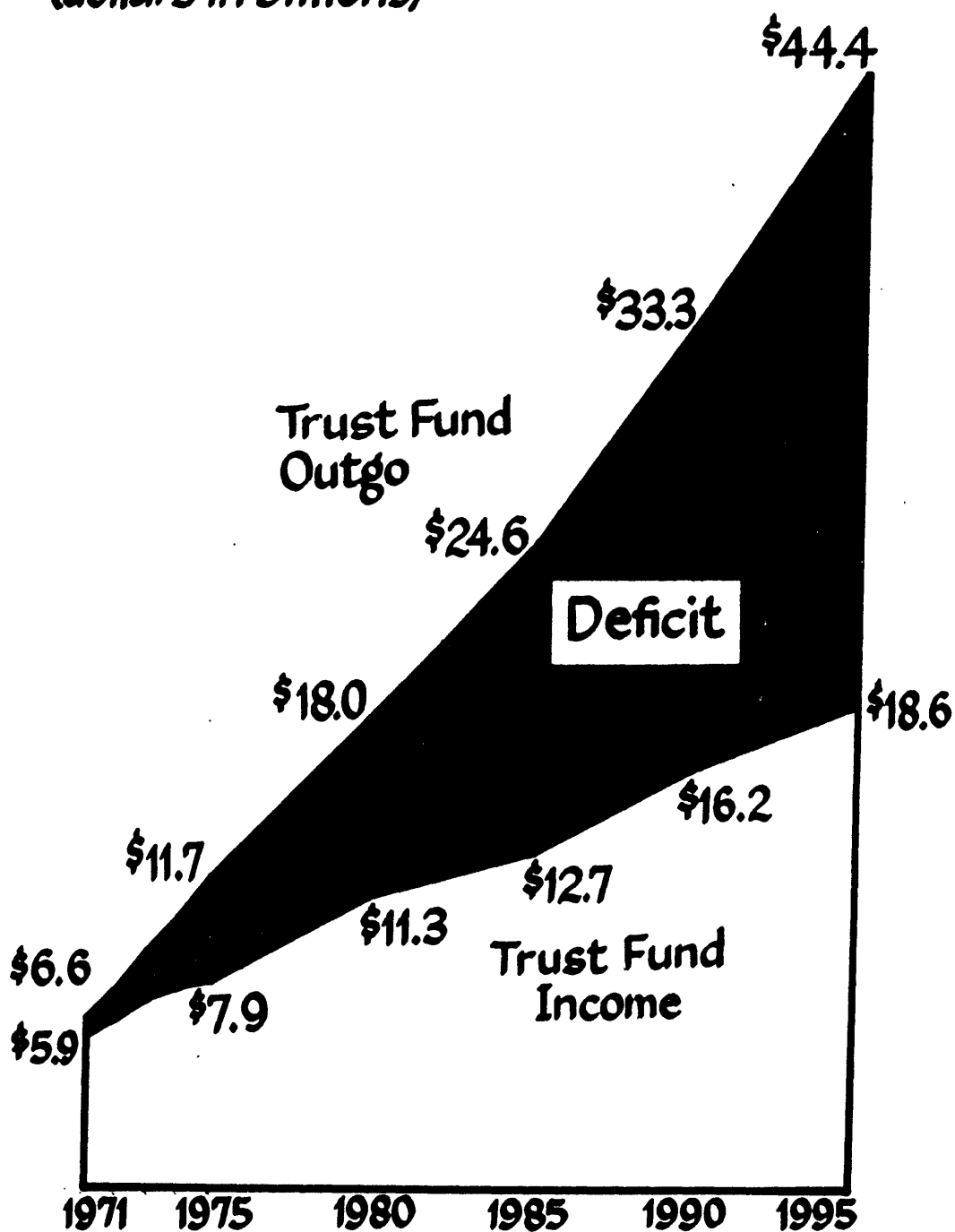


CHART SEVEN**Methods Adopted in H.R. 1 To Meet the Hospital Deficit**

In the past, Congress has deliberately chosen to place Medicare financing on a conservative basis. The approach consisted of assuming no increase in the taxable wage base over the period of the estimate but providing for progressively increasing tax rates on that fixed base sufficient to generate the income necessary to meet benefit costs.

H.R. 1 abandons the conservative approach by making the Medicare tax rates applicable to the same automatically increased wage base used for cash benefit purposes. Additionally, sharply increased tax rates—above the amounts necessary to finance coverage of the disabled—are also provided on the rising wage bases. For example, for 1972 the combined employer-employee rate would double from the schedule under present law—1.2% of taxable payroll to 2.4%. The percentage of increase in tax rates under H.R. 1 tails off somewhat in subsequent years so that in 1987 instead of the 1.8% combined rate as is presently authorized a rate of 2.6% would apply.

Methods of Meeting the \$242 Billion Hospital Insurance Deficit

- Abandon conservative assumption that wage base will remain constant, and
- Increase tax rates, beginning with a 100% increase in 1972

CHART EIGHT**Actuarial Deficit Under Present Law and H.R. 1**

Expressed as a percent of total taxable payroll, the hospital insurance deficit is estimated at 1.35% under present law. This is the negative result of estimated level costs of 2.89% of taxable payroll and estimated level contributions, on a \$9,000 wage base, of only 1.54% of taxable payroll.

Substantially less payroll is subject to taxation using the fixed \$9,000 wage base as opposed to the automatically increasing wage base taxable under H.R. 1. While the benefit costs remain the same in both cases, those costs are a smaller percentage of taxable payroll under H.R. 1 than under present law because of the higher amounts of earnings which would be taxable under H.R. 1. Thus, the 2.89% level cost of hospital insurance under present law is, in dollars, identical with the 2.20% level cost factor in H.R. 1.

Actuarial Status of Hospital Insurance Trust Fund

Present law -- \$9,000 wage base

Level cost of benefits and administrative expenses	-2.89%
--	--------

Level equivalent of contributions	+1.54%
-----------------------------------	--------

Actuarial deficit	-1.35%
(equal to \$242 billion over the next 25 years)	

H.R. 1 -- Automatically rising wage base

Level cost of benefits and administrative expenses	-2.20%
--	--------

Extension of Hospital Insurance to long-term disabled	-0.46%
---	--------

Subtotal	-2.66%
----------	--------

Level equivalent of contributions	+2.60%
-----------------------------------	--------

Actuarial deficit	-0.06%
(acceptably close balance)	

CHART NINE**Total Vendor Payments for Medicaid Continue To Climb**

The dollar increase in total Federal-State Medicaid expenditures was \$1.1 billion in FY 1971 over FY 1970 to a total of \$5.7 billion and a similar amount of increase—\$1.1 billion—is projected for fiscal 1972 to a total of \$6.8 billion. HEW projects that, under current law, total Medicaid expenditures will rise to \$16.6 billion in fiscal 1977 of which \$9.1 billion would consist of Federal funds. These Medicaid estimates do *not* include the costs of care in intermediate care facilities which are projected at \$700 million in Federal and State funds during fiscal 1972.

Vendor Payments for Medical Care Have Increased Fivefold Since Medicaid Was Enacted

(dollars in billions)

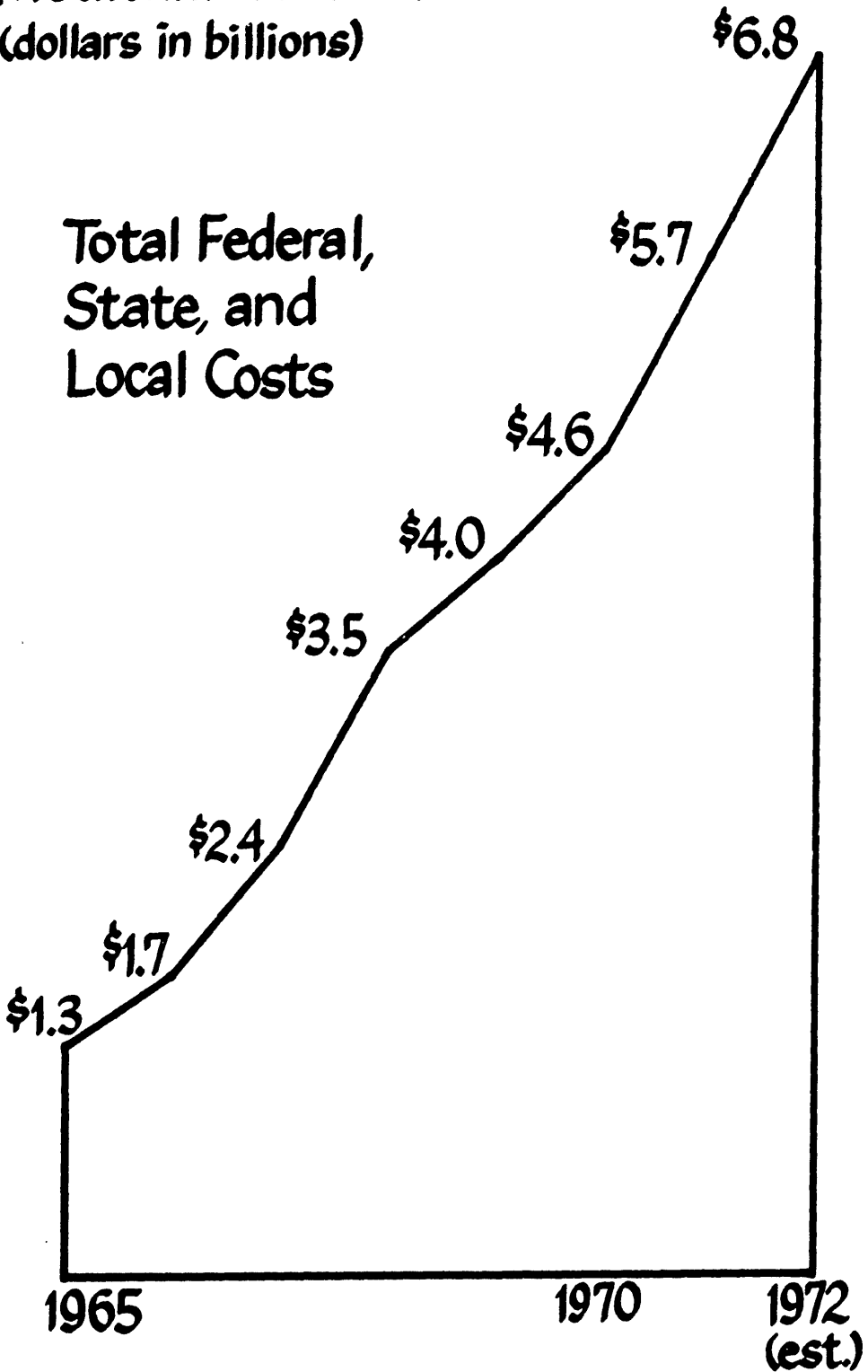


CHART TEN

**Mandatory Medicaid Deductible for Families With Earnings—
Case 1**

Section 209 was aimed at eliminating the "Medicaid Notch." This "notch" occurs because at a certain earnings point a family suddenly loses eligibility for Medicaid services.

Section 209 proposes to remove this "notch" by requiring AFDC recipients with earnings above \$720 (the amount allowed for work related expenses) to pay a medicaid deductible equivalent to one-third of their earnings. Thus rather than abruptly and totally losing Medicaid benefits, they would gradually be obligated to pay a higher deductible. In States with medical indigency levels above \$2,400 the Medicaid recipient would only have to pay a deductible in those cases where one-third of his earnings above \$720 was greater than the difference between the State Medical Indigency level and the State Cash Assistance level (see Case #2 and #3).

Section 209 results in elimination of the Medicaid "notch" but, at the same time, impairs the only work incentive under present law which permits recipients with earnings to keep one-third of their earnings above \$720. This portion of earned income which recipients are currently able to retain would, under Section 209, become the amount of the Medicaid deductible which the recipient would have to pay for necessary care before Medicaid benefits would be available.

In case #1 a family with earnings of \$1,320 would have a Medicaid deductible of \$200 (one-third of the earnings over \$720). As earned income rose to \$2,520, the Medicaid deductible would also rise to \$600. Thus, out of the increased earnings of \$1,200, \$800 would be deducted from the welfare payment and the other \$400 would become a Medicaid deductible.

Mandatory Medicaid Deductible for Families with Earnings

Case 1 -- State with \$2,400 cash
assistance level for family of 4;
no medically needy category

A) EARNINGS OF \$1,320

Countable earnings for welfare	\$400
Welfare payment	2,000
Countable income for Medicaid . . .	2,600
Medicaid deductible	200

B) EARNINGS OF \$2,520

Countable earnings for welfare . .	\$1,200
Welfare payment	1,200
Countable income for Medicaid . .	3,000
Medicaid deductible	600

SUMMARY:

Increase in earnings	+1,200
Reduction in welfare	-800
Increase in Medicaid deductible	-400
	<hr/>
Net gain	0

CHART ELEVEN**Mandatory Medicaid Deductible for Families With Earnings—
Case 2**

In case #2 the State has a medical indigency level which is \$800 above the cash assistance level. Thus a recipient's retained earnings above \$1,520 (\$720 plus \$800) would become the Medicaid deductible.

With earnings of \$3,420 the Medicaid deductible would be \$100. As earnings rose to \$4,320 the Medicaid deductible would rise to \$400.

Thus, of the increased earnings of \$900, \$600 would be deducted from the welfare payment and the other \$300 would become a Medicaid deductible.

Mandatory Medicaid Deductible for Families with Earnings

Case 2 -- State with \$2,400 cash assistance
level for family of 4; \$3,200 Medicaid
eligibility level

A) EARNINGS OF \$3,420

Countable earnings for welfare ...	\$1,800
Welfare payment	600
Countable income for Medicaid ...	3,300
Medicaid deductible	100

B) EARNINGS OF \$4,320

Countable earnings for welfare ...	\$2,400
Welfare payment	0
Countable income for Medicaid ...	3,600
Medicaid deductible	400

SUMMARY:

Increase in earnings	+900
Reduction in welfare	-600
Increase in Medicaid deductible	-300
	<hr/>
Net gain	0

CHART TWELVE**Mandatory Medicaid Deductible for Families With Earnings—
Case 3**

In case #3 the State has a medical indigency level which is \$1000 above the cash assistance level. In this case one-third of a recipient's earnings above \$1,720 (\$720 plus \$1,000) would become the Medicaid deductible.

With earnings of \$4,020 the Medicaid deductible would be \$100. As earnings rose to \$5,220 the Medicaid deductible would rise to \$500.

Out of the increased earning of \$1200, \$800 would be deducted from the welfare payment and the other \$400 would become a Medicaid deductible.

Mandatory Medicaid Deductible for Families with Earnings

Case 3-- State with \$3,000 cash assistance
level for family of 4; \$4,000 Medicaid eligibility level

A) EARNINGS OF \$4,020

Countable earnings for welfare	\$2,200
Welfare payment	800
Countable income for Medicaid	4,100
Medicaid deductible	100

B) EARNINGS OF \$5,220

Countable earnings for welfare	\$3,000
Welfare payment	0
Countable income for Medicaid	4,500
Medicaid deductible	500

SUMMARY:

Increase in earnings	+1,200
Reduction in welfare	- 800
Increase in Medicaid deductible	<u>-400</u>
Net gain	0

CHART THIRTEEN**Increased General Revenues Financing for Social Security**

Under present law, general revenues finance: the Federal Government's one-half share of the costs of Part B of Medicare; the cost of hospital insurance for persons ineligible for Social Security but who attained age 65 on or before December 31, 1967; the costs of monthly cash benefits for qualified individuals who attained age 72 on or before December 31, 1967, but who are ineligible for regular Social Security cash benefits; and the cost of gratuitous social security credits for certain military service.

The principal increase in general revenues expenditures authorized under H.R. 1 relates to payment for the disabled of that portion of the Part B premium cost above the normal amount resulting from their much greater use of medical services than the regular Medicare population.

Social Security General Fund Costs

(in millions of dollars)

	<u>FY 1973</u>	<u>FY 1977</u>
Present law	\$2,588	\$3,572
Increases or decreases under H. R. 1:		
Cash benefit programs	---	+115
Medical insurance coverage for long-term disabled	+400	+617
Increase in supplementary medical insurance deductible	-88	-103
Limitation on supplementary medical insurance premium	<u>+30</u>	<u>+130</u>
Subtotal, net increase	+342	+759
Total under H. R. 1	2,930	4,331

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Medicare and Medicaid Amendments

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Principal New Medicare-Medicaid Provisions in H.R. 1

- Coverage of disabled
- Future increases in Part B premium
- Change in Part B deductible
- Change in hospital coinsurance
- Contingent cutback in Medicaid matching
- Medicaid cost sharing
- Mandatory Medicaid deductible
- Limit on skilled nursing home payments
- Medicaid maintenance of effort

Medicare Coverage for Disabled Beneficiaries

Problem

The disabled, as a group, are similar to the elderly in those characteristics—low incomes and high medical expenses—which led Congress to provide health insurance for older people. They use about seven times as much hospital care, and about three times as much physicians' services as does the nondisabled population. In addition, disabled persons are often unable to obtain private health insurance coverage. Cost estimates for coverage of the disabled under Medicare were estimated, in 1970, at about \$2.8 billion for the first full year.

House Bill

Effective July 1, 1972, a social security disability beneficiary would be covered under Medicare after he had been entitled to disability benefits for not less than 24 consecutive months. Those covered would include disabled workers at any age; disabled widows and disabled dependent widowers between the ages of 50 and 65; beneficiaries age 18 or older who receive benefits because of disability prior to reaching age 22; and disabled qualified railroad retirement annuitants. An estimated 1.5 million disabled beneficiaries would be eligible initially. Estimated first full-year cost is \$1.5 billion for hospital insurance and \$350 million for supplementary medical coverage.

Recent Legislative History

Coverage of the disabled under Medicare was considered but not included in either the House or Senate versions of H.R. 17550 last year.

Hospital Insurance for the Uninsured

Problem

A substantial number of people reaching or presently over age 65 are ineligible for Social Security and thus cannot secure Part A (hospital insurance) coverage under Medicare. These people have difficulty in securing private health insurance coverage with benefits as extensive as those of Medicare.

House Bill

Permits persons age 65 or over who are ineligible for Part A of Medicare to voluntarily enroll for hospital insurance coverage by paying the full cost of coverage (initially estimated at \$31 monthly and to be recalculated annually). Where the Secretary of HEW finds it administratively feasible, those State and other public employee groups which have, in the past, voluntarily elected *not* to participate in the Social Security program could opt for and pay the Part A premium costs for their retired or active employees age 65 or over.

Recent Legislative History

Provision included in both the House and Senate passed versions of H.R. 17550. Senate version also required enrollment in Part B as condition of "buying" into Part A.

Part B Premium Charges

Problem

During the first 5 years of the program it has been necessary to increase the Part B premium almost 87 percent—from \$3.00 monthly

per person in July 1966 to a scheduled \$5.60 rate in July 1971. The government pays an equal amount from general revenues. This increase and projected future increases represent an increasingly significant financial burden to the aged living on incomes which are not increasing at a similar rate.

House Bill

Limits Part B premium increase to not more than the percentage by which the Social Security cash benefits had been generally increased since the last Part B premium adjustment. Costs above those met by such premium payments would be paid out of general revenues in addition to the regular general revenue matching. No cost estimate available.

Recent Legislative History

New provision.

Increase in Part B Deductible

Problem

The Medicare Part B program requires the beneficiary to pay the initial \$50 of covered expenses during a year plus at least 20% of the balance. With the increase in medical care costs, the \$50 deductible no longer bears the same relationship to total program costs or individual incomes as it did initially when Medicare became effective on July 1, 1966.

House Bill

Increases the Part B deductible to \$60 effective January 1, 1972.

Recent Legislative History

New provision.

Increase in Hospital Co-Payment and Lifetime Reserve Days

Problem

It is contended that prolonged hospitalization is sometimes unnecessary and is encouraged in Medicare through lack of sufficient financial barriers and deterrents. Medicare covers 90 days of hospitalization during a spell of illness, with the beneficiary being responsible for the first \$60 of a bill and, a co-payment amount of \$15 for each day from the 61st through 90th. Present law also provides each beneficiary with a non-renewable lifetime reserve of 60 days of in-patient coverage, subject to a co-payment of \$30 daily.

House Bill

Requires a daily co-payment by beneficiaries of \$7.50 from the 31st through 60th days of hospitalization (retaining the \$15 daily co-payment from the 61st through 90th days).

The number of lifetime reserve days would be increased from 60 to 120. The beneficiary would remain responsible for co-payment of \$30 for each lifetime reserve day.

The estimated increased costs of these changes generally offset the savings. Those costs and savings are estimated to total \$5,350 million respectively over the next 25 years.

Recent Legislative History

New provision.

Automatic Enrollment for Part B

Problem

Under present law, eligible individuals must initiate action to enroll in Part B of Medicare. Nearly 96 percent of eligible older people so enroll. Some eligibles, however, due to inattention or inability to manage their affairs, fail to enroll in timely fashion and lose several months or even years of necessary medical insurance coverage.

House Bill

Effective January 1, 1972, the House bill provides for automatic enrollment under Part B for the elderly and the disabled as they become eligible for Part A hospital insurance coverage. Persons eligible for automatic enrollment must also be fully informed as to the procedure and given an opportunity to decline the coverage.

Recent Legislative History

New provision.

Incentives for States To Undertake Required Institutional Care Review Activities and To Emphasize Comprehensive Health Care Under Medicaid

Problem

Both GAO and the HEW Audit Agency have found substantial unnecessary and overutilization of costly institutional care under Medicaid, accompanied by insufficient usage of less costly alternative out-of-institution health care.

House Bill

To discourage overutilization of institutional care, effective June 30, 1971, the House bill would provide for a one-third reduction in the Federal Medicaid matching share for stays in a fiscal year which exceed: 60 days in a general or TB hospital; 60 days in a skilled nursing home (unless the State can make a showing satisfactory to the Secretary that the State has an effective program of control over the utilization of nursing home care); 90 days in a mental hospital (except that an additional 30 days would be allowed if the State shows that the patient will benefit.) In addition, there would be no Federal matching for care in a mental hospital after 365 days of such care during a patient's lifetime.

The House bill would also provide for an increase of 25% (up to a maximum of 95%) in the Federal Medicaid matching formula for amounts paid by States under contracts with Health Maintenance Organizations or other comprehensive health care facilities.

Further, the bill would provide authority for the Secretary to assure that average Statewide reimbursement for intermediate care in a State is reasonably lower than average payments for higher-level skilled nursing home care in that State.

Recent Legislative History

A somewhat similar provision was included in the House version of H.R. 17550 last year. The major Senate modification to that provision, suspension of the reduction in nursing home matching if adequate utilization controls exist in a State, has been incorporated into H.R. 1 except that the State must now make an affirmative showing of proper

control rather than the Secretary making a negative finding of non-compliance. The 25 percent increase in Federal matching percentages for amounts paid to HMO's is a new feature of the provision, and replaces last year's 25 percent increase in Federal matching for all outpatient clinic and home health services. The 25 percent "bonus" was deleted from the House bill by the Finance Committee last year.

Cost Sharing Under Medicaid

Problem

Under present law, States may require payment by the medically indigent of deductibles and co-payment amounts with respect to Medicaid services provided them but such amounts must be "reasonably related to the recipient's income." States cannot require cash assistance recipients to pay any deductibles or co-payments.

House Bill

Requires States to impose on the medically-indigent premium enrollment fees graduated by income in accordance with standards prescribed by the Secretary. In addition, States could, at their option, require payment by the medically-indigent of deductibles and co-payment amounts which would not have to vary by level of income.

With respect to cash assistance recipients, nominal deductible and co-payment requirements, while prohibited for the six mandatory services (inpatient hospital services; outpatient hospital services; other x-ray and laboratory services; skilled nursing home services; physicians' services; and home health services) required under Federal law, would be permitted with respect to optional Medicaid services such as prescribed drugs, hearing aids, etc.

Recent Legislative History

New provision.

Relationship Between Medicare and Federal Employees' Benefits

Problem

Federal retirees and older employees have been required to take full coverage and pay full premiums for Federal employee coverage despite the fact that the Federal Employees' Programs *will not pay* any benefits for services covered under Medicare. Thus the retiree, who also has earned entitlement to Medicare, is paying a portion of his premium to F.E.P. for coverage for which no benefits will be paid him. This is particularly true in the case of hospitalization. The F.E.P. does not presently offer such employees or retirees with dual eligibility the option of electing a lower-cost policy which supplements rather than duplicates Medicare benefits.

House Bill

Effective January 1, 1975, Medicare would not pay a beneficiary, who is also a Federal retiree or employee, for services covered under his Federal Employee's health insurance policy which are also covered under Medicare unless he has had an option of selecting a policy *supplementing* Medicare benefits. If a supplemental policy is not made available, the F.E.P. would then have to pay first on any items of care which were covered under both the F.E.P. program and Medicare.

Further, the Government contribution toward the cost of the supplemental health policy must at least be equal to the amount it contributes for high-option coverage under the Government-wide Federal Employees Health Benefit Program. Thus, F. E. P. could not reduce the Government contribution even though the supplemental coverage cost less.

Recent Legislative History

Provision was in both the House and Senate approved versions of H.R. 17550 *except* the effective date has been changed from January 1, 1972 to January 1, 1975.

Medicare Benefits for Border Residents

Problem

At present, coverage for care in a foreign hospital near the U.S. border is available only where an emergency occurs *within* the United States and where the foreign institution is the closest adequate facility. This limitation creates difficulty in securing necessary non-emergency care by border residents who ordinarily do and would use the nearest hospital suited to their medical needs, which may be a foreign hospital.

House Bill

Authorizes use of a foreign hospital by a U.S. resident where such hospital was closer to his residence or more accessible than the nearest suitable United States hospital. Such hospitals must be approved under an appropriate hospital approval program.

In addition, the provision authorizes Part B payments for necessary physicians' services furnished in conjunction with such hospitalization.

Recent Legislative History

Identical to the Senate-passed version of H.R. 17550. The House has included the Senate modification which authorizes coverage of physicians' services furnished in conjunction with covered foreign hospitalization.

Limitation on Federal Payments for Disapproved Capital Expenditure

Problem

A hospital or nursing home can, under present law, make large capital expenditures which may have been disapproved by the State or local health care facilities planning council and still be reimbursed by Medicare and Medicaid for capital costs (depreciation, interest on debt, return on net equity) associated with that expenditure.

House bill

Prohibits reimbursement to providers under the Medicare and Medicaid programs for capital costs associated with expenditures of \$100,000 or more which are specifically determined to be inconsistent with State or local health facility plans.

Recent Legislative History

Identical with the House-passed version of H.R. 17550. The House did not include the Senate modification which would waive the provision with respect to construction included in formal plans for expansion or replacement toward which preliminary expenditures of \$100,000 or more had been made during the three-year period ended December

17, 1970 by a health care facility providing services as of December 18, 1970.

Experiments in Prospective Reimbursement and Peer Review

Problem

Reimbursement on the present reasonable costs basis contains little incentive to decrease costs or to improve efficiency, and retrospective cost-finding and auditing have caused lengthy delays and confusion. Payment determined on a prospective basis might provide an incentive to cut costs. However, under prospective payment providers might press for a rate less favorable to the Government than the present cost method, and they might cut back on the quality, range and frequency of necessary services so as to reduce costs and maximize return.

House Bill

Instructs the Secretary to experiment with various methods of prospective reimbursement, and to report to the Congress with an evaluation of such experiments by July 1, 1972. The provision further authorizes experiments with peer review mechanisms such as Professional Standards Review Organizations.

Recent Legislative History

Similar to both the House and Senate passed versions of H.R. 17550 except that the House *added* the authorization to experiment with peer review mechanisms and deleted the requirement that descriptions of all proposed experiments be sent to the Committees on Ways and Means and Finance.

Limitations on Coverage of Costs

Problem

Certain institutions may incur excessive costs, relative to comparable facilities in the same area, as a result of inefficiency or "the provision of amenities in plush surroundings." Such excessive costs are now reimbursed under Medicare.

House Bill

Authorizes Secretary to establish limits on overall direct or indirect costs which will be recognized as reasonable for comparable services in comparable facilities in an area. He may also establish maximum acceptable costs in such facilities with respect to items or groups of services (for example, food costs, or standby costs). The beneficiary is liable for any amounts determined as excessive (except that he may not be charged for excessive amounts in a facility in which his admitting physician has a direct or indirect ownership interest). The Secretary is required to give public notice as to those facilities where beneficiaries may be liable for payment of costs determined as not "necessary" to efficient patient care.

Recent Legislative History

Essentially the same as the House and Senate passed versions of H.R. 17550 except that the House *did not* include the Senate modification specifying that disallowed costs must be "grossly" in excess of reasonable costs.

Limitation on Prevailing Charge Levels

Problem

Under the present reasonable charge policy, Medicare pays in full any physician's charge that falls within the 75th percentile of customary charges in an area. However, there is no limit on how much physicians, in general, can increase their customary charges from year to year and thereby increase Medicare payments and costs.

House Bill

Recognizes as reasonable, for Medicare reimbursement purposes only, only those charges which fall within the 75th percentile. Starting in 1973, increases in physicians' fees allowable for Medicare purposes, would be limited by a factor which takes into account increased costs of practice and the increase in earnings levels in an area.

With respect to reasonable charges for medical supplies and equipment, the bill would provide for recognizing only the lowest charges at which supplies of similar quality are widely available.

Recent Legislative History

Similar to both the House and Senate passed versions of H.R. 17550, except that H.R. 1 does not include the Senate modification allowing recognition of the *lower* charges in an area, as opposed to the *lowest* charges, for supplies and equipment.

Limits on Medicaid Payments for Skilled Nursing Home and Intermediate Care

Problem

Payments for skilled nursing homes and ICF care have been increasing rapidly over the past years.

House Bill

Effective January 1, 1972, Federal financial participation in reimbursement for skilled nursing home and intermediate care per diem costs would not be available to the extent such costs exceed 105 percent of prior year levels of payment. In other words, a ceiling of 5 percent a year would be placed on nursing home and intermediate care payment increases in per diem costs for purposes of eligibility for Federal matching. The provision would except increased payment resulting from increases in the Federal minimum wage or other new Federal laws.

Recent Legislative History

New provision.

Payments to Health Maintenance Organization

Problem

Certain large medical care organizations (such as the Kaiser and San Joaquin Foundations) seem to deliver medical care more efficiently and economically than the medical care community at large, attributed in part to their operation on a prepaid basis at fixed amounts which may give them incentives to keep costs low and control utilization.

Medicare does not currently pay these comprehensive programs on a prepayment basis, and consequently the financial incentives to economical operation in such programs have not been available to Medicare.

House Bill

Authorizes Medicare to make a single combined Part A and B payment, prospectively, on a capitation basis, to a "Health Maintenance Organization," which would agree to provide care to a group not more than one-half of whom are Medicare beneficiaries who freely choose this arrangement. Such payments may not exceed 95 percent of present Part A and B per capita costs in a given geographic area.

The Secretary could make these arrangements with existing pre-paid groups and foundations, and with any new organization which meets the broadly defined term "Health Maintenance Organization."

Recent Legislative History

Provision is similar to the House and Senate passed versions of H.R. 17550 except that the House has not included a number of Senate modifications designed as safeguards against inappropriate reimbursement and substandard quality care. The omitted Senate conditions required HMO's to provide out-of-plan maintenance therapy; required HMO's to have a minimum size of 10,000 enrollees; authorized the Secretary to make retroactive adjustment of the 95% reimbursement level based upon actual actuarial experience; and limited dollar retention on premiums for the elderly to not more than 150 percent of the amount retained for persons under age 65.

Payment for Physicians' Services in the Teaching Setting*Problem*

Physicians in private practice are generally reimbursed on a fee-for-service basis for care provided to their bona fide private patients. Difficulties have arisen—including abuse and possible fraud—in determining how and whether payments should be made in teaching hospitals where the actual care is often rendered by interns and residents under the direction (sometimes nominal) of an attending physician who is assigned to (but not selected by) the Medicare patient.

The issue relates to the compensation of the attending physician often termed the supervisory or teaching physician. The salaries of interns and residents are now covered in full as a Part A hospital cost. In general, patients were not billed for the services of teaching physicians prior to Medicare and, since Medicare, billings have been essentially limited to Medicare and Medicaid patients. The proceeds are most frequently used to finance and subsidize medical education rather than being paid directly to the teaching doctor. While charges have often been billed on a basis comparable to those charged by a private physician to his private patients the services provided are often less.

House Bill.

Provides that services of teaching physicians would be reimbursed on a costs basis unless:

(A) The patient is bona fide private or;

(B) Since 1965 the hospital has charged all patients and collected from a majority on a fee-for-service basis.

For donated services of teaching physicians, a salary cost would be imputed equal to the prorated usual costs of full-time salaried

physicians, and the payment would be made to a special fund designated by the medical staff to be used for charitable or educational purposes.

Recent Legislative History

Provision identical to the Senate-passed provision in H.R. 17550. The House included all of the Senate changes verbatim.

Advance Approval of ECF and Home Health Coverage

Problem

Uncertainty about determinations of eligibility for care in an extended care facility or home health program following hospitalization have created major difficulties for intermediaries, institutions and beneficiaries. The essential problem is in determining whether the patient is in need of skilled nursing and medical services or in fact, needs a lesser level of care. Retroactive claims denials resulting from determinations that skilled care was not required, while often justified, have created substantial friction and ill will.

House Bill

Authorizes Secretary to establish by diagnosis minimum periods during which the post-hospital patient would be presumed to be eligible for benefits.

Recent Legislative History

Same as the House-passed version of H.R. 17550. The House did not accept the Senate modifications which would put more emphasis on obtaining approvals, in advance, of extended and home health care from appropriate review groups, and less emphasis on presumptive eligibility for a certain number of days of care by diagnosis. The Administration pointed out to the Finance Committee last year that it is difficult to determine usual length of stay for convalescent and rehabilitative care for patients who, in many cases, have more than one diagnosis.

Termination of Payment to Suppliers of Service

Problem

Present law does not provide authority for the Secretary to withhold future payments for services rendered by an institution or physician who abuse the program, although payments for past claims may be withheld on an individual basis where the services were not reasonable or necessary.

House Bill

The Secretary would be authorized to suspend or terminate Medicare payments to a provider found to have abused the program. Further, there would be no Federal participation in Medicaid payments which might be made subsequently to this provider. Program review teams would be established in each State to furnish the Secretary with professional advice in discharging this authority.

Recent Legislative History

Identical provision in both House and Senate passed versions of H.R. 17550.

Mandatory Medicaid Deductible for Families with Earnings

Problem

The "earnings disregard" provisions are intended as an incentive to employment by public assistance recipients. However, the consequent gradual loss of cash assistance as earned income increases can have a work disincentive effect at points in the earnings scale where the earning of an extra dollar can mean the phase-out of cash assistance and the loss of medicaid coverage.

Even in States which do cover the medically indigent a problem exists, since the maximum eligibility level for the medically needy (133 $\frac{1}{3}$ % of the payment level) is, in a number of States several thousand dollars below the income level where cash assistance phases out under the earnings disregard provision. Consequently, a family which has worked off of cash assistance and lost Medicaid coverage would have to spend down to the eligibility level for the medically needy to re-establish their eligibility for Medicaid.

House Bill

Provides complete Medicaid coverage to cash assistance families with children *only* if their income falls below the eligibility level established for medical assistance (in determining income for this purpose the first \$720 of earned income would be considered necessary for work related expenses and would be disregarded).

The medical assistance eligibility level would be defined by the State at, or in the range between the payment level for an eligible family without income, up to 133 $\frac{1}{3}$ % of that payment level.

Under the cash assistance program, the first \$720 of earnings plus one-third of the balance is disregarded in calculating payments.

To the extent that the one-third of earned income (disregarded for cash assistance purposes) plus the assistance payments exceed the Medicaid level established by the State, the family is required to "spend down"—dollar for dollar to the Medicaid level—before becoming eligible for Medicaid payments in their behalf.

Example: Family of four with cash assistance payment and Medicaid eligibility levels identical at \$2,400. Earned income of \$3,720.

Cash assistance calculation:

Total earnings.....	\$3, 720
Disregard.....	— 720
Balance.....	3, 000
$\frac{1}{3}$ disregard.....	— 1, 000
Countable earnings.....	2, 000
Assistance payment.....	400

Medicaid calculation:

Total earnings.....	3, 720
Disregard.....	— 720
Balance.....	3, 000
Assistance payment.....	400
Countable income.....	3, 400
Medicaid level.....	— 2, 400
Medicaid deductible.....	1, 000

States would continue to have the option of providing coverage to the medically needy aged, the blind, the disabled, foster children, AFDC families, and needy children under 21.

Recent Legislative History

New provision.

Elimination of Requirement That States Move Toward Comprehensive Medicaid Program

Problem

The Medicaid program has been a significant burden on State finances. Section 1903(e) of Title 19 requires each State to show that it is making efforts in the direction of broadening the scope of services in its Medicaid program and liberalizing eligibility requirements for medical assistance. These required expansions of Medicaid programs have been forcing many States to either cut back on other programs or to consider dropping Medicaid. The original date for attainment of those objectives was 1975. The Finance Committee, the Senate and the House approved an amendment in 1969 postponing the date to 1977.

House Bill

Repeals section 1903(e).

Recent Legislative History

Provision identical to both House and Senate passed versions of H.R. 17550.

Reductions in Care and Services Under Medicaid Program

Problem

The Medicaid program has been a significant burden on State finances. Section 1902(d) (Finance Committee amendment approved by Congress in 1969) of Title 19 provides that while a State may reduce the range and duration or frequency of services, it cannot reduce its aggregate expenditures for the State's share of Medicaid from one year to the next. This maintenance of effort requirement has forced a few States to either cut back on other programs or to consider dropping Medicaid.

House Bill

Provides for a continuance of the maintenance of effort clause with respect to the six mandatory health care services. The provision would, however, amend section 1902(d) by restricting the maintenance of effort requirement to those six basic services. The State would be able to modify the scope, extent and expenditures for optional services provided, such as drugs, dental care and eyeglasses.

Recent Legislative History

No provision in House-passed version of H.R. 17550.

The Senate version of H.R. 17550 repealed section 1902(d) entirely, and included a provision to waive the maintenance of effort requirement for Missouri retroactive to July 1, 1970.

Determination of Reasonable Hospital Costs Under Medicaid

Problem

Under present HEW regulations States are required to reimburse hospitals under Medicaid on the basis of the Medicare reasonable cost formula. Many States maintain that use of the Medicare formula for Medicaid reimbursement can result in their paying more than the actual costs of providing inpatient care to Medicaid recipients and hampers their efforts at controlling the costs of hospital care.

House Bill

Allows States to develop their own methods of hospital reimbursement. The method developed must cover actual reasonable costs but may not exceed the reasonable cost determined under Medicare.

Recent Legislative History

Similar to both the House and Senate passed versions of H.R. 17550, except that the House has deleted their previous condition which specifically stated that hospitals or private patients could not subsidize in any fashion the costs of inpatient care for title 19 recipients nor could payment for such recipients subsidize the costs of caring for other patients.

Amount of Payment Where Customary Charges Are Less Than Reasonable Costs

Problem

Under present law, Medicare reimbursement is based upon "reasonable costs." This results occasionally, in the program paying higher amounts for beneficiaries than the beneficiaries would be charged if they were not covered by Medicare, inasmuch as the customary charges in some institutions are lower than Medicare cost calculations.

House Bill

Provides that reimbursement for services under Medicaid and Medicare cannot exceed the lesser of reasonable costs determined under Medicare, or the customary charges to the general public. The provisions would not apply to services furnished by public providers free of charge or at a nominal fee. In such cases reimbursement would be based on those items included in the reasonable cost determination which would result in fair compensation.

Recent Legislative History

Identical provision in both the House and Senate passed versions of H.R. 17550.

Institutional Budget Planning Under Medicare Program

Problem

Under present law there is no requirement that providers of services develop fiscal plans, such as operating and capital budgets, generally regarded as sound business practices.

House Bill

To remedy those deficiencies in the management of some hospitals and extended care facilities, all providers would be required, as a condition of Medicare participation, to have a written overall plan

and budget reflecting an operating budget and a capital expenditures plan which would be updated at regular intervals.

The required annual operating budget would not have to be a detailed item budget.

Recent Legislative History

Identical to the provision in the Senate-passed version of H.R. 17550. The House has included the Senate modification which stipulated that the budgets need not be detailed item budgets.

Payments to States Under Medicaid for Installation and Operation of Claims Processing and Information Retrieval Systems

Problem

Many States do not have effective claims administration or properly designed information storage and retrieval systems for their Medicaid programs and do not possess the financial and technical resources to develop them.

House Bill

Authorizes 90 percent Federal matching payments toward the cost of designing, developing and installing mechanized claims processing and information retrieval systems deemed necessary by the Secretary. The Federal government would assist States with technical advice and development of model systems. Federal matching at 75 percent would be provided toward the costs of operating such systems.

Recent Legislative History

Similar to both the House and Senate-passed versions of H.R. 17550, except that the House has added a provision to provide 90% matching for 2 years (up to a total of \$150,000 annually) for the development of cost determination systems for State-owned general hospitals.

Prohibition Against Reassignment of Claims to Benefits

Problem

Medicare and Medicaid presently pay providers directly under assignment, but the law is silent with respect to reassignment of these payments. HEW has allowed reassignments to other organizations including discount and collection agencies. These reassignments have led to added administrative costs and inflated claims.

House Bill

Prohibits payment to anyone other than the physician or other person who provided the service, unless such person is required as a condition of his employment to turn his fees over to his employer.

Recent Legislative History

Identical to both the House and Senate passed versions of H.R. 17550.

Utilization Review Requirements for Hospitals and Skilled Nursing Homes Under Medicaid and Maternal and Child Health Programs

Problem

Inadequate and uncoordinated utilization review in Medicaid and the Maternal and Child Health Programs.

House Bill

Requires hospitals and skilled nursing homes participating in Titles 5 and 19 to use the same utilization review committees and procedures now required under Title 18 for those programs. This requirement is in addition to any other requirements now imposed by the Federal or State governments.

Recent Legislative History

Identical to both the House and Senate passed versions of H.R. 17550.

Notification of Unnecessary Hospital Admission*Problem*

Institutional utilization review committees must review all long-stay cases and a sample of all admissions. If, in the review of a long-stay case, further hospitalization is found unnecessary, the committee must promptly notify the physician and patient, and Medicare payments stop 3 days after such notifications. Under present law notification and a payment cut-off is not required where unnecessary hospitalization is determined during a sample review of admissions.

House Bill

Would require notification and a payment cut-off after 3 days, in those cases where unnecessary utilization is discovered during a sample review of admissions.

Recent Legislative History

Identical to both House and Senate passed versions of H. R. 17550.

Use of State Health Agency To Perform Certain Functions Under Medicaid*Problem*

Under present law, one State agency may certify health facilities for participation in Medicare, and another for participation in Medicaid, resulting in a duplication of effort.

Also, some State agencies lack the capability to perform Statewide utilization reviews of services provided under Medicaid.

House Bill

Requires that the same State health agency (or other appropriate State medical agency) certify facilities for participation under both Medicare and Medicaid.

Requires that Federal participation in Medicaid payments be contingent upon the State health agency establishing a plan for statewide review of appropriateness and quality of services rendered.

Recent Legislative History

Identical to the Senate-passed version of H.R. 17550. The House has included the Senate modification which provides for the use of the appropriate State medical agency (such as a State Department of Hospitals), rather than limiting the requirement to the State health agency.

Relationship Between Medicaid and Comprehensive Health Programs

Problem

State agencies often cannot make pre-payment arrangement which might result in more efficient and economical delivery of health services to Medicaid recipients because such arrangements might violate present Title 19 requirements that the same range and level of services be available to all recipients throughout the State.

House Bill

Permits States to waive Federal statewideness and comparability requirements with approval of the Secretary if a State contracts with an organization which has agreed to provide health services in excess of the State plan to eligible recipients who reside in the area served by the organization and who elect to receive services from such organization. Payment to such organizations could not be higher on a per-capita basis than the per-capita medicaid expenditures in the same general area.

Recent Legislative History

Provision was a Senate amendment to H.R. 17550.

Program for Determining Qualifications for Certain Health Care Personnel

Problem

There is a shortage of qualified manpower in the health care field and many facilities have difficulty hiring sufficient qualified personnel. At the same time there are persons available who do not meet full licensing or Medicare educational requirements, but who have had years of experience and have been granted "waivered" status (for example, waived licensed practical nurses).

House Bill

Requires the Secretary to develop and apply appropriate means of determining the proficiency of health personnel who are disqualified or restricted in responsibility under present regulations because of lack of formal training or educational requirements.

Senate

Similar to a Senate amendment to H.R. 17550 except that the Senate stipulated that after December 31, 1975, all health personnel initially licensed after that date would be expected to meet otherwise required formal training or educational criteria.

Penalties for Fraudulent Acts and False Reporting Under Medicare and Medicaid

Problem

Present penalty provisions applicable to Medicare do not specifically include as fraud such practices as kickbacks and bribes. There is no criminal penalty provision applicable to Medicaid. Additionally, there are no penalties at present for false reporting with respect to health and safety conditions in participating institutions.

House Bill

Establishes penalties for soliciting, offering or accepting bribes or kickbacks, or for concealing events affecting a person's rights to benefit with intent to defraud, and for converting benefit payments to improper use, of up to one year's imprisonment and a \$10,000 fine or both. Additionally, the bill establishes false reporting of a material fact as to conditions or operations of a health care facility as a misdemeanor subject to up to 6 months' imprisonment, a fine of \$2,000, or both.

Recent Legislative History

Similar to a Senate amendment to H.R. 17550. The House expanded the amendment to make concealing knowledge of events affecting a person's right to benefits with intent to defraud, and converting benefits to improper use a Federal crime.

Provider Reimbursement Review Board*Problem*

Under present law, there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination, although administrative procedures exist to assist providers and intermediaries to reach reasonable settlement on disputed items.

House Bill

Establishes a Provider Reimbursement Review Board to consider disputes between a provider and intermediary where the amount at issue is \$10,000 or more and where the provider has filed a timely cost report. Decisions of the Review Board would be final unless the Secretary reversed the Board's decision within 60 days. If such a reversal occurs the provider would have the right to obtain judicial review.

Recent Legislative History

Similar to a Senate Amendment to H.R. 17550. The House did not include those portions of the Senate amendment which would allow providers, as a group, to appeal aggregate amounts of \$10,000 on a common issue; and which would allow appeals to the Board by a provider where the intermediary fails to make timely final costs determinations.

Physical Therapy Services and Other Services Under Medicare*Problem*

Physical therapy is presently covered as an inpatient service, and as an outpatient service when furnished through a participating facility or home health agency. Services cannot be provided in a therapist's office, even though it may be more accessible to the beneficiary than the participating facility.

An additional problem relating to physical therapy is that a patient can exhaust his inpatient benefits and continue to receive payment for treatment *only* if the facility can arrange with another facility to furnish the therapy as an outpatient service.

A final problem is the rapidly increasing cost of physical therapy services and findings of abuse in institutions.

House Bill

Would include as covered services under Part B, physical therapy provided in the therapist's office under such licensing as the Secretary may require and pursuant to a physician's written plan of treatment.

Would authorize a hospital or extended care facility to provide outpatient physical therapy services to its inpatients, so that an inpatient could conveniently receive his Part B benefits after his inpatient benefits have expired.

Would control physical therapy costs by limiting total payments in one year for services by an independent practitioner in his office or the patient's home to \$100, and by limiting reimbursement for services provided by physical and other therapists in an institutional setting to a reasonable salary-related basis rather than fee-for-service basis.

Recent Legislative History

Similar to the House passed version of H.R. 17550 but including Senate modifications on reimbursement to other therapists and consultants. Last year, the Senate deleted the provision which established a separate benefit of up to \$100 of physical therapy services in the therapist's office or patient's home.

Coverage of Supplies Related to Colostomies*Problem*

Medicare covers the bags and straps used in conjunction with some colostomies (an artificial opening of the bowel to the abdominal wall which is often made necessary by surgery for cancer of the bowel). This equipment is covered as it is considered a prosthetic device (a replacement for a body organ). Some bowel cancer patients have surgery which results in a different type of colostomy necessitating daily irrigation and flushing rather than attachment of a bag. Medicare does not cover this equipment, which results in unequal treatment by the program of patients with colostomies.

House bill

Provides for Medicare coverage of supplies directly related to the care of a colostomy.

Recent Legislative History

Identical to Senate amendment to H.R. 17550.

Coverage of Ptosis Bars

Medicare covers such items as leg, arm, back and neck braces which are used to support weak body members. However, Medicare does not pay for ptosis bars which are used to support the drooping eyelids of patients suffering from paralysis of the muscles of the upper eyelids.

House Bill

Provides Medicare coverage for ptosis bars.

Recent Legislative History

New provision.

Inclusion Under Medicaid of Care in Intermediate Care Facilities

Problem

Intermediate care was intended, where appropriate, as a less-costly alternative to skilled nursing home and mental hospital care for those persons who would otherwise remain or be placed in skilled nursing homes or mental institutions. The independent professional audits intended to assure proper patient placement in an ICF and the independent medical audits of each patient in a skilled nursing home, required by law, are not being carried out in a substantial number of States. In a number of States substandard nursing homes have been reclassified as ICFs with wholesale paper transfer of patients. The original HEW regulations required that such institutions have at least one full-time licensed practical nurse on their staffs. Present regulations have removed that requirement and the ICF program is being construed by HEW as covering persons in need of residential care but who do not necessarily have a health-related condition requiring institutional care. Additionally, while the Intermediate Care benefit is closely related to effective and economical use of skilled nursing home and mental hospital care, the program is being administered by HEW cash assistance personnel instead of the medical assistance personnel.

House Bill

Transfers the ICF benefit from Title 11 to Title 19, thereby making the medically indigent eligible for such care. The bill would provide that the mentally retarded receiving active treatment in a public institution whose primary purpose is health and rehabilitative care, would be eligible for Medicaid matching. ICFs would be subject to the same independent professional audit requirements as skilled nursing homes.

Recent Legislative History

Similar to a Senate amendment to H.R. 17550. The House did not include the Senate modification which would require at least one full-time licensed practical nurse in an ICF.

Prosthetic Lenses Furnished by Optometrists Under Part B

Problem

Medicare will pay for prosthetic lenses furnished by an optometrist, provided that the medical necessity for such lenses has been determined by a physician.

Optometrists contend that to require their patients to obtain a physician's order for prosthetic lenses is unfair to both the patient and the optometrist. Moreover, because the physician who furnishes the order is generally an ophthalmologist, the requirement may serve to encourage patients to use an ophthalmologist in preference to an optometrist.

House Bill

Provides that, for the purposes of the medicare program, an optometrist be recognized as a "physician" under section 1861(r) of the Act, but only with respect to establishing the medical necessity of prosthetic lenses for medicare beneficiaries. An optometrist would not be recognized as a "physician" for any other purposes under

medicare and no additional services performed by optometrists would be covered by the proposal.

Recent Legislative History

Identical to Senate amendment to H.R. 17550.

Prohibition Against Requiring Professional Social Workers in ECFs Under Medicare

Problem

Present regulations specify that an extended care facility must have effective arrangements with a public or private agency to provide social service consultation. Many facilities have had difficulty obtaining such consultation, and where obtainable, the consultants have often been quite expensive.

House Bill

Specifies that the provision of medical social services not be required as a condition of participation for an extended care facility under Medicare.

Recent Legislative History

New provision.

Waiver of Requirement of Registered Professional Nurse in Rural Skilled Nursing Homes Under Medicaid

Problem

Present law requires that skilled nursing homes under Medicaid have at least one full-time registered professional nurse on their staff. Some rural facilities have had difficulty in meeting this requirement.

House Bill

Authorizes a waiver of the requirement for a full-time registered nurse in those cases where the nursing home is in a rural area and the facility is necessary to meet patient needs, and is making a goodfaith effort to comply with the requirement.

Recent Legislative History

New provision. The amendment is modeled after the "Yarborough" amendment of 1970 which authorized partial waiver of the "round-the-clock" registered nurse requirement under certain conditions in rural hospitals. However, in contrast with the provision for hospital waiver, the House amendment would completely waive the registered nurse requirement for rural nursing homes under specified conditions.

Licensure Requirement for Nursing Home Administrators

Problem

Present law requires administrators of skilled nursing home under Medicaid to be licensed by the States. Such licensure involves satisfactory completion of a licensure examination.

House Bill

Permits States to establish a permanent waiver from licensure requirements for those persons who served as nursing home administrators for the three-year period prior to the establishment of the State's licensing program.

Recent Legislative History

New provision.

Increase in Medicaid Matching to Puerto Rico*Problem*

There is presently a \$20 million ceiling on Medicaid matching for Puerto Rico. With the rise in health care costs this ceiling has severely limited Puerto Rico's program.

House Bill

Provides that the ceiling for Federal Medicaid matching for Puerto Rico be raised to \$30 million.

Recent Legislative History

Identical to Senate amendment to H.R. 17550.

Study of Chiropractic Coverage*Problem*

Substantial discussion and debate have occurred over the appropriateness and cost of covering chiropractic services under Medicare. Many citizens have urged the Congress to include such coverage.

House Bill

Requires the Secretary to conduct a study of chiropractic services in those States in which the services are presently covered under Medicaid, in order to determine whether and under what conditions chiropractic services should be covered under Part B of Medicare. The Secretary would be required to report to Congress within two years on the results of the studies and his findings and recommendations.

Recent Legislative History

Same as the House-passed version of H.R. 17550. The Senate included chiropractic coverage under Medicare.

MAJOR SENATE AMENDMENTS NOT INCLUDED IN H.R. 1

Establishment of Professional Standards Review Organizations
Inspector General for Medicare and Medicaid
Medicaid Coverage of Mentally Ill Children
Coverage of Chiropractic Services
Conform Medicare and Medicaid Standards for Nursing Facilities
Provide for Simplified Reimbursement of Extended Care Facilities
Early Diagnosis and Screening for Children under Medicaid
Consultants for Extended Care Facilities
Public Disclosure of Information Regarding an Institution's Deficiencies

Establishment of Professional Standards Review Organizations

Problem

There are substantial indications that a significant amount of health services paid for by Medicare and Medicaid are in excess of those which would be found to be medically necessary under appropriate professional standards. Furthermore, in some instances services provided are of unsatisfactory professional quality.

Senate Amendment

The Committee provided for the establishment of Professional Standards Review Organizations sponsored by organizations representing substantial numbers of practicing physicians (usually 300 or more) in local areas to assume responsibility for comprehensive and ongoing review of services covered under the Medicare and Medicaid programs. The purpose of the amendment is to assure proper utilization of care and services provided in Medicare and Medicaid utilizing a formal professional mechanism representing the broadest possible cross-section of physicians in an area. Appropriate safeguards are included so as to adequately provide for protection of the public interest and to prevent pro forma assumption and carrying out of the vitally important review activities in the two highly expensive programs. The amendment provides discretion for recognition of and use by the PSRO of effective utilization review committees in hospitals and medical organizations.

Inspector General for Medicare and Medicaid

Problem

There is, at present, no independent reviewing mechanism charged with specific responsibility for ongoing and continuing review of Medicare and Medicaid in terms of the efficiency and effectiveness of program operations and compliance with Congressional intent. While

HEW's Audit Agency and GAO have done some helpful work, there is a need for day-to-day monitoring conducted at a level which can promptly call the attention of the Secretary and the Congress to important problems and which has authority to remedy some of those problems in timely, effective and responsible fashion.

Senate Amendment

An Office of Inspector General for Health Administration would be established within the Department of Health, Education, and Welfare. The Inspector General would be appointed by the President, would report to the Secretary, and would be responsible for reviewing and auditing the Social Security health programs on a continuing and comprehensive basis to determine their efficiency, economy, and consonance with the Statute and Congressional intent.

Medicaid Coverage of Mentally Ill Children

Problem

Present law limits reimbursement under Medicaid for care of the mentally-ill in public institutions to those otherwise eligible individuals who are 65 years of age or older.

Senate Amendment

Authorized coverage of inpatient care in State and local mental institutions for Medicaid eligibles under age 21, provided that the care consisted of a program of active treatment, that it was provided in an accredited medical institution, and that the State maintained its own level of fiscal expenditures for care of the mentally ill under 21.

Coverage of Chiropractic Services

Problem

Chiropractors are not currently eligible to participate as physicians in the Medicare program.

Senate Amendment

The Committee amendment deleted the study of chiropractic services called for in H.R. 17550 and substituted a provision providing for the coverage under Medicare of services involving treatment by means of manual manipulation of the spine by a licensed chiropractor who met certain minimum standards established by the Secretary of Health, Education, and Welfare. The same limitations on chiropractic services applicable to Medicare would also pertain to States providing such care under Medicaid.

Conform Medicare and Medicaid Standards for Nursing Care Facilities

Problem

Although the extended care facility, as defined under Medicare in 1965, was an institution offering a different and more highly skilled level of care than the general nursing home, the differences between the two types of institutions were largely eliminated by the passage in 1967 of legislative standards for skilled nursing homes participating under Medicaid. While the emphasis of the care under the two programs may differ somewhat, patients under both programs require the availability of essentially the same types of services and are often in the same institution. Because of the substantial similarities in the services

required, the existence of separate requirements (which even now differ only slightly) and separate certification processes for determining institutional eligibility to participate, is both administratively cumbersome and unnecessarily expensive. The same facility is more often than not approved under both programs.

Senate Amendment

The Committee added to the House bill a provision which would require that health, safety, environmental, and staffing standards for extended care facilities be uniform under Medicare with those established for skilled nursing homes under Medicaid.

Provide for Simplified Reimbursement of ECF's

Problem

Under Medicare, reimbursement to extended care facilities is based on the reasonable costs incurred by the facility in providing covered services. While interim payments are made on the basis of projected costs, individual facilities must submit annual reports which identify costs incurred; after analysis, retroactive payment adjustments are made to reflect costs incurred, to the extent they are deemed reasonable.

Under Medicaid, States generally establish (in advance) per diem or similar rates payable for patients receiving skilled nursing home care. Such rates are ordinarily based on analyses of overall costs of providing such care to eligible recipients.

The reasonable cost reimbursement approach of the Medicare program has created several difficulties for extended care facilities. The detailed and expensive cost-finding requirements have proved extremely cumbersome, and the lack of advance knowledge of actual payments impedes effective budgeting and planning. Further, the extended care facility has no incentive to contain costs or control delivery of services since virtually all costs are reimbursable.

Under Medicaid, however, institutions know in advance how much income can be expected as well as the types of services which are expected to be furnished to their patients. The skilled nursing home has an economic incentive to contain costs and deliver its services economically and efficiently.

Senate Amendment

The Committee provision would authorize the Secretary of Health, Education, and Welfare to adopt (and adjust as specified), as reasonable-cost payments for extended care facilities in any State, the rates developed in that State under Medicaid for reimbursement of skilled nursing care, if the Secretary finds that they are based upon reasonable analyses of costs of care in comparable facilities.

Early Diagnosis and Screening for Children

Problem

Section 1905(a)(4)(B) requires all States to provide health screening programs for children under Medicaid.

HEW had delayed issuance of implementing regulations because of the great cost which full implementation and application of the screening requirement would entail for both the Federal and State governments.

Senate Amendment

The Committee provision would authorize the Secretary to establish orderly priorities in the implementation of the presently required health care screening for children programs, with initial priority being given to preschool children. This amendment would, in effect, provide statutory sanction for the policy adopted by HEW in regulations it published subsequent to inclusion of the amendment in H.R. 17550.

Consultants for Extended Care Facilities*Problem*

Medicare conditions of participation require extended care facilities to retain consultants in specialty areas such as medical records, dietary and social services. Reimbursement is made to each facility *only* for that portion of the costs of these services that represents services provided to Medicare patients.

In many parts of the country these consultants are in short supply. Consequently, the demand for their services is high and their services on a per diem basis are expensive. Many facilities have considerable difficulty in obtaining these experts and even more difficulty in paying for their services. This is particularly true where a large number of a facility's patients are on Medicaid and the facility receives a fixed per diem payment from the State for their care. Often, the State has provided similar consultative services for these Medicaid patients and no additional allowance is made for the outside consultants employed to meet the Medicare conditions of participation.

Senate Amendment

The Committee added to the House bill a provision to authorize State agencies to provide, with the approval of the Secretary, appropriate consultative services to those extended care facilities which request them in such specialty areas as maintenance of medical records and the formulation of policies governing the provision of dietary and social services. Medicare payment would be made directly to the State agency for the salary and related costs incurred in rendering these consultative services. The provision of such services by the State would satisfy the Medicare requirements relating to the use of consultants in the specialty areas.

Public Disclosure of Information Regarding Deficiencies*Problem*

Physicians and the public are currently unaware as to which hospitals and extended care facilities have deficiencies and which facilities fully meet the statutory and regulatory requirements. This operates to discourage the direction of physician, patient, and public concern toward deficient facilities, which might encourage them to upgrade the quality of care they provide to proper levels.

Senate Amendment

The Committee added to the House bill a provision under which the Secretary of Health, Education, and Welfare would be required to make reports of an institution's significant deficiencies (such as deficiencies in the areas of staffing, fire safety, and sanitation) a matter of public record readily and generally available at social security district offices if, after a reasonable lapse of time (not to exceed 90 days), such deficiencies were not corrected.

HEW MEDICAID ASSUMPTIONS AND ESTIMATED FEDERAL SAVINGS (SECTION BY SECTION)

TABLE 1.—Medicaid benefit cost estimates under current law and under H.R. 1, 1973-77¹

[In millions of dollars]

	1973	1974	1975	1976	1977
Total:					
Under current law.....	8,124	9,766	11,640	13,902	16,607
Under H.R. 1.....	6,393	7,659	9,161	10,950	13,104
Net savings under H.R. 1.....	1,731	2,107	2,485	2,952	3,503
Federal costs:					
Under current law.....	4,468	5,371	6,405	7,646	9,134
Under H.R. 1.....	3,554	4,255	5,083	6,065	7,259
Net savings under H.R. 1.....	914	1,116	1,322	1,581	1,875
State and local costs:					
Under current law.....	3,656	4,395	5,241	6,256	7,473
Under H.R. 1.....	2,839	3,404	4,078	4,885	5,845
Net savings under H.R. 1.....	817	991	1,163	1,371	1,628

¹ HEW estimates excluding costs of intermediate care and administrative costs.

The State by State estimates of the impact of H.R. 1, Title 11 on State and Federal costs have been based in large part on the estimates, prepared by the States in February 1971, of their anticipated expenditures in 1973, under current Medicaid law. These estimates of the impact of H.R. 1 differ somewhat from earlier projections, in that they reflect more recent forecasts by the States and recent substantial amendments to H.R. 1.

In estimating savings or increases in costs in any category it is assumed that they would be distributed to the individual States in much the same way as the States' anticipated expenditures in that category in 1972. For example, a State which expected to make ten percent of the Medicaid expenditures in hospitals is assumed to gain ten percent of the overall savings in hospitals. A more reliable estimate, beyond the limits of this study, would take account of the differences in State programs, Medicaid populations and local conditions of costs and resources.

Section 207—Incentives to Ambulatory Care

HMO's.—Fiscal 1972, +\$1 million; fiscal 1973, +\$2 million

The additional Federal costs resulting from the increased Federal matching for State contracts for HMO's would be offset by the savings resulting from using a more efficient and lower cost means of providing health care. States would benefit from their share of the savings resulting from HMO efficiency as well as from the increased Federal participation.

Hospitals.—Fiscal 1972, -\$14 million; fiscal 1973, -\$34 million

Savings to the Federal Government would result from the decreased Federal matching for general and tuberculosis hospitals and the concomitant incentive to the States to transfer patients to lower cos-

facilities. States would also benefit when such transfers could be made, since the average daily cost in skilled nursing homes is less than one-fourth that in hospitals. Furthermore these savings will increase markedly over time as nursing home per diem rates are subject to further limitations.

Fiscal 1972, —\$10 million; fiscal 1973, —\$88 million

The reduction in Federal matching for stays in mental hospitals beyond 90 days (and 365 days in a lifetime) would result in Federal savings and in State savings as patients in these mental institutions could be transferred to lower cost facilities.

Skilled Nursing Homes.—Fiscal 1972, —\$24 million; fiscal 1973, —\$55 million

If States fail to satisfy the certification and utilization review requirements with regard to nursing homes, then stays in nursing homes beyond 60 days would be subject to reduced Federal matching. On the other hand, if States introduce and maintain adequate U/R and certification methods, then patients who are not in need of nursing home services will be transferred to lower cost facilities or be discharged. It is assumed that the proportion of these transfers will increase over time.

Section 208—Cost Sharing

Premiums.—Fiscal 1972, —\$20 million; fiscal 1973, —\$43 million

Under this section, the Secretary will issue regulations establishing a schedule of premiums, to be paid by the medically needy, according to their income and resources. The total amount of these premiums would be equivalent to about six percent of the cost of this program in 1972 and about seven percent after that as the medically needy population increase in size. The income from the cost sharing by recipients would presumably be shared by both the Federal and State governments.

Nominal Copayments.—Fiscal 1972, —\$5 million; fiscal 1973, —\$10 million

States would have the option to introduce "nominal" copayments on the optional services received by cash assistance recipients. It is assumed that States would introduce such charges only in those programs with obvious over-utilization problems; the total savings would be very small.

Copayments for the Medically Needy.—Fiscal 1972, —\$95 million; fiscal 1973, —\$219 million

Following the removal of restrictions on cost sharing within the medically needy programs, it is assumed that many States would introduce copayments on many services for this group. Medicaid expenditures for the medically needy would therefore be reduced by one-fifth as a result both of the cost-sharing by the recipients and of the reduction in utilization of medical services by this group.

Section 209—Medicaid Notch

Fiscal 1973, —\$70 million

The proposed solution to the Medicaid notch would require recipients with earnings above \$720 (the amount allowed for work-related expenses), to pay a portion of their earnings for medical care.

The estimate was prepared on the assumption that States without current programs for the medically needy would set the eligibility level at their current payment standard or \$2400, whichever was higher; and States with a current program for the medically needy would maintain the Medicaid eligibility level at the current medically needy standard. If States instead choose to adopt lower Medicaid eligibility levels, more families would be required to contribute to their own medical care, and title XIX savings would increase.

The estimate is based on data from the 1969 AFDC Study conducted by the National Center for Social Statistics, SRS, which indicates a total of 13.7 percent of AFDC families have earned income; approximately 10.8 percent have income in excess of \$720 per year. [NCSS Report AFDC-4 (69), Part II, Table 62]. Estimates are based on a projected AFDC-related population. It is assumed that the savings as a result of this section will increase over time with the increase in the number of recipients, who have to spend-down to receive medical assistance, and the increases in their deductibles.

For the purposes of estimating the savings to each of the States, it has been assumed that the distribution of their savings would parallel the distribution of medical vendor payments for AFDC cash assistance recipients. A more sophisticated estimate, beyond the limits of these data, would have to take into account the State payment levels, and the distribution of income in that State, and the proportion of the cash assistance recipients who have earnings.

Section 225—Ceilings on Nursing Home Per Diem

Fiscal 1972, —\$10 million; fiscal 1973, —\$21 million

This section would restrict Federal participation in the States costs of skilled nursing homes and intermediate care facilities to no more than a five percent increase in per diem charges over the previous year (plus any increases mandated by law, such as changes in minimum wage laws). Savings would be derived from the differences in projected costs and the legislative limits. These savings would increase over time with increases in Medicaid nursing home population and utilization.

Section 231—Maintenance of Mandated Services

Fiscal 1972, —\$157 million; fiscal 1973, —\$376 million

The current fiscal crises in many States and the competing demands on limited funds for many social welfare programs have created pressure to reduce some of the restrictions on "maintenance of effort" in the Medicaid program. Section 231 establishes that reductions may take place in the optional services. For the purposes of this estimate, it is assumed that States will reduce their optional services by as much as one-half. Savings will, accordingly, increase over time with increases in population and medical care prices.

Section 235—Management Information Systems

Fiscal 1972, +\$5 million; fiscal 1973, +\$10 million

Ninety percent Federal matching will be available for the development and installation of automated management information systems which fulfill certain specifications. Seventy-five percent matching will be available for their operation. It is assumed that the immediate cost to the Federal Government of this increased matching will result in savings to the States. In the long run, these systems should result in

greater efficiency of operation, more rapid and reliable compliance with regulations, and therefore far greater savings to both the States and the Federal Government. The latter "efficiency" savings have not been taken into account in these estimates.

Section 270—Increase of Limits to Puerto Rico

Fiscal 1972, +\$10 million; fiscal 1973, +\$10 million

The changes in the limitations on the Federal participation in Puerto Rico's Medicaid program would result in an increased cost to the Federal Government of \$10 million and a parallel saving to the Commonwealth.

TABLE 2.—Estimated percent of increase in daily hospital costs over previous year¹

Year.....	Year of estimate (percent)—				Actual Increase
	1965	1967	1969	1971	
1966.....	5.7				8.3
1967.....	5.7	15.0			12.3
1968.....	5.7	15.0	13.0		13.5
1969.....	5.7	10.0	12.0		14.1
1970.....	4.35	6.0	9.0	14.0	14.0
1971.....	4.35	5.2	7.5	13.5	
1972.....	4.35	4.6	6.5	13.5	
1973.....	4.35	4.1	5.5	12.5	
1974.....	4.35	3.6	4.5	11.0	
1975.....	4.35	3.0	3.5	9.5	
1976.....	3.0	3.0	3.5	8.0	
1977.....	3.0	3.0	3.5	7.0	
1978.....	3.0	3.0	3.5	6.0	
1979.....	3.0	3.0	3.5	5.0	
1980.....	3.0	3.9	3.5	4.5	

¹ HEW estimates.

TABLE 3.—SOCIAL SECURITY GENERAL REVENUE COSTS

[In millions of dollars]

	Fiscal year—				
	1973	1974	1975	1976	1977
Present law:					
Military service credits (cash benefit programs).....	\$189	\$191	\$192	\$194	\$196
Special payments to certain persons age 72 and over.....	335	293	243	204	167
Hospital insurance for uninsured beneficiaries.....	658	676	681	682	676
Military service credits (hospital insurance program).....	48	48	48	48	48
General fund share of supplementary medical insurance premium.....	1,358	1,681	1,881	2,061	2,485
Subtotal, present law.....	2,588	2,889	3,045	3,189	3,572
Increases under H.R. 1:					
Military service credits (cash benefit programs).....				14	89
Special payments to certain persons age 72 and over.....			27	24	26
Medical insurance coverage for long-term disabled.....	400	458	500	558	617
Increase in supplementary medical insurance deductible....	-88	-91	-95	-99	-103
Limitation on supplementary medical insurance premium rate.....	30	60	90	110	130
Subtotal, increases.....	342	427	522	607	759
Total under H.R.1.....	2,930	3,316	3,567	3,796	4,331

TABLE 4.—Total, Federal, and State medicaid expenditures, fiscal year 1973, under current law and H.R. 1

[In millions of dollars]

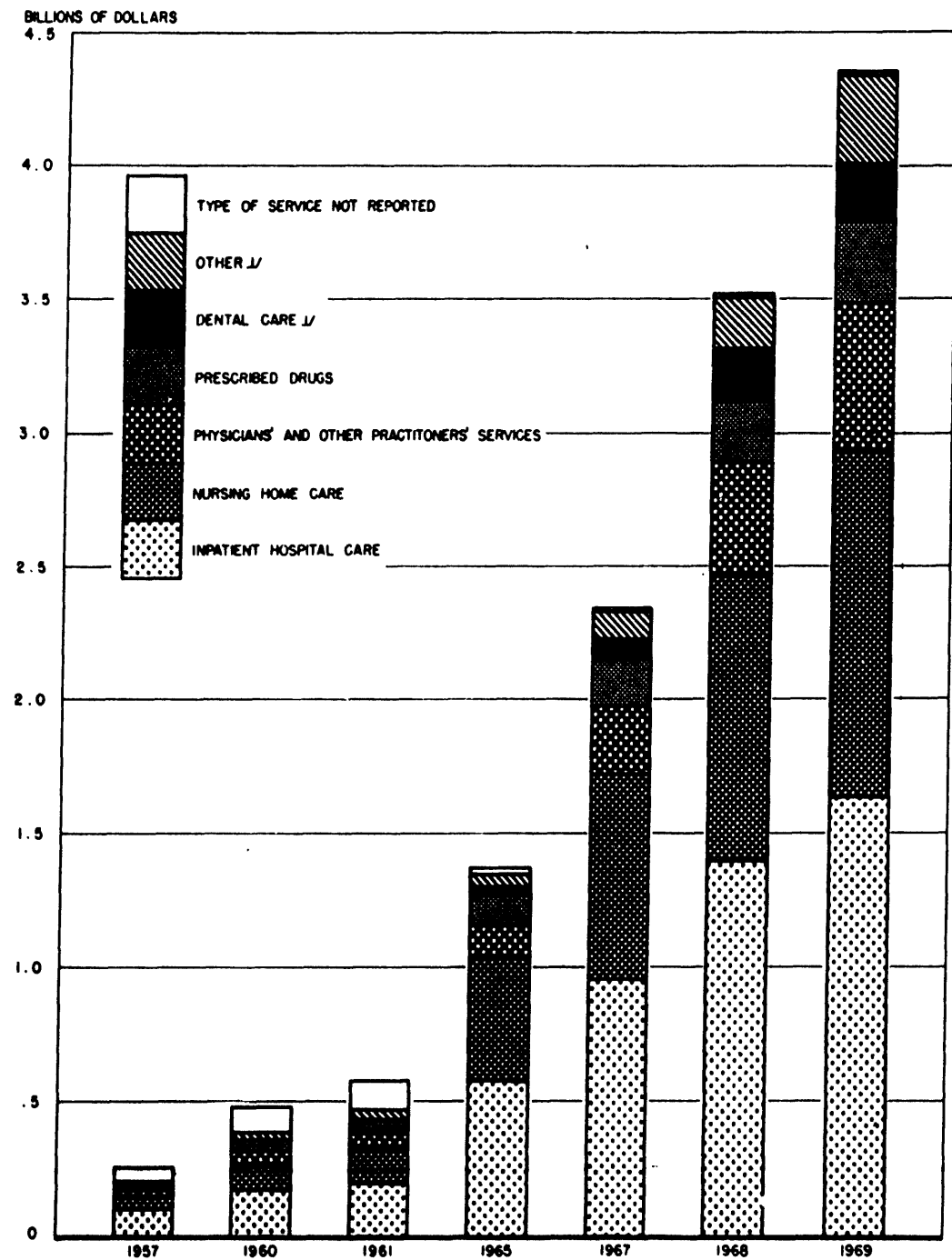
State	Total public expenditures			Federal share			State share		
	Current law	Savings under H.R. 1	Expenditures under H.R. 1	Current law	Savings under H.R. 1	Expenditures under H.R. 1	Current law	Savings under H.R. 1	Expenditures under H.R. 1
United States.....	8,124	1,731	6,393	4,468	914.0	3,554	3,656	817.0	2,839
Alabama.....	138	27	111	108	14.0	94	30	13.0	17
Alaska ¹									
Arizona ¹									
Arkansas.....	16	3	13	13	2.0	11	3	2.0	2
California.....	1,511	210	1,301	755	110.0	645	755	100.0	656
Colorado.....	73	11	62	42	6.0	36	31	5.0	25
Connecticut.....	138	34	104	69	18.0	51	69	16.0	53
Delaware.....	8	2	6	4	1.8	3	4	1.0	3
District of Columbia.....	49	17	32	24	9.0	16	24	8.0	17
Florida.....	146	30	117	89	16.0	74	57	14.0	43
Georgia.....	203	23	180	142	12.0	130	61	10.0	49
Hawaii.....	32	5	27	17	3.0	14	16	2.0	13
Idaho.....	16	1	15	12	.5	11	5	1.0	4
Illinois.....	317	83	233	158	45.0	113	158	38.0	120
Indiana.....	81	20	61	45	11.0	34	37	10.0	27
Iowa.....	49	13	36	28	7.0	21	20	6.0	14
Kansas.....	57	16	41	34	8.0	25	23	8.0	16
Kentucky.....	97	30	68	71	16.0	55	26	14.0	12
Louisiana.....	81	14	67	59	7.0	52	22	7.0	15
Maine.....	41	6	35	28	3.0	25	13	3.0	10
Maryland.....	122	41	81	61	22.0	39	61	19.0	42
Massachusetts.....	382	131	251	191	70.0	121	191	61.0	130
Michigan.....	349	60	289	175	32.0	142	175	28.0	146
Minnesota.....	130	43	87	74	23.0	51	56	20.0	36

Mississippi.....	57	11	45	47	6.0	41	10	5.0	4
Missouri.....	81	15	66	49	8.0	41	37	7.0	25
Montana.....	16	3	13	11	1.0	9	5	1.0	4
Nebraska.....	24	9	15	14	5.0	9	10	4.0	6
Nevada.....	8	1	7	4	1.0	3	4	1.0	3
New Hampshire.....	16	4	12	10	2.0	7	7	2.0	5
New Jersey.....	244	48	195	122	26.0	96	122	22.0	100
New Mexico.....	24	5	20	18	2.0	15	7	2.0	4
New York.....	1,722	411	1,311	861	222.0	639	861	189.0	672
North Carolina.....	130	39	91	95	21.0	74	35	18.0	17
North Dakota.....	16	6	11	12	3.0	9	5	3.0	2
Ohio.....	162	31	131	88	16.0	71	75	15.0	60
Oklahoma.....	122	17	105	84	9.0	75	38	8.0	30
Oregon.....	32	5	27	19	3.0	16	14	2.0	12
Pennsylvania.....	463	121	342	255	65.0	189	208	56.0	152
Puerto Rico.....	81	38	43	41	10.0	30	41	28.0	13
Rhode Island.....	57	14	43	28	8.0	21	28	7.0	22
South Carolina.....	49	8	41	38	4.0	34	11	4.0	7
South Dakota.....	16	1	15	11	0.4	11	5	0.4	4
Tennessee.....	49	10	38	37	5.0	31	12	5.0	7
Texas.....	203	12	191	137	6.0	126	71	6.0	65
Utah.....	24	6	18	17	3.0	14	7	3.0	4
Vermont.....	24	4	21	16	2.0	14	9	2.0	7
Virgin Islands.....	2	.....	2	1	.....	1	1	.....	1
Virginia.....	97	25	72	62	13.0	49	35	12.0	23
Washington.....	138	22	116	69	12.0	57	69	11.0	59
West Virginia.....	24	5	20	19	2.0	16	6	2.0	3
Wisconsin.....	219	40	180	123	22.0	101	97	18.0	79
Wyoming.....	2	.....	2	1	.....	1	1	.....	1

¹ No Medicaid program.

CHART A

PAYMENTS FOR PUBLIC ASSISTANCE VENDOR MEDICAL BILLS BY
TYPE OF SERVICE, SELECTED FISCAL YEARS 1957-1969



✓ FOR FISCAL YEARS 1957, 1960, AND 1961 "DENTAL CARE" INCLUDED IN "OTHER".