STUDY OF THE OPERATION OF THE PROGRAM FOR STATE AID TO MEDICALLY INDIGENT

Bulletin No. 87-20

LEGISLATIVE COMMISSION

OF THE

LEGISLATIVE COUNSEL BUREAU

STATE OF NEVADA

August 1986

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STATE OF NEVADA

AUGUST 1986

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Senate Concurrent Resolution No. 34— Senators Townsend, Glover, Mello, Neal, O'Connell, Raggio, Rawson, Ryan, Shaffer, Vergiels and Wagner

FILE NUMBER....120

SENATE CONCURRENT RESOLUTION—Directing the legislative commission to study the operation of the state's program of aid to the medically indigent.

WHEREAS, The continuing increase in the cost of medical services and treatment is a source of great concern to the citizens of Nevada; and

WHEREAS, This increase has a direct and adverse effect on the state's program of aid to the medically indigent; and

WHEREAS, A complete review of the operation of the state's program should be made to identify possible improvements in the program and the need for further legislation; now, therefore, be it

RESOLVED BY THE SENATE OF THE STATE OF NEVADA, THE ASSEMBLY CONCURRING, That the legislative commission is hereby directed to study the operation of the state's program of aid to the medically indigent to identify possible improvements in the operation of the program; and be it further

RESOLVED, That the results of the study and any recommendations for legislation be reported to the 64th session of the legislature.

19 85

REPORT OF THE LEGISLATIVE COMMISSION
TO THE MEMBERS OF THE 64TH SESSION OF THE NEVADA LEGISLATURE:

This report is being submitted in compliance with Senate Concurrent Resolution No. 34 of the 63rd session of the Nevada legislature which directed the legislative commission to study the operation of the state's program of aid to the medically indigent.

In order to conduct the study the legislative commission, under the auspices of the Joint Committee on Human Resources, appointed a subcommittee to recommend appropriate action to the 1987 session of the legislature. Legislative members of the subcommittee were:

Senator Randolph J. Townsend, Chairman
Assemblyman James J. Banner, Vice Chairman
Senator Ann O'Connell
Assemblyman Eugene Collins
Assemblyman Bill R. O'Donnell

The subcommittee held three meetings and received considerable testimony concerning the status and limitation of the state Medicaid program (Title XIX). The committee also received testimony from county officials and the Nevada Association of Counties (NACO) concerning the financial problems faced by the counties in providing needed medical services to Nevada's indigent population.

The subcommittee reviewed a great deal of information and has attempted in this report to present its findings and recommendations briefly and concisely. All supporting documents and minutes are on file in the fiscal division of the legislative counsel bureau and available to any member. The subcommittee wishes to recognize and thank the many persons who attended and participated in meetings of the subcommittee for their cooperation in providing valuable information about the operation of the state's program of aid to the medically indigent. The subcommittee would also like to thank the staff of the state welfare division for their assistance.

This report is transmitted to the members of the 64th session of the Nevada legislature for its consideration and appropriate action.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

Carson City, Nevada
August 1986

* *

LEGISLATIVE COMMISSION

Assemblyman Louis W. Bergevin, Chairman

Senator James H. Bilbray	Assemblyman Bob L. Kerns
Senator Helen A. Foley	Assemblyman Robert M. Sader
Senator Lawrence E. Jacobsen	Assemblyman James W. Schofield
Senator Kenneth K. Redelsperger	Assemblyman Danny L. Thompson
Senator Sue Wagner	Assemblyman Barbara A. Zimmer

SUMMARY OF RECOMMENDATIONS

This summary represents the major conclusions reached by the subcommittee. These conclusions are based upon (1) suggestions which were made to the committee at public hearings by representatives of interested groups and concerned citizens; (2) information and data presented by the welfare division; (3) other correspondence to the members and staff of the committee.

The subcommittee recommends:

1. Continuation of the levy of up to 3 cents per $100 of assessed valuation to support a fund for medical assistance to indigent persons in each county, as established by assembly bill 422 (Chapter 629, Statutes of Nevada 1985) which expires by limitation on June 30, 1987. The 3 cent levy would continue to be divided with 2.7 cents going to a fund in the county of origin and 0.3 cents going to a statewide supplemental fund (BDR S-215). The subcommittee further recommends continuation of all other provisions contained in A.B. 422 except the sunset provision.

2. That NRS 428.050 be amended to eliminate the reference to the levy to provide aid and relief to indigents being "diminished by 11 cents per $100 of assessed valuation." The 1979 legislature, as part of the tax reform package, passed S.B. 204 which statutorily reduced the maximum constitutional $5 property tax rate to $3.64 per $100 of assessed valuation. Part of that reduction consisted of repealing the requirement that counties levy 11 cents for the state's Title XIX (Medicaid) program and insuring that the 11 cents was not reimposed. However, the 1981 legislature placed caps on the overall ad valorem revenues of local governments, effectively eliminating the need for this provision. (BDR 38-216)

REPORT TO THE 64TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION SUBCOMMITTEE TO STUDY THE OPERATION OF STATE AID TO THE MEDICALLY INDIGENT

I. INTRODUCTION

The 63rd session of the Nevada legislature in 1985, adopted Senate Concurrent Resolution No. 34 which directs the legislative commission to study the operation of state programs for the medically indigent. Senate Concurrent Resolution No. 34 recognized that the continuing increase in the cost of medical services and treatment is a source of great concern to the citizens of Nevada and these increases have a direct and adverse affect on the state's program for aid to the medically indigent. The commission was directed to complete a review of the operation of the state's program and identify any possible improvements in the program for further consideration by the 64th session of the Nevada legislature.

SUBCOMMITTEE MEETINGS

The S.C.R. 34 subcommittee held three meetings with the first meeting being divided into two parts: the morning session was held in Carson City and the afternoon session, a joint meeting with the Nevada Association of Counties (NACO), was held in Minden. Both the second and third meetings were held in Carson City.

SUBCOMMITTEE STUDY METHODOLOGY

The subcommittee conducted its study through the public hearing process and requested and received input from governmental entities within the State of Nevada, private non-profit entities, interested parties and representatives from the department of human resources and the state welfare division.

The S.C.R. 34 subcommittee worked closely with and kept abreast of the activities of two other legislative subcommittees studying topics somewhat related to the medical indigency study. Those were the S.B. 460 subcommittee to study ways of restraining the costs of health care, (Chapter 645, Statutes of Nevada 1985) and the S.C.R. 45 subcommittee to study the adequacy of the state's standard of need for aid to families with dependent children program (File No. 131, Statutes of Nevada 1985).

II. HISTORY AND OPERATION OF THE STATE'S TITLE XIX (MEDICAID PROGRAM)

Medicaid is a term used to describe medical assistance and services provided to persons who receive public assistance or who are medically needy inpatients of hospitals or nursing homes. In 1965, the 89th Congress of the United States added Title XIX to the Social Security Act authorizing varied percentages of federal participation to states and United States protectorates that offer such medical programs.

Nevada in 1967 initiated a comprehensive program for the categorically needy under state legislation titled "state aid to the medically indigent." The authorization for this program is found in Chapter 428 of the Nevada Revised Statutes and is often referred to by the acronym "SAMI" or "Title XIX."

Medicare, as enacted in Title XVIII of the Social Security Act, is the medical program for aged and certain disabled persons who contribute premiums and receive medical benefits similar to an insurance policy. Medicare is often confused with the state administered medicaid program because some people may receive benefits from both programs.

In 1974, the Social Security administration implemented the Supplemental Security Income (SSI) program. Eligibility for cash assistance for the aged, blind, and disabled then became the responsibility of the SSI program. Persons receiving SSI could be eligible for Medicaid coverage if they submitted an application to the welfare division.

In 1975, Nevada reviewed optional medicaid coverage groups and began providing medical assistance to the categorically needy, institutionalized, aged, blind, and disabled.

The present Medicaid program covers basic medical needs of approximately 24,000 people in the State of Nevada. State budgetary limitations created by the lack of revenues and increased medical costs has placed emphasis on health care cost containment and has been a pressing issue for the legislature and the state administration. Capped budgets and money committee directives in 1981 to freeze the level of practitioner reimbursements underscored the concern with Medicaid funding.

III. HISTORY OF MEDICAID FUNDING

Exhibit 1 details the history of state participation in the Title XIX program from fiscal year 1970 through fiscal year 1985. Exhibit 2 is a display of the approved appropriation and authorization levels and the expenditure category descriptions for fiscal years 1986 and 1987.

Exhibit 1

MEDICAL CARE PROGRAM - TITLE XIX
FISCAL STATEMENT
FOR THE PERIOD JULY 1, 1969 TO JUNE 30, 1987

	Fiscal Year 1970	Fiscal Year 1971	Fiscal Year 1972	Fiscal Year 1973	Fiscal Year 1974	Fiscal Year 1975	Fiscal Year 1976	Fiscal Year 1977
State Appropriation	$1,980,214	$2,396,552	$ 3,641,455	$ 4,479,480	$ 6,905,823	$ 7,817,592	$ 8,498,840	$ 2,631,646
Supplemental Appropriation								4,546,878
Salary Adjustment Funds	5,864						16,100	34,630
Federal Funds	3,830,129	4,089,295	5,291,632	8,450,742	5,637,744	13,337,770	11,217,688	11,406,701
County Advalorem Funds	1,891,628	2,100,357	2,267,863	2,615,037	2,904,949	3,262,655	3,656,771	3,952,119
Other Funds	39,696	20						
Total Funds	7,747,531	8,586,224	11,200,950	15,545,259	15,448,516	24,413,017	23,389,399	22,571,974
Expenditures	7,662,583	7,973,835	10,392,104	12,675,628	14,315,626	23,433,272	23,293,922	22,497,151
Reversion to General Fund	84,948	612,389	808,846	2,869,631	1,132,890	979,745	95,477	74,823
Percentage of Reversion to Total Non-Federal Funding	2.2	13.6	13.7	40.4	11.6	8.8	.8	.7

	Fiscal Year 1978	Fiscal Year 1979	Fiscal Year 1980	Fiscal Year 1981	Fiscal Year 1982	Fiscal Year 1983	Fiscal Year 1984	Fiscal Year 1985
State Appropriation	$ 8,952,641	$10,303,699	$23,367,141	$32,304,573	$37,368,303	$42,987,724	$41,679,517	$42,649,632
Supplemental Appropriation	819,022	1,425,430	150,000					
Salary Adjustment Funds			10,000	26,300		69,215		81,753
Federal Funds	15,069,506	17,851,609	24,487,433	32,669,754	34,342,774	37,207,211	33,172,215 (1)	35,916,750 (2)
County Advalorem Funds	4,428,252	5,430,950	595	142	24	64		
Other Funds					107		20,420	33,998
Total Funds	29,269,421	35,011,608	48,015,169	65,000,769	71,711,208	80,264,214	74,872,152	78,682,133
Expenditures	29,109,680	34,956,943	48,014,574	63,693,828	71,581,903	77,477,932	70,372,152 (1)	74,082,133 (2)
Reversion to General Fund	159,733	54,745	595	1,306,941	129,305	2,786,282 (3)	4,500,000 (1,3)	4,600,000 (2,3)
Percentage of Reversion to Total Non-Federal Funding	1.1	.3	.0	4.3	.4	6.5	10.8 (1)	10.8 (2)

(1) Estimated as fiscal year will not be completed until June 30, 1986.

(2) Estimated as fiscal year will not be completed until June 30, 1987.

(3)

Estimated	FY 83	FY 84	FY 85
6/30/85 reversion	$2,786,282	$2,000,000	$2,100,000
6/30/86 reversion		2,500,000	
6/30/87 reversion			2,500,000
Estimated Total	$2,786,282	$4,500,000	$4,600,000

Exhibit 2

	1985-86 LEGISLATURE APPROVED	1986-87 LEGISLATURE APPROVED
MEDICAL CARE PROGRAMS	$91,229,699	$96,073,527
GENERAL FUNDS	43,709,789	45,955,877
FEDERAL FUNDS	45,999,860	48,443,550
OTHER FUNDS	1,400,050	1,550,100
INTERAGENCY TRANS	120,000	124,000
EXPENDITURE CATEGORIES		
Category Description		
Salary/Payroll	$ 1,513,241	$ 1,547,898
Out-of-State Travel	570	570
In-State Travel	49,348	50,722
Operating	213,498	219,245
Office Furn. & Equip.	3,826	1,000
Training	1,000	1,000
Fiscal Agent Charge	1,680,056	1,789,305
Data Processing	389,540	412,312
Medical Payments	84,186,873	88,513,067
Contract Service Health	89,400	93,870
Contract - O/S Review	2,100	2,200
Contractual Services	292,100	333,784
Utilities	8,147	8,554
County Indigent Program	2,800,000	3,100,000
Total Expenditures	$91,229,699	$96,073,527

Mandatory and Optional Features of the Medicaid Program in Nevada.

Federal regulations differentiate between "mandated" and "optional" benefits. Mandated benefits are those services which must be provided in order for the state to qualify to participate in the medical assistance program. Optional benefits are those which a state may provide at its own discretion but which also may qualify for federal funding. Exhibits 3 A, B and C identifies benefits under the medical assistance program categorized by mandated and optional services in accordance with federal regulations. Federal laws and regulations further stipulate that covered services provided to the categorically needy not be less than services provided to the medically needy and that services for the categorically needy and medically needy not be restricted or limited to certain recipients within the respective eligibility category. Appendix A contains additional detailed information concerning mandatory and optional coverage groups in Nevada.

Exhibit 3

MEDICAID SERVICES AUTHORIZED BY FEDERAL REGULATIONS

	1985 Expenditures
MANDATED SERVICES	
Inpatient Hospital Services	$16,553,038
Outpatient Hospital Services	1,190,579
Rural Health Clinic Services	3,474
Laboratory and X-ray Services	322,885
Skilled Nursing Services	2,060,604
Early Periodic, Screening, Diagnosis and Treatment	171,179
Family Planning Services and Supplies	
Physician Services	5,989,452
Home Health Services	150,894
Ambulance	167,848
Transportation	408,724
Prosthetics, Disposable Supplies, Durable Medical Equipment	595,980
OPTIONAL SERVICES	
Podiatrists	18,189
Optometrists (includes eyeglasses)	161,652
Chiropractors	1,341
Other Practitioners	18,261
Certified Registered Nurse Anesthetist (CRNA)	
Certified Registered Nurse Practitioner (CRNP)	
Home Health Care, Physician Aide, RN's	450,219
Clinic Services	96,391
Dental Services (dentures)	1,079,887
Therapy (occupational, physical, speech, hearing)	84,227
Prescription drugs	3,447,720
Intermediate Care Facilities Services	21,505,324
Mental Institutions	
Inpatient Hospital	224,791
Intermediate Care Facility Mental Retardation (ICF-MR)	8,534,990
Medicare (Part B) Insurance Coverage	974,000

Exhibit 3B

Optional Service Not Covered by Medicaid

Inpatient psychiatric hospital services for individuals under 21 years of age.

Christian Science nurses and sanitariums.

Certain diagnostic, screening, preventative and rehabilitative services.

Exhibit 3C

Options Offered by Other Western States
But Not Offered in Nevada

Five states (California, Hawaii, Montana, Utah, and Washington) have both categorically and medically needed programs.

Nine states (California, Hawaii, Idaho, Montana, New Mexico, Oregon, Utah, Washington, and Wyoming) provide rehabilitation services.

Seven states (Alaska, California, Colorado, Montana, Oregon, Utah, and Washington) offer inpatient psychiatric services to those under 22.

Two states (California, Oregon) provide for Christian Science healing services.

Two states (Alaska and California) offer inpatient hospital, SNF and ICF services to TB patients 65 or older.

The subcommittee also examined what other states are providing through state programs of assistance for the medically indigent. A state by state comparison of medicaid services is shown in Exhibit 4*.

In testimony before the S.C.R. 34 subcommittee, Mr. Keith MacDonald, chief of the Medicaid program, testified that hospital costs, nursing homes, physicians and prescription drugs make up 90 percent of the costs in Medicaid. Mr. MacDonald further stated that the ADC recipients accounted for 62.6 percent of the Medicaid caseload in 1984 and received 19.9 percent of the medical benefits paid. Mr. MacDonald further pointed out that aged, blind and disabled account for 37.4 percent of the recipients and received approximately 80 percent of the Medicaid benefits paid. Mr. MacDonald said that it is the institutionalized cases who incur the greatest portion of the medical care expenditures under the Medicaid program. Charts depicting state medical expenditures are contained in Appendix 2, which is titled, Medicaid, An Overview 1985, prepared by the state welfare division.

*Desonia, Randolph A. and Kathleen M. King, State Programs of Assistance for the Medically Indigent, Intergovernmental Health Policy Project, (George Washington University HRP-0906759), November 1985, p. 297.

MEDICAID SERVICES STATE BY STATE

Basic Required Medicaid Services

October 1, 1983

Medicaid recipients receiving federally supported financial assistance must receive at least these services
- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Other laboratory and X-ray services
- Skilled nursing facility services and home health services for individuals 21 and older
- Early and periodic screening, diagnosis, and treatment for individuals under 21
- Family planning
- Physician services

Federal financial participation is also available to States electing to expand their Medicaid Programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients or may substitute a combination of seven services

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on the chart

● CN[2]
◗ Both CN and MN[3]

BASIC REQUIRED MEDICAID SERVICES SEE ABOVE

Optional Services in State Medicaid Programs

FMAP[1]	BASIC REQUIRED MEDICAID SERVICES SEE ABOVE		Podiatrists Services	Optometrists Services	Chiropractors Services	Other Practitioners Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in IMD Institutions: A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Services for Age 65 or Older in Mental Inst: A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Services for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services	
71	●	Alabama																			●														12	AL
50	●	Alaska		●				●																●			●		●			●			10	AK
61		Arizona[5]																																		AZ
74	◗	Arkansas	◗	◗	◗	◗		◗	◗	◗		◗	◗	◗	◗	◗					◗			◗			●		●			●		●	21	AR
50	◗	California	◗	◗	◗	◗		◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	30	CA
50	●	Colorado	●	●				●	●				●		●									●		●	●				●	●			14	CO
50	◗	Connecticut	◗	◗		◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗				◗			◗		◗		◗	◗			24	CT
50	●	Delaware	●					●	●				●		●		●							●		●	●				●	●			17	DE
50	◗	D C	◗					◗		◗			◗		◗					◗							◗		◗		◗	◗		◗	19	DC
55	●	Florida	●	●				●	●			●	●		●	●					●			●			●		●			●			14	FL
67	●	Georgia	●					●					●		●	●					●	●	●	●		●	●		●			●			13	GA
50	◗	Guam	◗	◗				◗					◗		◗	◗																			6	GU
50	◗	Hawaii	◗	◗				◗	◗	◗	◗		◗		◗	◗	◗	◗		◗							◗		◗			◗			20	HI
67	●	Idaho	●	●	●			●		●			●		●					●				●		●	●				●	●			12	ID
50	◗	Illinois	◗	◗	◗	◗		◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	29	IL
60	●	Indiana	●	●	●		●	●	●	●	●	●	●		●	●	●		●	●				●			●	●	●	●	●	●			24	IN
65	●	Iowa	●	●	●	●		●	●	●	●	●	●		●	●				●				●			●		●			●			19	IA
51	◗	Kansas	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗		◗	◗				◗				◗			◗		◗		◗	◗		◗	23	KS
71	◗	Kentucky	◗	◗	◗	◗		◗	◗	◗	◗	◗	◗		◗	◗	●	●	●	◗				◗			◗		◗		◗	◗			22	KY
64	◗	Louisiana	◗	◗	◗			◗	◗	◗		◗	◗		◗	◗					●			●		●	●		●			●			17	LA
71	◗	Maine	◗	◗	◗	●		◗	◗	◗	◗		◗		◗	◗								◗			◗		◗	◗	◗	◗			25	ME
50	◗	Maryland	◗	◗	◗			◗	◗	◗	◗	◗	◗		◗	◗					◗			◗			◗		◗		◗	◗			18	MD
50	◗	Massachusetts	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗		◗	◗	◗	◗	◗	◗	◗			◗			◗		◗	◗	◗	◗	◗	◗	28	MA
50	◗	Michigan	◗	◗	◗			◗	◗	◗	◗	◗	◗		◗	◗					◗			◗			◗		◗		◗	◗			24	MI
53	◗	Minnesota	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗		◗	◗				◗	◗	◗	◗	◗	◗	◗	◗		◗		◗	◗		◗	31	MN
78	●	Mississippi	●	●				●	●	●			●		●	●		●			●			●			●		●			●			15	MS
61	●	Missouri	●	●	●			●	●		●	●	●		●	●					●			●			●								16	MO
64	◗	Montana	◗	◗		◗	◗	◗	◗	◗	◗		◗		◗	◗				◗				◗			◗		◗		◗	◗		◗	26	MT
57	◗	Nebraska	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗		◗	◗					◗			◗			◗		◗		◗	◗		◗	22	NB
50	●	Nevada	●	●	●	●	●	●	●	●	●		●		●	●					●			●			●		●		●	●		●	22	NV
69	◗	New Hampshire	◗	◗	◗	◗	◗	◗	◗	◗	◗		◗		◗	◗					◗			◗			◗		◗	◗	◗	◗		◗	26	NH
50	●	New Jersey	●	●	●			●	●	●	●	●	●		●	●	●	●	●	●	●			●			●		●		●	●			26	NJ
69	●	New Mexico	●	●		●		●	●	●			●		●	●				●				●			●				●	●			15	NM
50	◗	New York	◗	◗		◗		◗	◗	◗	◗	◗	◗		◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	28	NY
68	◗	North Carolina	◗	◗	◗			◗	◗	◗	◗	◗	◗		◗	◗	◗	◗	◗	◗	◗			◗			◗		◗		◗	◗			19	NC
51	◗	North Dakota	◗	◗	◗			◗	◗	◗	◗		◗		◗	◗					◗			◗			◗		◗		◗	◗			23	ND
50	◗	N Mariana Islands	◗	◗				◗	◗	◗	◗		◗		◗	◗																			6	NMI
55	●	Ohio	●	●	●	●	●	●	●	●	●	●	●		●	●				●	●		●	●		●	●		●		●	●			24	OH
58	◗	Oklahoma	◗	◗	◗	◗		◗	◗	◗	◗	◗	◗		◗	◗					◗			◗			◗		◗		◗	◗			11	OK
57	●	Oregon	●	●	●	●	●	●	●	●	●		●		●	●				●	●			●			●		●		●	●		●	25	OR
58	◗	Pennsylvania	◗	◗	◗	◗		◗	◗	◗	◗	◗	◗		◗	◗					◗			◗			◗		◗		◗	◗			17	PA
50	◗	Puerto Rico	◗	◗	◗	◗		◗	◗	◗	◗	◗	◗		◗	◗				◗											◗	◗			12	PR
68	◗	Rhode Island	◗	◗				◗	◗				◗		◗	◗	●				◗			◗			◗		◗		◗	◗			11	RI
71	●	South Carolina	●			●		●					●		●						●			●			●		●		●	●			12	SC
66	●	South Dakota		●				●	●	●			●		●							●	●	●			●				●	●	●		14	SD
71	◗	Tennessee	◗	◗	◗	◗		◗	◗				◗		◗	◗					◗	◗	◗	◗	◗		◗		◗		◗	◗			17	TN
64	●	Texas	●	●	●	●		●					●		●	●				●	●			●			●				●	●			14	TX
68	◗	Utah	◗	◗		◗	◗	◗	◗	◗		◗	◗		◗	◗					◗	◗	◗	◗			◗		◗		◗	◗			20	UT
69	◗	Vermont	◗	◗	◗			◗					◗		◗	◗					◗			◗			◗		◗		◗	◗			14	VT
50	◗	Virgin Islands	◗	◗				◗	◗	◗	◗	◗	◗		◗	◗																			9	VI
57	◗	Virginia	◗	◗				◗		◗	◗		◗		◗	◗					◗	◗	◗	◗	◗	◗	◗		◗		◗	◗	◗			20	VA
50	◗	Washington	◗	◗	●	◗	◗	◗	●	◗	◗	◗	◗		◗	◗	●		◗	◗	◗	◗	◗	◗	◗	◗	◗		◗		◗	◗				28	WA
71	◗	West Virginia	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗	◗		◗	◗					◗			◗			◗		◗		◗	◗			16	WV
57	◗	Wisconsin	◗	◗	●	●	◗	◗	◗	●	◗	◗	●		◗	◗					◗			◗			◗	●	◗	◗	◗	◗	◗		26	WI
50	●	Wyoming		●				●		●					●									●			●				●				7	WY
●	20		18	17	14	12	4	17	18	12	7	11	18	17	18	18	8	3	4	10	8	1	1	15	9	13	24	23	13	1	8	20	18	5		
◗	34		24	29	16	21	14	33	28	24	20	22	33	24	28	24	17	14	16	19	13	7	7	24	16	17	28	26	20	9	10	26	24	14		
	54	Total	42	46	30	33	18	50	46	36	27	33	51	41	46	42	25	17	20	29	21	8	8	39	25	30	52	49	33	10	18	46	42	19		

[1]Federal Medicaid Assistance Percentage (FMAP) Rate of Federal financial participation in a State's Medical Assistance Program under Title XIX of the Social Security Act. Percentages are rounded and effective as of October 1, 1983
[2]Categorically Needy: People receiving federally supported financial assistance
[3]Medically Needy: People who are eligible for medical but not for financial assistance
[5]Arizona operates a medical assistance program under a Section 1115 Demonstration project

Reference: The data shown were reported by individual states and compiled by the Office of Intergovernmental Affairs.

Department of Health & Human Services
Health Care Financing Administration
Office of Intergovernmental Affairs

HCFA Pub. No. 02156-84

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Exhibit 4

IV. COUNTY PARTICIPATION IN NEVADA MEDICAID

The 1985 legislature reviewed a proposal contained in the executive budget for a new program to allow counties to participate in the Medicaid program and thereby receive federal financial participation in meeting the costs for the medically indigent. The counties were to provide up to $1.4 million in fiscal year 1986 and $1.5 million in fiscal year 1987 to match a like amount of federal Title XIX funds to meet the costs of the medically indigent, primarily those living in nursing homes or a similar facility. The legislature authorized the program but required that the welfare division receive interim finance approval before the program could be initiated. The S.C.R. 34 subcommittee reviewed this proposal to determine the status of the program and the continued feasibility of the concept.

The majority of the individuals who would be eligible to participate in this program are patients in skilled nursing facilities and intermediate care facilities who are aged, blind, disabled. Individuals eligible under the county participation option would be those with income between $714 and $1,008 per month. The Welfare Division's institutional income limit of $714 per month was set in 1980 as 300 percent of the federal Supplemental Security Income (SSI) program maximum payment level at that time.

Since 1980, the payment to retirees and pensioners receiving SSI has increased with cost-of-living increases. At the time the subcommittee reviewed this, the maximum payment was $1,008; however, this payment level increases yearly. Many counties, which are statutorily responsible for medical indigents have established eligibility criteria encompassing those institutionalized persons whose incomes are in the $714 to the $1,008 range. County governments have experienced a dramatic increase of expenditures for this group.

The medicaid budget as presented to the 1985 legislature, did not include an increase for state institutional cases. A rationale was presented depicting the advantages of matching federal dollars for county participation and medical assistance. The executive branch accepted the argument for leveraging federal dollars. Included within its budget was a proposal that county funds could be matched with federal financial participation in the amount of $2.8 million in fiscal year 1986 and $3.1 million in fiscal year 1987 for medical care of institutionalized persons. In testimony before the S.C.R. 34 subcommittee, officials of the state welfare division pointed out that several requirements had to be met to conform with federal regulations in order to implement the use of the county participation with Medicaid funding. These requirements are as follows:

1. Eligibility standards for county participation must be set by state eligibility standards and be uniform in all 17 counties.

2. A fund must be established in advance and be adjusted thereafter based upon program participation.

3. Require all counties to continue participation.

In testimony before the subcommittee, welfare officials indicated a number of problems which still exist for county participation in this program. They include the following:

1. Inability of the counties and the state welfare division to agree on the number of persons and the exact amount of dollars involved.

2. Several counties negating their participation in the program.

3. No definitive mechanism to collect and disperse the matching funds.

At this time, the counties are not participating in this program option. The welfare division indicated that it has met with various county officials, NACO officials and other interested parties to try to facilitate an agreement for participation in this program but has been unable to do so at this point in time. The division indicated that it would continue to work with the counties to pursue their participation under this option if so desired.

V. OPTIONS FOR MEDICAID EXPANSION

The S.C.R. 34 subcommittee worked closely with the S.C.R. 45 subcommittee studying the needs standard for aid to dependent children and the S.B. 460 subcommittee studying medical care cost containment. Both these committees were involved in areas which would directly affect possible expansion of the Medicaid (Title XIX) program. As pointed out earlier, those individuals eligible for aid to dependent children are also eligible for participation in the Medicaid program.

In addition to considerable work being done by those two subcommittees pertaining to possible expansion or changes to the current Title XIX program, the S.C.R. 34 subcommittee also considered the possibility of expanding Medicaid. The subcommittee examined a number of options for Medicaid expansion and looked at the present county liabilities within those areas. Exhibit 5 is a summary of medical indigency in Nevada and presents the current Medicaid coverage options for medicaid expansion and the current county liability.

Exhibit 5

SUMMARY OF MEDICAL INDIGENCY IN NEVADA

Present Medicaid Coverage

1) Families who qualify for the Aid to Dependent Children (ADC) program.

2) Pregnant women and children under age five who qualify for CHAP coverage.

3) Individuals/Families who qualify for the Refugee Resettlement Program.

4) Individuals who qualify for Medical Assistance to the Aged, Blind or Disabled (MAABD).

   - Receiving SSI
   - Institutionalized with income below $714 per month.
   - Protected by Public laws/regulations

5) Children in the state's custody for child welfare services and foster care.

Options For Medicaid Expansion

1) Expansion of the ADC program to include the unemployed parent option. Would allow two-parented families with low income to be eligible.

2) Increase ADC Need Standard

3) Expand coverage under CHAP to include children over the age of five who are in families that have income below the ADC standard.

4) Raise the limit on monthly income for institutionalized individuals from $714 to the maximum allowed by Regulation ($1008)

5) Implement a medically needy program.

Present County Liabilities

1) Individuals in Long Term Care with income over $714.

2) Individuals institutionalized less than a full calendar month.

3) Individuals who can't qualify for SSI but still have medical needs.

4) Intact families who don't qualify for ADC or CHAP.

5) Single parented families who don't qualify for ADC.

6) Mental patients.

7) Balance of costs above what Medicare will pay.

The following section titled "Medical Indigency in Nevada," further examines 1.) the groups eligible for medicaid; groups that could receive medicaid coverage but the state has not elected that option, and 3.) groups not covered by medicaid that are county liability.

Medical Indigency in Nevada

I. Groups eligible for Medicaid

A. Aid to dependent children (ADC) recipients:

Individuals eligible to receive ADC cash grants are also eligible for medicaid coverage. Families eligible are most always headed by single females. Deprivation of support from at least one parent is an eligibility requirement. Both parents may be in the home if one or both are incapacitated. Families may not have resources in excess of $1,000. Monthly gross income must be below 185 percent of the state's need standard (i.e., mother and one child $423.65, mother and two children $527.25, etc.).

Number of January 1986 eligibles: 15,538

B. Child Health Assurance Program (CHAP):

Pregnant women in two parent households and children born after September 30, 1983, under age five, who meet the income and resource requirements of the ADC program are eligible for medicaid coverage.

Number of January 1986 eligibles: 15

C. Refugee program:

Medicaid coverage is provided to individuals/families who qualify for the refugee resettlement program. Eligibility is determined basically with the same criteria as the ADC and MAABD programs.

Number of January 1986 eligibles:

36 ADC-linked families
71 Non-ADC related families
13 MAABD related

D. Medical Assistance to the Aged, Blind or Disabled (MAABD)

Aged, blind and disabled individuals can qualify for medicaid coverage if they receive SSI, are institutionalized or hospitalized longer than a full calendar month and have income below $714 per month, or

are protected by specific public laws/regulations. An individual's resources may not exceed $1,700.

Number of January 1986 eligibles: 8,343

Group	Aged	Blind	Disabled	Total
SSI	3,123	300	3,307	6,730
Institutional	1,210	26	217	1,453
Public Laws	110	9	41	160
Totals	4,443	335	3,565	8,343

E. Child Welfare/Foster Care:

Medicaid coverage is provided to children who have been placed in the state's custody because of situations such as abuse, neglect, abandonment, voluntary placements, etc. Also covered are pregnant women who are not eligible for ADC, and are planning to relinquish their child for adoption.

Number of January 1986 eligibles: 1,771

II. Groups that could receive Medicaid coverage but state has not elected option.

A. ADC - Unemployed parent program:

Federal regulations allow states the option of covering only single-parent households or both single and two-parent households when the principal bread winner is unemployed. The unemployed parent option has never been funded in Nevada, but could provide Medicaid coverage to a number of families.

B. Expanded ADC Coverage:

The ADC need standard could be increased which would allow more families to be eligible.

C. Extended CHAP Coverage:

CHAP Medicaid coverage could be made available to children over the age of five. Presently only children under age five are covered, which is the minimum required coverage.

D. Increase institutional income limit:

Federal regulations allow states to set the maximum income limit for institutionalized individuals at an amount not to exceed 300 percent of the federal SSI payment maximum. Presently, the income limit can not exceed $1,008. Nevada's income limit is $714. Raising the standard would result in additional institutionalized individuals eligible for Medicaid.

E. Medically Needy Program:

The Medically Needy Program is an option available to states to make individuals and families eligible for Medicaid benefits who would otherwise qualify for the ADC or SSI programs except their income is too high. This program requires the families to apply certain amounts of income they have towards their medical bills with the Medicaid program paying the remainder.

III. Groups not covered by Medicaid, that are county liability.

A. Individuals in long-term care who have income above the state's $714 limit but cannot afford private pay rates.

B. Individuals who have been institutionalized or hospitalized less than a full calendar month. The state provides Medicaid coverage after the full month of institutionalization for individuals with income under $714; however, the county may have to pay costs during the first month.

C. Individuals not institutionalized who cannot qualify for SSI, but still have an expressed medical need. This group often includes the homeless and transient.

D. Intact families (two parents in the home) who do not qualify for the ADC program because deprivation does not exist and do not qualify for CHAP coverage because their income is higher than the state's standard but lower than the county standard.

E. Single-parent families with income too high to qualify for ADC program, but who have income below the county standard.

F. Mental patients who are prohibited from Medicaid covering by regulation.

G. The balance of costs above what Medicare will pay for aged or disabled recipients. Often Medicare has limitations on services and prescriptions.

Children's Health Assurance Program (CHAP)

The S.C.R. 34 subcommittee looked at the current Children's Health Assurance Program (CHAP) which provides medicaid coverage (no cash benefits) to pregnant women in two-parent households and to children born after September 30, 1983 up to the age of five in non-ADC households. Eligibility for the CHAP program basically follows the same guidelines as the ADC program. In fact, if Nevada had ADC coverage for two-parented households (the unemployed parent option), the eligibility determination process would be very much the same. The unemployed parent option of ADC provides assistance to the same group as CHAP.

Previous studies done by the state welfare division of other states Aid to Dependent Children - Unemployed Parent (ADC-UP) programs have shown that Nevada can expect an approximate 19 percent ratio of ADC-UP recipients to regular ADC recipients in Nevada. This equals approximately 3,000 ADC-UP recipients including both adults and children. There are 1,500 potential recipients for CHAP if coverage is expanded to include all children under age 18. The S.C.R. 34 subcommittee examined 1980 census data which shows the following breakouts may be expected at the noted age groupings in Nevada.

Ages	Percentages	Potential Eligibles
0- 4	26.01	390
5- 9	25.81	387
10-14	28.61	429
15-17	19.59	294

Nevada's experience with the CHAP program has been that without the incentive of the cash grant, CHAP participation has not measured up to its potential. This is evidenced by 390 children potentially eligible in the 0-4 age group with only 41 participating during the month of May 1986. It is felt households only apply for CHAP coverage when a family needs help with a major medical problem. With this in mind, the state welfare division presented the estimated number of eligibles to be covered under an expansion of the CHAP program as follows:

Age Group	Potential Eligibles	Participation Percentage	Projected Eligibles
0 - 4	390	10.5	41
5 - 9	387	10.5	41
10 - 14	429	10.5	45
15 - 17	294	10.5	31

Medical Cost Projections:

Costs for Medical payments for the new groups are as follows:

Age Group	Number of Eligibles	Monthly Average	Annual Cost
5-9	41	$1,056.95	$ 520,019.40
10-14	45	1,056.95	570,753.00
15-17	31	1,056.95	393,185.40
TOTAL	117	1,056.95	1,483,957.80

These projected costs are based upon average costs incurred since CHAP was implemented in March 1985. Included in this average are costs for pregnant women who are also eligible for CHAP coverage. The high cost of prenatal care and delivery may contribute to the overall average being higher than it would for children only. The lack of information on the costs for children only, results in projected costs being made using the overall average.

Arguments may also be made that if older children are provided CHAP coverage, their medical costs will be less than younger children. While this is generally true, the welfare division has limited experience with the CHAP group of Medicaid eligibles and has no data on which a lower cost can be based. Exhibits 6, 7, and 8 prepared by the state welfare division contain caseload and cost information relative to the CHAP program.

Exhibit 6

SUMMARY OF CHAP APPLICATION AND APPROVALS

MONTH	APPS REC'D	APPROVALS	DENIED	W/D	OTHER
3/22/85	78	3	42	2	7
4/19/85	76	7	60	6	12
5/24/85	59	3	38	4	9
6/02/85	44	1	37	4	7
7/26/85	41	3	24	7	8
8/23/85	37	6	28	2	10
9/20/85	26	6	17	2	3
10/25/85	44	6	28	3	6
11/22/85	33	11	19	2	6
12/20/85	48	5	37	3	4
1/24/86	54	8	40	2	2
2/21/86	45	17	32	6	7
3/21/86	51	10	37	3	3
4/25/86	71	11	39	6	5
5/23/86	67	15	51	3	0
TOTALS	774	112	529	55	89

Source: Case Action Report (WL00777)

MW/lg

Exhibit 7

SUMMARY OF CHAP CASES AND RECIPIENTS

MONTH	ELIG. CASES	ELIGIBLE ADULTS	ELIGIBLE CHILDREN	TOTAL RECIPIENTS
3/85	1		1	1
4/85	8	2	6	8
5/85	9	3	6	9
6/85	6		6	6
7/85	9	1	11	12
8/85	11	4	8	12
9/85	12	5	9	14
10/85	15	7	13	20
11/85	22	10	18	28
12/85	22	7	20	27
1/86	22	6	20	26
2/86	28	12	21	33
3/86	38	20	26	46
4/86	41	22	29	51
5/86	59	28	41	69

Source: Medical Certificate Register (WL00452)

MW/lg

Exhibit 8

SUMMARY OF CHAP UTILIZATION AND COSTS

MONTH	*COUNT	TOTAL PAYMENTS	AVERAGE
3/85	Ø	Ø	Ø
4/85	Ø	Ø	Ø
5/85	5	$ 882.37	$ 176.47
6/85	8	15,083.93	1,885.49
7/85	7	1,271.79	181.68
8/85	10	46,851.80	4,685.18
9/85	11	6,087.96	553.45
10/85	17	32,732.48	1,925.44
11/85	21	10,344.63	492.60
12/85	33	18,404.87	557.72
1/86	40	29,771.60	744.29
2/86	32	12,481.11	390.03
3/86	38	8,353.65	219.83
4/86	44	65,206.01	1,481.95
5/86	50	86,524.68	1,730.49
TOTAL	316	$333,996.88	$1,056.95 month

* Unduplicated count of recipients using services.

Source: Report 7 (WL80R06)

MW/lg

Administrative Costs:

Finally, if CHAP coverage was expanded, administrative costs must be addressed. When CHAP was implemented in March 1985, the welfare division absorbed the impact within existing staffing.

Presently, the division is using staffing standards of 35 intake cases per worker and 190 ongoing cases per worker. Using these standards and assuming CHAP was expanded to include all eligible children under age 18, caseload staffing needs would be as follows:

Activity	Projected Caseload	Staffing Standard	FTE Required
Intake	150	35	4.3
Ongoing	120	190	0.6

Using the standard of one clerical to support every four professional staff, then one clerical position would also be needed. Additionally, funding for data processing would be required. Total annual administrative costs would be as follows:

Item	Positions	Per Item Cost	Total Cost
Eligibility Worker	5	$27,933*	$139,665
Admin. Aide II	1	19,629*	19,629
Data Processing		2,000	2,000
TOTAL			$161,294

*Includes costs for salary, telephone, equipment and space.

VI. MEDICAL INDIGENT AND THE COUNTIES

The S.C.R. 34 subcommittee worked in close conjunction with the Nevada Association of Counties (NACO) and with various county officials in examining the problems faced by the counties in providing and funding necessary medical services for the indigent population within their counties. Part of the first meeting of the S.C.R. 34 subcommittee was a joint meeting with NACO to receive testimony from county officials concerning problems faced by the counties in providing necessary medical services for the indigent population.

The S.C.R. 34 subcommittee was provided a copy of a report titled County Hospital and County Medical Indigency Finances in the State of Nevada, prepared by NACO. The report which is contained in Appendix 3 was presented to the 1985 session of the Nevada legislature. The report details some of the financial problems faced by the various hospitals in the State of Nevada that provide services to the medically indigent and also includes listings of county expenditures for medically indigents by category for fiscal years 1983, 1984 and 1985 (tables 26, 27, and 28). As shown in table 28, actual county expenditures for the medically indigent increased from $9.7 million in fiscal year 1983 to $17.9 million in fiscal year 1984.

The S.C.R. 34 subcommittee requested that NACO, in conjunction with the counties, update some of the information contained within this report and present that information to the subcommittee. NACO presented updated information to the S.C.R. 34 subcommittee in late February 1986. Their response and the updated tables are contained in Appendix 4. The report shows county expenditures for medical indigents of approximately $16.1 million in fiscal year 1985 and an estimated expenditure in excess of $22.2 million in fiscal year 1986.

Response by 1985 Legislature

The 1985 legislature recognized the ongoing problems faced by the counties in providing necessary medical services to the indigent population within the state. The legislature, with passage of A.B. 422, provided a levy of up to 3 cents per $100 of assessed valuation to support a fund for medical assistance to indigent persons in each county. An amount of 2.7 cents goes to the county of origin and 0.3 cents goes to a statewide supplemental fund for medical assistance to indigent persons. Exhibit 9 details the revenue provided by the 3 cent property tax to support the funds during fiscal year 1985-86. Exhibit 10 shows the tax levy required and the revenue generated for fiscal year 1986-87.

Exhibit 9

1985-86 MEDICAL INDIGENT LEVY

ENTITY	1985-86 MEDICAL INDIGENT LEVY	1985-86 ASSESSED VALUE	1985-86 ALLOWED TAX RATE
CARSON CITY	$124,395	$414,651,140	0.0300
CHURCHILL COUNTY	$42,235	$140,782,855	0.0300
CLARK COUNTY	$2,255,450	$7,518,167,324	0.0300
DOUGLAS COUNTY	$182,380	$607,934,999	0.0300
ELKO COUNTY	$108,128	$360,426,042	0.0300
ESMERALDA COUNTY	$10,965	$36,550,940	0.0300
EUREKA COUNTY	$21,871	$72,903,425	0.0300
HUMBOLDT COUNTY	$70,924	$236,413,492	0.0300
LANDER COUNTY	$20,835	$69,448,994	0.0300
LINCOLN COUNTY	$14,527	$48,423,723	0.0300
LYON COUNTY	$63,631	$212,102,966	0.0300
MINERAL COUNTY	$21,740	$72,465,477	0.0300
NYE COUNTY	$93,207	$310,689,722	0.0300
PERSHING COUNTY	$24,365	$81,216,413	0.0300
STOREY COUNTY	$12,887	$42,955,274	0.0300
WASHOE COUNTY	$1,044,589	$3,481,961,729	0.0300
WHITE PINE COUNTY	$23,618	$78,727,990	0.0300
STATE TOTAL	$4,135,747	$13,785,822,505	0.0300

Exhibit 10

1986-87 MEDICAL INDIGENT LEVY

ENTITY	1986-87 MEDICAL INDIGENT LEVY	1986-87 ASSESSED VALUE	1986-87 ALLOWED TAX RATE
CARSON CITY	$131,004	$436,680,760	0.0300
CHURCHILL COUNTY	$9,156	$158,177,914	0.0058
CLARK COUNTY	$2,336,456	$7,788,186,676	0.0300
DOUGLAS COUNTY	$31,992	$653,778,565	0.0049
ELKO COUNTY	$19,229	$388,479,782	0.0049
ESMERALDA COUNTY	$1,439	$34,797,990	0.0041
EUREKA COUNTY	$15,626	$112,085,259	0.0139
HUMBOLDT COUNTY	$16,559	$256,900,178	0.0064
LANDER COUNTY	$436	$71,115,299	0.0006
LINCOLN COUNTY	$14,837	$49,456,908	0.0300
LYON COUNTY	$65,421	$218,069,994	0.0300
MINERAL COUNTY	$21,879	$72,930,970	0.0300
NYE COUNTY	$98,447	$328,156,388	0.0300
PERSHING COUNTY	$23,752	$79,174,962	0.0300
STOREY COUNTY	$13,348	$44,494,574	0.0300
WASHOE COUNTY	$1,025,901	$3,656,731,785	0.0281
WHITE PINE COUNTY	$21,974	$73,245,657	0.0300
STATE TOTAL	$3,847,456	$14,422,463,661	0.0267

Other major provisions contained in A.B. 422 are as follows:

1. Money in the fund, including interest and recovered charges, may only be used for reimbursement of any unpaid charges for medical care furnished to an indigent person who falls sick in the county other than for care required because of a motor vehicle accident.

2. Money in the fund at the end of each year does not revert to the county general fund.

3. The tax rate for fiscal years after 1985-86 must be set to yield revenue equal to the amount calculated by multiplying the assessed valuation by the 3 cent tax rate and subtracting the unencumbered money remaining in the fund on May 1 of the current fiscal year.

4. The tax to support the fund is outside the calculation of maximum allowable revenue for each county.

5. Money in the fund may only be used to provide assistance after a county has expended all the money budgeted for medical assistance for indigent persons in a fiscal year. The money budgeted for such medical assistance in fiscal year 1985-86 must be 4.5 percent greater than budgeted in the previous fiscal year. The budgeted amount is to increase by a 4.5 percent in each subsequent fiscal year.

6. The supplemental fund includes the money received from the counties equivalent to a 0.3 cent tax levy, interest earned, and any money from recovered charges.

7. Any balance in the supplemental fund in excess of $1 million is credited prorata against the amounts due from the counties.

8. The board of trustees for the fund for hospital care to indigent persons also administers the supplemental fund.

9. Money in the supplemental fund may only be used to provide assistance after a county has expended all the money budgeted for medical assistance for indigent persons in that fiscal year. The assistance may only be used to reimburse all or part of unpaid charges for hospital care in excess of $25,000 for any one person.

10. The act expires by limitation on June 30, 1987.

Recommendation from Health Care Cost Containment Subcommittee (S.B. 460)

The S.C.R. 34 subcommittee received a letter from the chairman of the health care cost containment subcommittee (S.B. 460)

requesting that the S.C.R. 34 subcommittee recommend continuation of the 3 cent ad valorem tax for medical indigents. A copy of that letter is contained in Appendix 5.

Committee Review of Programs in Place in Other States

The funding of health care for medically indigents is not a unique problem to the State of Nevada but rather a problem being dealt with in all 50 states. The S.C.R. 34 subcommittee reviewed the efforts of other states to finance medical services for their indigent populations within those states. A copy of a report prepared by the National Conference of State Legislatures (NCSL) is contained in Appendix 6. One of the primary source documents used by the subcommittee in evaluating what other states are doing is titled State Programs of Assistance for Medically Indigent, November 1985, a copy of this report is available in the Legislative Counsel Bureau research library and in the fiscal analysis division of the legislative counsel bureau.

VII. FINDINGS AND RECOMMENDATIONS

1. Providing the necessary medical services to the indigent population within the counties of the State of Nevada is a financial hardship on those counties.

   THE SUBCOMMITTEE RECOMMENDS CONTINUATION OF THE LEVY OF UP TO 3 CENTS PER $100 OF ASSESSED VALUATION TO SUPPORT COUNTY AND STATE FUNDS FOR MEDICAL ASSISTANCE TO INDIGENT PERSONS. AS ESTABLISHED BY ASSEMBLY BILL 422 (CHAPTER 629, STATUTES OF NEVADA, 1985) WHICH EXPIRES BY LIMITATION ON JUNE 30, 1987. THE 3 CENT LEVY WOULD CONTINUE TO BE DIVIDED WITH 2.7 CENTS GOING TO A FUND IN THE COUNTY OF ORIGIN AND .03 CENTS GOING TO A STATEWIDE SUPPLEMENTAL FUND. THE SUBCOMMITTEE FURTHER RECOMMENDS CONTINUATION OF ALL OTHER PROVISIONS CONTAINED IN A.B. 422 EXCEPT THE SUNSET PROVISION.

2. The reference to the levy of 11 cents per $100 of assessed valuation contained in NRS 428.050 is ambiguous and unnecessary.

   THE SUBCOMMITTEE, THEREFORE, RECOMMENDS THAT NRS 428.050 BE AMENDED TO ELIMINATE THE REFERENCE TO THE LEVY TO PROVIDE AID AND RELIEF BEING "DIMINISHED BY 11 CENTS PER $100 OF ASSESSED VALUATION."

   The 1979 legislature as part of the tax reform package, passed S.B. 204 which statutorily reduced the maximum constitutional $5 property tax rate to $3.64 per $100 of assessed valuation. Part of that reduction consisted of repealing the requirement to counties levying 11 cents for the state's Title XIX (Medicaid Program) and insuring that

the 11 cents was not reimposed. However, the 1981 legislature placed caps on the overall ad valorem revenues of local governments effectively eliminate the need for this provision.

It was requested by various county officials that this cleanup legislation be included as part of the recommendations of the S.C.R. 34 subcommittee.

SCR34B/20

VIII. APPENDICES

APPENDIX A

Mandatory and Optional Coverage Groups for Title XIX

MANDATORY COVERAGE GROUPS 42 CFR

Citation	Definition	Category of Aid in Nevada
435.110	Individuals receiving ADC (Aid to Dependent Children)	40 ADC 41 Incapacitated Parent 43 Refugee 44 Stepparent in the Home
435.112	Families terminated from ADC due to increased earnings or hours of employment (4 months of additional Medicaid Coverage)	42
435.113	Persons ineligible for ADC because of requirements which are prohibited under Title XIX; i.e.: 1. Stepchildren ineligible due to deemed income from a stepparent 2. Grandchildren ineligible due to deemed income from their grandparent(s) 3. Aliens ineligible because of deemed income/ resources from a sponsor.	40 ADC 41 Incapacitated Parent 43 Refugee 44 Stepparent in the Home
435.114	Persons who would be eligible for ADC except for the July 1, 1972 20% increase in Social Security benefits - Retirement, Survivors, Disability Insurance (RSDI)	40 ADC 41 Incapacitated Parent 43 Refugee 44 Stepparent in the Home
435.115	Persons deemed to be receiving ADC; i.e.: 1. Those people denied a cash payment because the grant amount is less than $10 2. Pregnant women with no other children.	40 ADC 41 Incapacitated Parent 43 Refugee 44 Stepparent in the Home
435.118	Children for whom adoption assistance or foster care payments are made.	53 Adoption Assistance 54 Parental Placement - Higher Rate 55 Court Ordered Foster Care - Higher Rate 56 Court Ordered Foster Care - Regular Rate 57 Parental Placement - Regular Rate

Citation	Definition	Aged	Blind	Disabled	
435.120	Persons receiving SSI (Supplemental Security Income)	10	30	90	Independent Living
		15	35	95	Institutional
		14	34	94	Adult Group Care

Citation	Definition	Category of Aid in Nevada
435.121	Persons in States using more restrictive requirements for Medicaid than the SSI requirements	N/A in Nevada
435.122	Persons ineligible for SSI because of requirements that are prohibited under Title XIX	None identified in Nevada
435.130	Persons receiving Mandatory State Supplements (Persons receiving medical assistance and grant at the time of conversion to SSI December 1973 - guaranteed their income would not fall below their income level at the time of conversion)	Any of the SSI Categories of Aid (not specifically identified)
435.131	Persons eligible as essential spouses in December 1973	N/A in Nevada
435.132	Institutionalized persons who were eligible in December 1973	Not specifically identified
435.133	Blind and Disabled persons who were eligible in December 1973	Not specifically identified
435.134	Persons who would be eligible except for the July 1972 20% increase in Social Security Benefits - Retirement, Survivors & Disability Insurance (RSDI)	Not specifically identified
435.135	Persons who became ineligible for SSI because of RSDI cost of living increases received after April 1977 (Pickle Amendment)	12 Aged 32 Blind 92 Disabled
435.211	Persons who would be eligible for SSI if they were not in an institution	13 Aged 33 Blind 93 Disabled

Citation	Definition	Category of Aid in Nevada
	CHILD HEALTH ASSURANCE PROGRAM (CHAP)	47
No Federal Regulations P.L. 98-369 Deficit Reduction Act	1. Pregnant women in two parent households where the principal wage earner is unemployed. 2. Children born after September 30, 1983, under five years of age. Persons in these categories must meet the income and resource requirements of the Aid to Dependent Children Program.	
P.L. 98-369 Deficit Reduction Act	Persons ineligible for ADC because they are no longer eligible for earned income deductions (9 months of additional Medicaid coverage)	45
P.L. 98-369 Deficit Reduction Act	Persons ineligible for ADC because child support collected by Support Enforcement exceeds income limits (4 months of additional Medicaid coverage)	46

OPTIONAL COVERAGE GROUPS COVERED IN NEVADA

Citation	Definition	Category of Aid in Nevada
435.222	Children (under age 21) who would be eligible for ADC but do not qualify as dependent children. We cover reasonable classifications: 1. Children in foster homes or private institutions 2. Subsidized adoptions 3. Children in ICF's/ICF-MR's	60 Foster Care & Institutional Care - Regular Rate 62 Medicaid Only - Other Agency - Not in Custody of Nevada State Welfare 63 Subsidized Adoptions 65 Foster Care & Institutional Care - Higher Rate
435.230	Persons receiving only optional State Supplements. An amount the State pays in excess of the regular Federal SSI payment - Nevada supplements only the Aged and Blind categories. Nevada optional supplements are federally administered - therefore these people are considered to be receiving SSI and are included in aid codes:	10 Aged) independent 30 Blind) living 14 Aged) adult group 34 Blind) care
435.231	Persons in institutions eligible under a special income level - must meet all SSI requirements except for income - Nevada's special income limit is $714.00 - These people must also be in the institution for a full calendar month.	11 Aged 31 Blind 91 Disabled
435.212	Persons who would be ineligible for Medicaid if they were not enrolled in a federally qualified HMO (Health Maintenance Organization) 1. Eligible no longer than 6 mo. from the date of enrollment in the HMO 2. Eligible only for the benefits provided to an HMO enrollee.	No recipients enrolled in HMO's in Nevada

OPTIONAL COVERAGE GROUPS NOT COVERED IN NEVADA

Citation	Definition	Category of Aid in Nevada
435.210	Persons who would be eligible for ADC or SSI but are not receiving these benefits.	
435.220	Persons who would be eligible for ADC if their child care costs were paid from their earnings rather than by a State agency.	
435.223	Persons who would be eligible for ADC if the ADC State Plan were as broad as allowed under Title IV-A; i.e.: unemployed parents in intact families.	
435.217	Individuals receiving Home- and Community-Based Services.	

MEDICALLY NEEDY

Individuals must meet eligibility requirements for one of the State's categorical groups (ADC, MAABD) except for income and resource criteria. Single individuals without children are not eligible unless they are aged, blind or disabled. Intact families (both mother and father in home) are not eligible unless a parent is disabled/incapacitated. Children may be eligible if disabled or blind.

The individual's medical expenses must exceed the difference between individual's income and 133 1/3% of the State's ADC standard of need based on family size.

435.308	Individuals under age 21.	
435.310	Caretaker Relatives - Persons who have in their care an individual determined to be a dependent.	
435.320	Aged individuals in states that cover persons receiving SSI.	
435.322	Blind individuals in states that cover persons receiving SSI.	

Citation	Definition	Category of Aid in Nevada
435.324	Disabled individuals in states that cover persons receiving SSI.	
435.326	Persons who would be ineligible if not enrolled in an HMO.	
435.330	Aged, blind and disabled individuals in states that have more restrictive requirements than SSI.	
435.340	Blind and disabled persons who were eligible in December 1973.	

APPENDIX B

Medicaid, An Overview, July 1985

MEDICAID

AN OVERVIEW

July 1985

HISTORY-BACKGROUND

Medicaid is the popular term used to describe medical assistance and services provided to persons who receive public assistance or who are medically needy inpatients of hospitals or nursing homes. In 1965, the 89th Congress of the United States added Title XIX to the Social Security Act authorizing varying percentages of federal participation to states and United States protectorates offering such medical programs.

Nevada, in 1967, initiated a comprehensive program for the categorically needy under State legislation titled "State Aid to the Medically Indigent". The authorization for this program is found in NRS 428 and is often referred to by the acronyms "SAMI" or "Title XIX". A "medically needy" program as described by federal regulation for non-institutionalized citizens has not been promulgated in Nevada.

Medicare, enacted in Title XVIII of the Social Security Act, is the medical program for aged and some disabled persons who contribute premiums and receive certain medical benefits similar to an insurance policy. Medicare is often confused with State administered Medicaid as some persons may receive benefits from both programs.

In 1974 the Social Security Administration implemented the Supplemental Security Income (SSI) Program. Eligibility for cash assistance for the aged, blind, and disabled then became the responsibility of the SSI program. Persons receiving SSI could be eligible for Medicaid coverage if they submitted an application to the Welfare Division.

In 1975 Nevada reviewed optional Medicaid coverage groups and began providing medical assistance to the categorically needy, institutionalized, aged, blind, and disabled persons.

FUNDING

Public funding for Medicaid is shared between state allocated spending authority and the Federal government on an approximate 50% matching basis. However in the past three years, federal participation has been reduced by 3%, 4% and 4.5%.

Overall spending authority is included in the Division cap for the biennium. Spending authority may be transferred from one year to the other with the approval of Interim Finance upon recommendation of the Governor.

Funding sources are:

	Federal %	State General Fund %
Federal Medicaid	50.5%	49.5%
Federal Indochinese	100%	--
Federal Health Facilities	100%	--

Category Description	Work Program FY 1984-85	Legislative Approved FY 1985-86	Legislative Approved FY 1986-87
Salary/Payroll	$ 1,634,734	$ 1,513,241	$ 1,547,898
Out-of-State Travel	1,000	570	570
In-State Travel	42,714	49,348	50,722
Operating	187,821	213,498	219,245
Office Furn. & Equip.	1,000	3,826	1,000
Training	1,500	1,000	1,000
Fiscal Agent Charge	1,676,314	1,680,056	1,789,305
Data Processing	418,665	389,540	412,312
Medical Payments	78,618,790	84,186,873	88,513,067
Contract Service Health Div.	79,698	89,400	93,870
Contract - O/S Review		2,100	2,200
Contractual Services	254,000	292,100	333,784
Utilities	18,401	8,147	8,554
County Indigent Program		2,800,000	3,100,000
Total Expenditures	$82,934,687	$91,229,699	$96,073,527

Additional Descriptions:

Fiscal Agent Charge -- Payment to the Medicaid fiscal agent (currently Blue Cross and Blue Shield of Nevada) for screening, processing and disbursement of medical payments. The contract includes third-party liability searches, provider relations, and auditing of long-term-care facilities.

Data Processing -- Provides for payment of claims and other services through the State Computer System. This includes claims processing services of the fiscal agent.

Medical Payments -- Payment of all medical services for Aid to Dependent Children (ADC) recipients, Child Welfare and SSI eligibles.

Contract Services Health Division -- Payment for certification process of long-term-care facilities by the State Health Division.

Contractual Services -- Provides for review of hospital services to help contain medical costs. Service is provided by Nevada Physicians Review Organization and is required by Federal Law.

County Indigent Program -- The additional spending authority of 2.8 and 3.1 millions was placed in the biennial budget allowing counties to participate in the Medicaid program and receive federal funds as reimbursement for certain institutionalized persons now cared for by the counties. This program required 17 county participation and Interim Finance Committee approval. The counties must contribute one half of the funding which will be matched with federal dollars.

ELIGIBILITY CRITERIA

Eligibility is determined by Eligibility Certification Specialists in each District Office.

Eligibility for Medicaid through the cash assistance programs (ADC, Refugee, Child Welfare) is described in write ups of those programs.

Eligibility for Medical Assistance to the Aged, Blind and Disabled (MAABD) requires the following:

A. Cooperation (SSI and State Cases)

Clients or their representatives are required to cooperate with the Welfare Division in securing all information needed to determine eligibility. Failure to refusal to do so will cause denial or termination.

B. Residence (SSI and State Cases)

In general, clients must be living in Nevada with the intention of making Nevada their home permanently or for an indefinite period. There are exceptions for out-of-state placements and individuals incapable of indicating intent.

C. Citizenship (State Cases)

D. Age (State Cases)

1. Blind and Disabled Programs: No age requirements.

2. Aged Program: Must be 65 years of age or older.

E. Disability/Blindness (State Cases)

Bureau of Supplemental Security Income (BSSI) and Retirement Survivors and Disability Income (RSDI) disability determinations are acceptable verifications of disability. Clients under 65 years old not receiving SSI or RSDI disability benefits require a medical determination by the Medical Review in the Nevada State Welfare Division (NSWD) Medicaid office. Clients ineligible for SSI and RSDI because they do not meet the Social Security Administration's blindness/disability standards are ineligible for Medicaid.

F. Resources/Property (State Cases)

Persons in institutions are considered individuals. Only their own resources are counted. When resources exceed $1,500 the case is ineligible. Resources are evaluated at market value less encumbrances. There are certain types of resources that are excluded, such as:

1. Life insurance policies, then the total face value is less than $1,500.

2. Vehicles necessary to produce income, necessary for transportation for medical treatment on a regular basis, specially equipped vehicles for the handicapped, or the value of a vehicle up to $4,500.

3. Burial plots/plans.

4. Household goods and personal effects.

C. Financial Eligibility/Income Limits (State Cases)

All income received is evaluated to determine whether it is budgetable or exempt. Gross countable income is then compared to the NEED STANDARD ($714.00) per month.

If countable income is less than or equal to the need standard, financial eligibility is established.

If countable income exceeds the need standard, the client is not eligible.

Patient Liability

Patient liability is established for patients in medical facilities who have qualified for Medicaid as an SSI recipient or who have met the State Institutional eligibility criteria.

Patient liability is an amount that must be paid monthly by the Welfare recipient towards his/her cost of care before Medicaid will pay.

Patient liability is determined by subtracting the following from the individuals countable income:

-- $35 personal needs allowance per month

-- Spouse/dependent children's monthly maintenance allowance (when requested).

-- Payments for health insurance premiums, deductibles and coinsurance charges.

-- Payments for medical care.

Patient liability is determined for all months of institutionalization including first and last months.

For a partial month, the amount of the patient liability is prorated according to the number of days the client is in a facility.

MEDICAL SERVICES

Medicaid will NOT reimburse for broken appointments, bills that have already been paid, or out-of-state services (except in emergencies or as prior authorized by Medicaid).

Medical payment for bills is made directly to the practitioner or institution who provides the service. Recipients are not responsible for medical bills for anything covered by Medicaid.

Providers must bill the recipient's health insurance carrier BEFORE requesting payment from Medicaid. Medicaid pays after all other insurances have been billed (except Crippled Childrens Services and Indian Health Services).

Medicaid will pay for:

* 2 visits to a doctor or clinic per month for illness/injury (co-payments $1 and $2 per visit).

* Family planning services without limit (doctor, clinic, or pharmacy).

* Hospital admissions for emergencies, childbirth or urgently needed care which has been prior authorized by the Nevada Professional Review Organization.

* Laboratory and x-ray services.

* Home health care and medical supplies.

* Care in a skilled nursing facility.

-- Care in an intermediate care facility or facility for the mentally retarded.

-- Care in an institution for mental diseases if age 65 or older.

-- Chiropractor or podiatrist if there is very severe pain (co-payment $1 each visit).

-- Outpatient habilitation services to the mentally retarded.

-- Prescriptions (3 per month, co-payment $1 each, plus family planning).

-- Use of ambulatory surgical centers within the two-visit per month limitation.

* Medical equipment (wheelchairs, braces, etc.).

-- Eye exam and glasses every 3 years (co-payment $2 exam, $3 glasses).

* Transportation to and from covered medical services (taxi $1 co-payment each visit).

-- Physical, occupational or speech therapy.

-- Qualifying prepaid health plans.

-- Emergency dental care (co-payment $2 for first visit, $3 each denture).

* Ambulance, medi-car (co-payment $3 or $2 each non-emergency use).

-- Total parenteral nutrition.

* Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

"Early screening" is a special Medicaid program for infants, children and young adults under 21 years of age. A free physical examination, immunizations and dental checkup are provided. Some children's health problems are hidden. When the problem is found early, it can be more easily treated and cured. If the screening examination shows that a child may have an illness or health problem, he will be referred to a physician or clinic for further examination and treatment. If a child needs a hearing aid, eyeglasses or regular dental care, he will be able to have these as an Early Screening benefit. There is no co-payment on Early Screening services.

* Mandatory services are those medical services required by Federal regulation to State for participation in the Medicaid program.

-- Optional services are those services, not mandated but provided optionally through State Plan adoption. Nevada Medicaid utilizes most optional services allowed with exceptions such as Christian Science Sanatoriums.

PROVIDERS

Providers is the term to describe medical institutions, practitioners and service or product suppliers to the Medicaid program.

In order to receive payment for covered services, a provider must sign a participating agreement under which he agrees:

1. To provide services to certified Medicaid recipients in accordance with the fee schedules and procedures of Nevada State Welfare Division.

2. To adhere to professional standards of medical or paramedical care and/or services, and to comply with all local, state and federal statutes, rules and regulations pertinent to the Provider's performance under the agreement.

3. That the patient's medical insurance resources, including but not limited to Medicare, private insurance, and insurance provided by employers and unions, will be utilized before claims are submitted to Medicaid.

4. To accept Medicaid payment in full, except for required recipient deductibles or co-payments, and as provided in 3 above, and not to bill, accept or retain payments from patients or relatives for any additional amount.

5. Not to discriminate in any way on the basis of race, color, national origin, sex, creed or handicap.

6. To conduct his practice, or his business, in such a way that the individual always has freedom of choice in choosing a Provider.

7. To keep and permit access to such records as are necessary fully to disclose the extent of the services provided to Medicaid recipients.

8. To furnish the Welfare Division, the Secretary of Health and Human Services, or other appropriate agencies with such information, by copy, as may be requested.

Any individual eligible for Medicaid has free choice of provider from among those who have signed participating agreements. Such choice is a matter of mutual agreement between patient and provider and in no way abrogates the right of the professional to accept or reject a given individual as his private patient or to limit his practice as he chooses. Waiver, by the Secretary of Health and Human Services, of free choice is required for enrollment in certain prepaid health plans.

Many patients eligible for Medicaid have coverage under private or group insurance, Medicare, Nevada's Industrial Insurance System, or some other protective plan. All such coverage is considered prior resource and must be billed and applied to payment before billing Medicaid.

Other agencies provide many services which supplement and/or duplicate those covered by Medicaid. The Department of Human Resources includes offices for Services to the Blind, Aging Services, Dental Health, Mental Hygiene, Mental Retardation, Speech and Hearing, Family Planning Clinics, Crippled Children, Maternal and Child Health, Communicable Disease Control, Developmental Disabilities, Alcoholism, and Mental Health Clinics. Other resources exist at the city, county, state or federal level which are too numerous to list.

Medicaid providers are frequently referred to by code numbers, particularly on computer generated reports and claim remittance information. They are:

10 Ambulatory surgery (outpatient)
11 Hospital, inpatient, acute
12 Hospital, outpatient
13 Mental hospital, inpatient
14 Mental health clinics, outpatient
15 Rural Health Clinics
16 Intermediate Care Facility-Mental Retardation (ICF/MR)
17 Special clinics
18 Skilled Nursing Facility (SNF)
19 Intermediate Care Facility (ICF)
20 Physician, Psychiatrist
21 Podiatrist
22 Dentist
23 Hearing aids
24 Certified Registered Nurse Anesthetist (CRNA)
Certified Registered Nurse Practitioner (CRNP)
25 Optometrist or optician

26 Psychologist
27 Lab, radiological or pathological
28 Pharmacy
29 Home Health Agency
30 Physician aide
31 EPSDT
32 Ambulance
33 Durable Medical Equipment (DME), prosthetics, disposables
34 Physical, occupational, speech therapy
35 Transportation
36 Chiropractor
38 Habilitation
99 Emergency foster care medical

	PROVIDER		PRIOR		EFFECTIVE 7-1-85 U.O.	
10	Ambulatory surgical center		Cost reimbursement: X code: % billed charge		No change	
11	Hospital, inpatient		1-85 Prospective rates:		7-85: Prospective rat	
			Maternity	$ 1520	Maternity	$ 1
			Newborn	$ 285	Newborn	$
			NICU	$ 7530	NICU	$ 7
			Group I (164)	$ 2815	Group I (164)	$ 2
			Group II (75-164)	$ 2365	Group II (75-164)	$ 2
			Group III (75)	$ 1625	Group III (75)	$ 1
			Per Diem 15 days	$ 545	Per Diem 15 days	$
			Admin days	$95/85	Admin days	$100
12	Hospital, outpatient:	74 CRVS:	Medicine	$ 3.76	Medicine	$ 3
			Anesthesia (A)	$10.55	Anesthesia (A)	$ 11
			Surgery	$72.44	Surgery	$ 75
			Radiology	$ 8.02	Radiology	$ 8
			Pathology	$ 0.90	Pathology	$ 0
		NRVS-T:	Therapy	$10.73	Therapy	$ 11
		C98000:	Supply/equip.	90% UC	Supplies	90%
13	Mental hospital, inpatient		Cost reimbursement: X code: % billed charge		No change	
14	Mental hospital, outpatient		Same as 12		Same as 12	
15	Rural Health Clinic		X code: T18 core rate		No change	
16	ICF/MR		Costs to maximum: X code: flat per diem		No change	
17	Clinic	74 CRVS:	Medicine	$ 3.08	Medicine	$ 3
			Surgery	$42.40	Surgery	$ 44
			Radiology	$ 4.64	Radiology	$ 4
			Pathology	$ 0.82	10-83: Pathology	--
18	SNF		X code: working rate: Flat or adj. maximums:		No change	
			Admin	$ 4.18 flat	$4.49(1-82)4.86(1-85)	
			Emp ben	cost adj.		
			Hskppg	$ 8.32 flat	$8.75(1-82)9.01(1-85)	
			Raw food	$ 2.60 adj.	$2.95(7-81)	
			Prop 4.40/5.70/6.25 adj.		$9.80(1-85)	
			Equity	2 x FHITF %	1½ x FHITF % (1-84)	
			Health care	3 hours	Hlth(1-85):HIS 4.5 hrs SNF 3.5 hrs	
19	ICF		X code: working rate: same as 18 with Health Care limited to:		X code: working rate: same as 18 with Health Care limited to:	
			ICF III	2.75 hours	3 hours (1-85)	
			ICF II	1.50 hours	2 hours (1-85)	
			ICF I	0.75 hour	1 hour (1-85)	
20	Physician/Psychiatrist	73 ASAC:	Anesthesiology	$18.37	Anesthesiology	$ 19
		74 CRVS:	Medicine	$ 3.76	Medicine	$ 3
			Anesthesia (A)	$10.55	Anesthesia (A)	$ 11
			Surgery	$88.43	Surgery	$ 92
			Radiology	$ 7.67	Radiology	$ 8
			Pathology	$ 0.90	10-83: Pathology	-

	PROVIDER		PRIOR		EFFECTIVE 7-1-85 U.O.N.	
21	Podiatrist	74 CRVS:	Medicine	$ 3.10	Medicine	$ 3.24
			Surgery	$49.99	Surgery	$52.24
			Radiology	$ 5.67	Radiology	$ 5.93
22	Dentist		$11.04 in NRVS-D		$11.54 in NRVS-D	
23	Hearing aids		X code: AWP + $170.90		AWP + $178.60	
24	CRNP	74 CRVS:	Medicine	$ 3.76	Medicine	$ 3.93
			Anesthesia (A)	$10.55	Anesthesia (A)	$11.02
			Surgery	$42.40	Surgery	$44.31
25	Optometrist/optician		$10.92 in NRVS-O		$11.41 in NRVS-O	
			Lab invoice on lens		No change	
			AWP on frames to $22		AWP on frames to $23.	
26	For future use		-		-	
27	Laboratory	74 CRVS:	Medicine	$ 2.27	Medicine	$ 2.37
			Radiology	$ 7.04	Radiology	$ 7.36
		10/83:	Pathology	$ 0.90	Pathology	$ 0.90
28	Pharmacy	NDC:	UC/EAC/MAC + $3.78		UC/EAC/MAC + $3.95	
			unit dose 37¢ + profee		unit dose 39¢ + profee	
29	Home Health Agency	C98000:	UC/fixed schedule/visit		UC/fixed schedule/visit:	
			RN	$44.00	RN	$47.00
			LPN	$33.00	LPN	$35.00
			Therapy	$35.00	Therapy	$37.00
			Aide	$19.00	Aide	$20.00
30	Home Care: Personal Care Aide		C98000: $5.10/6.60/hr		$5.35/6.90/hour	
	Private LPN/RN		C98000: $7.75/9.15/hr		$8.10/9.55/hour	
31	EPSDT	S09006:	Medicine	$ 3.76	Medicine	$ 3.93
32	Ambulance	R Code:	$65.00 base rate		$68.00 base rate	
			$27.00 sit-up		$34.00 sit-up	
			$ 3.00 out-of-town mi.		$ 3.50 out-of-town mi.	
			$20.00 special equip.		$21.00 special equip.	
			$ 8.00 special use		$ 8.50 special use	
33	Prosthetics/supplies		X Code: UC - discount		No change	
34	Therapy		$10.73 in NRVS-T		$11.21 in NRVS-T	
35	Transportation: Public		R code: UC(billed charge)		No change	
	Private		R code: 19¢/mile		20¢/mile	
36	Chiropractor	C97260:	Medicine	$ 3.43	Medicine	$ 3.58
37	Home IV supplies		7/82: hand-priced		No change	
38	Habilitation waiver		7/82: variable/services		No change	
40	Prepaid health plans, HMOs		11-83: variable/aid/mo: 22.77/27.30/29.32/55.43		1/85: variable/aid/mo: 25.66/26.99/29.43/48.58	

PROVIDES PAYMENTS

Reimbursement for medical services to providers is the largest single line item in the Medicaid budget. Efforts of health care cost containment are evidenced by reductions in FY '84 and FY '85.

	PERSONS	MEDICAL PAYMENTS*	CHANGE FROM PRIOR YEAR	ANNUAL COST PER PERSON
FY68		$ 5,117,412	NA	
FY69		6,913,703	+.351	
FY70		6,892,733	-.003	
FY71		7,405,962	+.074	
FY72		9,333,739	+.260	
FY73	21,431	11,697,835	+.253	$ 546
FY74	21,128	12,611,326	+.078	597
FY75	23,333	16,267,962	+.290	697
FY76	26,325	22,495,706	+.383	855
FY77	22,692	19,500,969	-.133	859
FY78	21,037	23,610,553	+.211	1,122
FY79	21,865	31,181,532	+.321	1,426
FY80	24,370	40,392,438	+.295	1,657
FY81	29,956	57,017,186	+.412	1,903
FY82	29,508	65,273,420	+.145	2,212
FY83	28,212	72,167,772	+.106	2,558
FY84	27,647	68,058,727	-.057	2,462
FY85	28,117	66,229,387	-.027	2,355

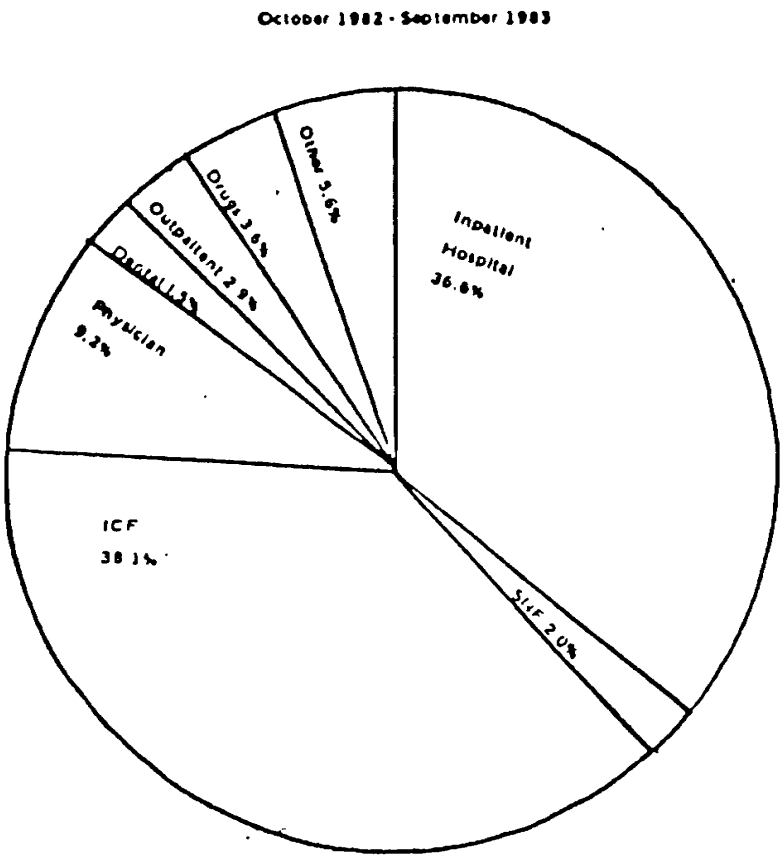
*Excludes purchase of Medicare Part B coverage

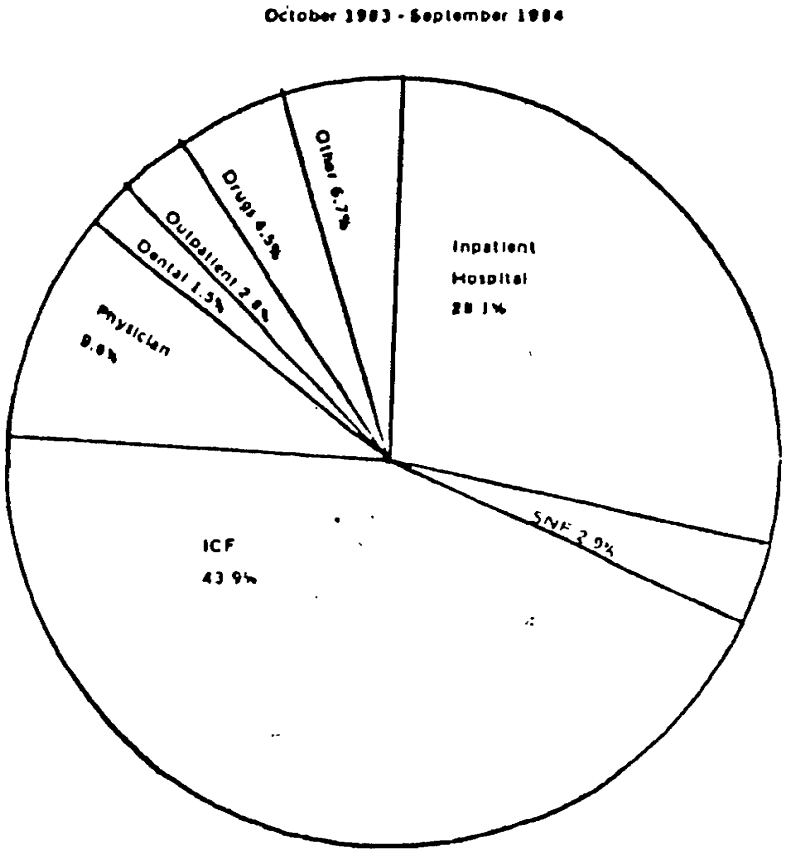
The following charts depict provider payments by percentage for the last eight years. NOTE: Difference of percentage figures in pie chart is caused by federal fiscal year reporting.

NEVADA MEDICAID
Percentages of Total Medical Payments

	FY78	FY79	FY80	FY81	FY82	FY83	FY84	FY85
Mental hospital	.00	.48	.68	.48	.39	.30	.22	.34
Mental retardation facility	3.42	7.59	8.73	7.64	8.28	8.46	11.20	12.89
Skilled nursing facility	26.83	5.32	2.03	1.69	1.93	2.40	2.70	3.11
Intermediate care facility	18.18	39.12	39.48	33.45	32.35	29.64	31.13	32.47
TOTAL LONG-TERM CARE	48.43	52.51	50.92	43.26	42.95	40.80	45.25	48.81
Hospital inpatient	28.68	25.58	28.22	31.80	35.09	37.11	30.77	24.99
TOTAL INPATIENT	77.11	78.09	79.14	75.06	78.04	77.91	76.02	73.80
Hospital outpatient services	2.93	2.61	2.16	2.94	2.43	2.47	2.12	2.30
Physicians, clinics	11.48	10.59	9.63	12.49	10.60	10.25	10.39	9.83
Laboratory, X-ray	.25	.25	.20	.26	.29	.24	.31	.49
Drugs	4.32	4.32	4.05	3.64	3.88	3.66	4.27	5.21
Home health care/supplies	.92	1.09	1.26	1.39	1.44	1.45	1.48	1.85
Dentists	1.49	1.50	1.47	1.96	1.61	1.49	1.54	1.63
MR Waiver Program						1.00	2.20	2.65
Prepaid health plan (UNR)							.20	.67
EPSDT	.47	.35	.48	.47	.36	.30	.29	.27
Transportation	.59	.58	.81	.96	.79	.75	.74	.87
Other practitioners	.44	.62	.80	.83	.56	.48	.44	.43
	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

By Type of Service





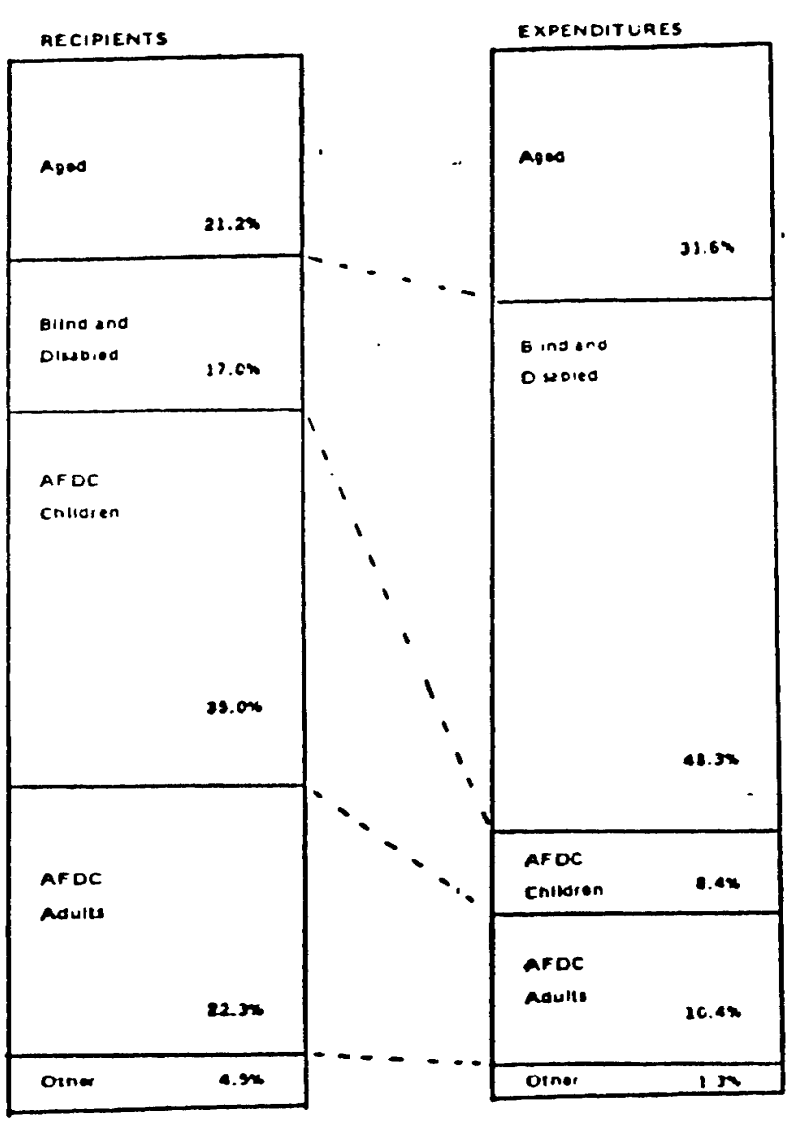
RECIPIENTS

Recipient is the term used for those persons eligible and receiving medical assistance and services.

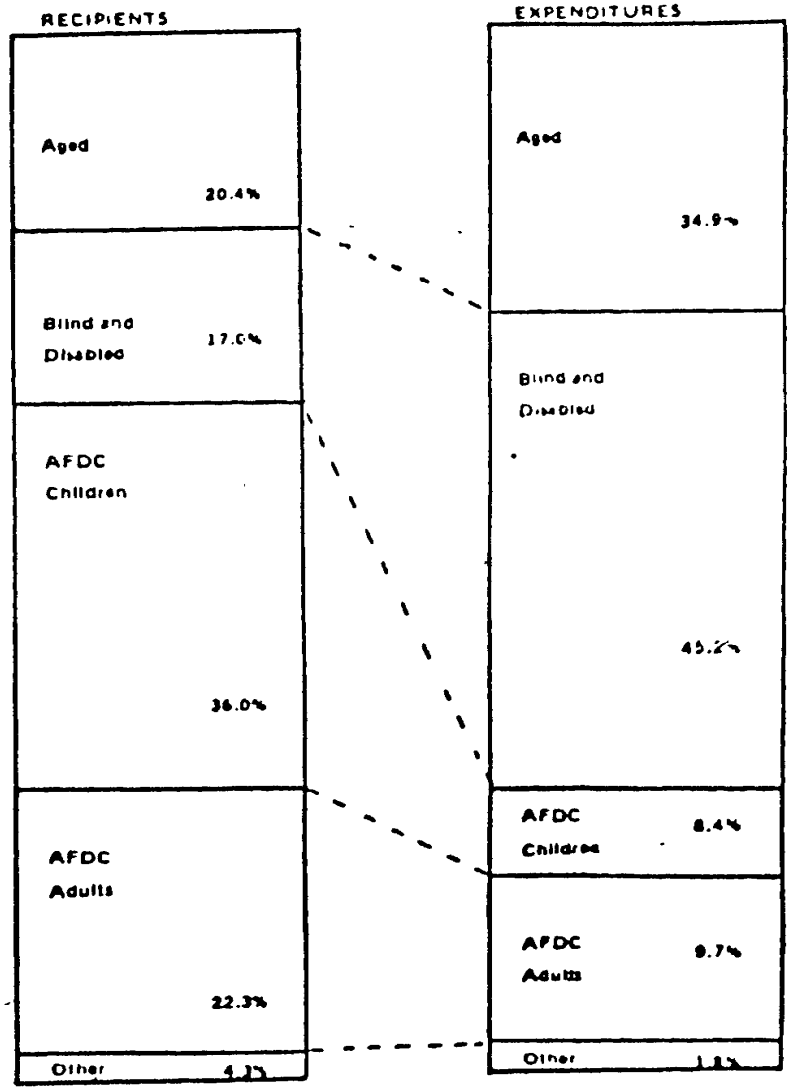
The public in general has a misconception about the persons using medical service and is critical of the sterotyped welfare person receiving health care. In reality, the largest user are the aged, blind, and disabled, who comprise 37% of the recipient population but receive 81% of all medical care expenditure. The aid to dependent children and adults who comprise 58% of the recipient population use only 18.1% of Medicaid funds.

MEDICAID RECIPIENTS AND EXPENDITURES

October 1982 - September 1983



October 1983 - September 1984



Statistics for services are often divided between the Aid to Dependent Children (ADC) population and the Medical assistance to the Aged, Blind, and Disabled (MAABD) population.

The following charts depicts the applications received and ongoing caseload of the two categories.

ADC STATISTICS
FY 85

Month	(1) Apps Rec'd	(2) Ongoing Cases	(3) People Participating	(4) Value of Grants
JUL 84	904	4,061	12,219	$804,482
AUG 84	1,086	4,134	13,024	841,206
SEP 84	935	4,174	12,840	844,106
OCT 84	984	4,211	12,822	866,860
NOV 84	870	4,169	13,275	895,416
DEC 84	849	4,265	13,386	904,906
JAN 85	838	4,348	13,741	921,328
FEB 85	703	4,378	13,395	914,510
MAR 85	839	4,431	13,845	934,630
APR 85	848	4,488	13,953	938,178
MAY 85	789	4,556	14,190	939,842
JUN 85	760	4,444	* 13,691	* 910,106

Sources: (1) Case Action Report
(2) Monthly Persons Count
(3) Monthly Aid Accounting Report
(4) Monthly Aid Accounting Report

* Figures are unofficial due to end of FY

MAABD STATISTICS
FY 1985

Month	(1) Apps Rec'd				(2) Ongoing Caseload			
	Aged	Blind	Disabled	Total	Aged	Blind	Disabled	Total
JUL 84	165	4	279	448	4,341	341	3,074	7,756
AUG 84	183	2	310	495	4,403	333	3,076	7,812
SEP 84	127	2	268	397	4,416	330	3,136	7,882
OCT 84	163	11	307	481	4,425	329	3,195	7,949
NOV 84	106	8	261	375	4,396	330	3,203	7,929
DEC 84	125	4	263	392	4,380	326	3,210	7,916
JAN 85	129	6	290	425	4,336	332	3,233	7,901
FEB 85	120	7	239	366	4,333	329	3,244	7,906
MAR 85	146	5	276	427	4,339	338	3,312	7,989
APR 85	197	4	340	541	4,385	331	3,370	8,086
MAY 85	143	4	271	418	4,404	335	3,414	8,153
JUN 85	122	6	267	395	4,378	331	3,376	8,085

Sources: (1) & (2) Case Action Report

Recipients are also listed by aid categories and frequently referred to by the code numbers in reports and conversation.

They are as follows:

AID CATEGORIES

10	Aged in independent living
11	Aged in hospital, SNF or ICF ($285-$714)
12	Aged with disregarded income
13	Aged in hospital, SNF or ICF ($45-$285)
14	Aged in ACCF or FCH
15	Aged in hospital, SNF or ICF ($0-$45)
16	Aged refugee
30	Blind in independent living
31	Blind in hospital, SNF or ICF ($358-$714)
32	Blind with disregarded income
33	Blind in hospital, SNF or ICF ($45-$358)
34	Blind in ACFC or FCH
35	Blind in hospital, SNF or ICF ($0-$45)
36	Blind refugee
85	Refugee resettlement program
86	Repatriated citizen program
90	Disabled in independent living
91	Disabled in hospital, SNF or ICF ($265-$714)
92	Disabled with disregarded income
93	Disabled in hospital, SNF or ICF ($45-$265)
94	Disabled in ACFC or FCH
95	Disabled in hospital, SNF or ICF ($0-$45)
96	Disabled refugee
40	ADC
41	ADC - incapacitated parent
42	ADC - post-eligible for 4 months
43	ADC - includes a refugee
50	ADC - child care payment through WIN
22	Child in Emergency Shelter Care
45	Child in institution ($ADC-FC)
46	Child in foster home ($ADC-FC)
60	Child in foster home ($FIC)
61	Child refugee
62	Child in institution or foster home
63	Child in subsidized adoption
65	Child in institution ($FIC)
70	Non-XIX child in foster home ($FIC)
72	Non-XIX child in Emergency Shelter Care
73	Non-XIX child in subsidized adoption
75	Non-XIX child in institution ($FIC)
79	Non-XIX single parent program

Glossary

Medicaid associated acronyms and abbreviations.

ADC (AFDC)	Aid to Dependent Children
AFCH	Adult Family Care Home
AGCF	Adult Group Care Facility
ASC	Ambulatory Surgical Center
ATO	Authorized Transportation Only
BC and BSN	Blue Cross and Blue Shield of Nevada
BHF	(obsolete) Bureau of Health Facilities
BORHS	Bureau of Regulatory Health Services
CHAP	Child Health Assurance Program
CO	Central Office
COLA	Cost of Living Adjustment
CPI	Consumer Price Index
CTP4	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CRNP	Certified Registered Nurse Practitioner
CRVS	California Relative Value Studies
DEFRA	Deficit Reduction Act
DME	Durable Medical Equipment
DMH/MR	Department of Mental Health/Mental Retardation
DO	District Office
DRG	Diagnostic Related Group
ECO	Emergency Care Only
EOB	Explnation of Benefits
EPSDT	Early Periodic Screening Diagnosis and Treatment
ESRD	End State Renal Disease
F&A	Fraud and Abuse
FFP	Federal Financial Participation
FI (FA)	Fiscal Intermediary, Fiscal Agent
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HHA	Home Health Agency
HHS	Health and Human Services
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facility for Mental Retardation
MEDI-CAL	California Medicaid
MMIS	Medicaid Management Information System
MRT	Medical Review Team
NevPRO	Nevada Physician's Review Organization
NMO	Nevada Medicaid Office
NRVS-D	Nevada Relative Value Scale - Dentistry
NRVS-O	Nevada Relative Value Scale - Ocular
NRVS-T	Nevada Relative Value Scale - Therapy
OIG	Office of Inspection General
OMB	Office of Management and Budget
OOS	Out-of-State
OT	Occupational Therapy
PCCM	Primary Care Case Management
PPS	Prospective Payment System
PRO	Peer Review Organization
PT	Physical Therapy
QC	Quality Control
RA	Remittance Advice

RT	Respiratory Therapy
SAMI	(obsolete) State Aid to Medically Indigent = Medicaid
SNF	Skilled Nursing Facility
ST	Speech Therapy
SURS	Surveillance Utilization Review System
TEFRA	Tax Equity and Fiscal Responsibility Act
TPL	Third Party Liability
TPN	Total Parenteral Nutrition
UR	Utilization Review

APPENDIX C

County Hospital and County Medical Indigency Finances in the State of Nevada

County Hospital and County Medical Indigency Finances

in the

State of Nevada

PREPARED BY THE

NEVADA ASSOCIATION OF COUNTIES

CONTRACT NO. CC005, GREATER NEVADA HEALTH SYSTEMS AGENCY

Carson City, Nevada

February, 1985

INTRODUCTION

The steady and continuing rise in the cost of health care, nationally, as well as in the State of Nevada, has impacted upon the operations of County Governments. Several of the dimensions of that impact are to be found in this report.

While the information herein demonstrably portrays the severe problems faced by the public (County) hospitals in the State, the report offers no solutions to same. The material highlights the fact that local public hospitals in the State, with few exceptions, are in a continuing financial malaise and that that malaise could lead toward the demise of some of these facilities unless action is taken to prevent same.

Similarly, the data in this document affirms the reality that County Governments in Nevada are expending a very large and growing proportion of their limited resources toward fulfilling their State-mandated responsibility of meeting the health care needs of the medically indigent. The financial burdens the Counties face in this area also increases inexorably. These increased burdens are attributable not only to the rise in health care costs, directly, but also to the "ripple" effects such rise in costs have upon increasing the number of persons who find themselves unable to purchase health insurance premiums or to pay out-of pocket expenses for basic health care services.

It is NACO's hope that the publication of this material will encourage the County Governments themselves, the State Legislature as well as the people of Nevada to give this matter greater attention and to work with NACO and the GNHSA in a variety of cooperative efforts to prevent programmatic failure with its potentially disastrous consequences for the citizens of this great State.

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ITEM PAGE

Tables

HOSPITALS

As of January, 1985, there were 34 facilities licensed as HOSPITALS in the State of Nevada. Of these 34 institutions, 12 are operated by county governments; 10 by for-profit corporations; 6 by non-profit corporations; 4 by the United States Government; and 2 by the State of Nevada.

In terms of geographic location, 13 hospitals are to be found in Clark County; 8 hospitals are in Washoe County; 2 in Elko County; 2 in Mineral County; and 1 each in Carson City, Churchill, Humboldt, Lander, Lincoln, Lyon, Nye, Pershing, and White Pine Counties. There are no hospitals in Douglas, Esmerelda, Eureka, or Storey Counties.

BEDS

The 34 hospitals contain a total of 4,055 beds. The distribution of those beds in terms of geographic location is: Clark County, 2,156 or 53.17%; Washoe County, 1,492 or 36.79%; all other counties (11), 407 beds or 10.04% of the total.

The distribution of hospital beds in terms of ownership reveals that 1,796 or 44.30% of the 4,055 beds are owned by for-profit corporations; 1,211 or 29.87% are owned by county governments or county hospital districts; 548 or 13.51% are owned by non-profit corporations; 354 or 8.72% are owned by the United States Government and 146 or 3.60% are owned by the State of Nevada.

HOSPITALS & BEDS: NEVADA COUNTY FACILITIES

The 12 county hospitals are located in Carson, Clark, Elko, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Washoe, and White Pine Counties. Counties not having county hospital facilities include Douglas, Churchill, Esmerelda, Eureka, and Storey. Churchill county operated a hospital until 1982. That hospital is now affiliated with a non-profit corporation and is therefore not included in the analysis of county hospital operations included in this report.

In 1978, the 12 county hospitals contained 1,162 beds. In 1984, these same facilities had 1,211 beds, an increase of 4.04% in that time period. The location of these beds, by geographical area is as follows: Washoe County, 537, 44.75%; Clark County, 336, 27.74%; Carson City, 116, 9.66%; Elko County, 52, 4.29%; 170 or 13.56% in the remaining 8 counties.

When examined in relationship to the "urban" and "rural" complexion of the State, 989 or 81.67%of the county operated hospital beds are located in urban counties, while 222 or 18.33% of the county operated hospital beds are to be found in rural counties.

In the State of Nevada, county governments may operate hospitals directly through their county commissioners or they may be operated by "hospital districts." The essential elements of both systems are delineated below.

County Hospitals and County Hospital Districts

Under the provisions of NRS 450.020 et sequalae, the County Commissioners of a Nevada County may, after appropriate approval of the electorate, appoint individuals to serve as members of the board of trustees of a county hospital. The County Commissioners also are responsible for the capital and operational funding of the facility.

Under the provisions of NRS 450.550 et sequalae, the electorate of a county may establish a "hospital district" in which instance they also directly elect the persons who are to serve on the board of trustees of the local hospital facility.

Under the "hospital district" structure, there is somewhat greater latitude of the board of trustees in areas of bonding, in contracting for services, and in the administration of the facility than otherwise.

The following counties operate their county hospitals under the provisions of NRS 450.550 related to hospital districts: Lander, Lincoln, Lyon, Mineral, Nye, Pershing and White Pine.

Revenues

In 1978, operating revenues for county hospitals totalled $80,512,730. By 1984 operating revenues were $183,646,684, an increase of 131.82%.

Of the $80,512,730 in 1978 revenues, $68,784,446 or 85.43% were earned by the 3 urban hospitals while $11,728,284 or 14.57% were earned by the 9 rural hospitals.

The 3 urban hospitals accounted for $164,553,681 or 89.60% of the $183,646,684 in revenues obtained in 1984; the 9 rural hospitals accounted for $19,093,003 or 10.40% of the revenues earned in that year.

Thus, in the seven year period, while revenues for urban hospitals increased 139%, they increased only 63% for rural facilities. Furthermore, the rural facilities suffered a 28% decrease in their proportion of total county hospital rever in that seven year time span.

Expenses

In 1978, operating expenses for county hosptials totalled $77,685,337. By 1984 operating expenses for county hospitals were $187,737,411, an increase of 142.66%.

Of the $77,685,337 in 1978 expenses, $64,096,092 or 82.50% are attributable by the 3 urban hospitals while $13,589,245 or 17.50% are attributable to the 9 rural hospitals.

The 3 urban hospitals accounted for $166,924,284 or 88.91% of the $187,737,441 expended in 1984; the 9 rural hospitals expended $20,813,217 or 11.09% of the total in 1984.

Revenues, Expenses, "Profits" and Losses: County Hospitals

During the 7 year period, 1978 through 1984, rural county hospitals in Nevada received a total amount in revenues of $102,486,433 or an average of $14,640,919 per year. In that same time span, rural hospitals in the State expended $117,323,054 or an average of $16,760,436 per year. Thus, rural hospitals in Nevada experienced a financial loss of $14,836,621 during the above 7 year period. This amount equates to an average loss of $2,119,517 per year.

Urban county hospitals in Nevada had revenues of $841,073,516 during the years 1978 through 1984 or an average amount in revenues per year of $120,153,359. These urban county institutions expended $820,679,983 during that same time span or an average expenditure per year of $117,239,998. Thus, urban county hospitals earned a "profit" in the 7 year period of $20,293,533 or an average, per year, of $2,913,361.

In sum, rural county hospital experienced an annual average deficit which was 14.47% greater than their income; urban county hospitals experienced an annual average "profit" which exceeded income by 2.42%. By comparison, all community hospitals in the State of Nevada earned an annual average "profit" of 8.50% in that same time period.

County Government Support of County Hospitals

Financial support of local county hospitals by county governments is a significant factor in the operations of these facilities as can be seen from the following table: for the year 1983.

HOSPITAL	INCOME	COUNTY SUPPORT CARE FOR MEDICALLY INDIGENT	SUBSIDY	TOTAL COUNTY SUPPORT	COUNTY SUPPORT AS PERCENT OF TOTAL INCOME
Battle Mountain	$392,268	$59,803	-	$59,803	15.24
Elko	4,938,035	29,183	$100,000	129,183	2.62
Grover C. Dils	892,376	-	-	-	-
Humboldt	2,249,612	59,708	333,281	392,989	17.46
Lyon	1,907,759	6,000	64,000	70,000	3.66
Mt. Grant	1,734,399	87,400	45,000	132,400	7.63
Nye	2,434,231	65,961	500,000	565,961	23.25
Pershing	1,266,669	36,500	181,400	217,900	17.20
Wm. Bee Ririe	2,027,892	17,210	28,400	45,610	2.24
Total	$17,843,241	361,765	1,252,081	1,613,846	9.21
Carson-Tahoe	15,210,483	49,000	-	49,000	.29
So. Nev. Mem.	65,699,935	2,726,853	8,574,515	11,301,368	17.20
Washoe Med.	85,467,918	3,521,278	-	3,521,278	4.11
	$167,378,236	6,297,131	8,574,515	14,871,646	8.88

The above relates solely to funds provided by counties to their hospitals in the provision of "acute care services." Not included are other services which are provided by some county hospitals such as "convalescent care" or "nursing home care." This does not include funds paid by counties to other, non-local facilities for care rendered to "their" medically indigent.

County Government Support of County Hospitals (Continued)

The outlays of local county governments to assist the medically indigent with respect to hospital care and to maintain their county hospital facilities increased in 1984 as can be seen from the following:

		COUNTY SUPPORT			
HOSPITAL	INCOME	CARE FOR MEDICALLY INDIGENT	SUBSIDY	TOTAL COUNTY SUPPORT	COUNTY SUPP AS A PERCEN TOTAL INCOM
Battle Mountain	$389,855	$75,000	-	$75,000	19.23
Elko	5,435,895	104,000	100,000	204,000	3.75
Grover C. Dils	903,891	2,000	-	2,000	.22
Humboldt	2,485,810	65,000	350,000	415,000	16.69
Lyon	2,119,203	10,000	-	10,000	.47
Mt. Grant	1,733,019	90,000	55,000	145,000	8.36
Nye	2,488,872	162,000	500,000	662,000	26.59
Pershing	1,320,272	23,500	200,000	223,500	16.92
Wm. Bee Ririe	2,216,186	26 000	30,000	56,000	2.52
Total	$19,093,003	$557,500	$1,235,000	1,792,500	9.38
Carson-Tahoe	$15,785,815	$45,000	-	$45,000	.20
S. Nev. Mem.	61,719,485	2,610,000	10,372,400	12,982,400	21.03
Washoe Med.	87,048,381	3,788,000	-	3,788,000	4.35
Total	164,553,681	6,443,000	$10,372,400	$16,815,400	10.21

In brief, then, the counties noted in this report expended $16,485,492 to pay for care provided to medically indigent or to subsidize local county hospitals in 1983 and $18,607,900 in 1984, or, an increase of 12.00% in that one year period.

This matter is given sharper focus when expenditures by counties in this category are compared with respect to the years 1982 and 1984. For, in 1982 the counties expended $7,001,569 and in 1984 they expended $18,607,900 or, an increase in the three year span of 165.70%!

County Governments and Non-Hospital Medical Indigency Services

Aside from expenditures for hospital services or subsidies, the counties of the State expened $1,335,000 in 1983 for a variety of other medical indigency care services such as home health care, convalescent home care, mental health, and other program. These counties conservatively estimate that expenditures in these areas will rise to 1,413,200 in fiscal 1984-5 or an increase of 5.12% in the year.

It is also noteworthy to suggest from the information thus far gathered that significant increases are anticipated in "convalescent home care" and in "prisoner care."

TABLE 1

HOSPITAL AND HOSPITAL BEDS
NEVADA
1985

HOSPITAL	BEDS	OWNERSHIP	COMMUNITY	COUNTY	TYPE
Battle Mountain	16	County	Battle Mountain	Lander	Community
Boulder City	35	Non-Profit	Boulder City	Clark	Community
Care Unit	50	For-Profit	Las Vegas	Clark	Community
Carson-Tahoe	116	County	Carson City	Carson City	Community
Churchill Regional	40	Churchill	Fallon	Non-Profit	Community
Community, N. Las Vegas	163	For-Profit	North Las Vegas	Clark	Community
Desert Springs	225	For-Profit	Las Vegas	Clark	Community
Elko General	52	County	Elko	Elko	Community
Grover C. Dils	7	County	Caliente	Lincoln	Community
Humana	679	For-Profit	Las Vegas	Clark	Community
Humboldt General	18	County	Winnemucca	Humboldt	Community
Lakeside Community	29	Non-Profit	Incline Village	Washoe	Community
Las Vegas Mental Hlth.	36	State	Las Vegas	Clark	Special
Lyon Health Center	26	County	Yerington	Lyon	Community
Mt. Grant General	15	County	Hawthorne	Mineral	Community
Nathan Adelson Hospice	20	Non-Profit	Las Vegas	Clark	Special
Nellis Air Force Base	133	U.S.	Nellis AFB	Clark	Community
Nevada Mental Health.	110	State	Reno	Washoe	Special
Nye General	21	County	Tonopah	Nye	Community
Pershing General	24	County	Lovelock	Pershing	Community
Raleigh Hills	34	For-Profit	Las Vegas	Clark	Special
Raleigh Hills	34	For-Profit	Sparks	Washoe	Special
St. Mary's	350	Non-Profit	Reno	Washoe	Community
St. Rose de Lima	74	Non-Profit	Henderson	Clark	Community
So. Nevada Memorial	336	County	Las Vegas	Clark	Community
Sparks Family	145	For-Profit	Sparks	Washoe	Community
Truckee Meadows	95	For-Profit	Reno	Washoe	Special
U.S. Public Health	15	U.S.	Owyhee	Elko	Community
U.S. Puglic Health	14	U.S.	Schurz	Mineral	Community
Valley Medical	310	For-Profit	Las Vegas	Clark	Community
Veterans Administration	192	U.S.	Reno	Washoe	Community
Washoe Medical Center	537	County	Reno	Washoe	Community
William Bee Ririe	43	County	East Ely	White Pine	Community
Women's	61	For-Profit	Las Vegas	Clark	Community

TOTAL: 34 Hospitals 4,055 Beds

Community Hospital: Short-Term General Acute Care Hospital
Special Hospital : Facility Providing Care Primarily for Specific Disease or Illness.

Source: "Licensed and/or Certified Health Facilities", Nevada State Division of Health, January, 1985.

TABLE 2

HOSPITALS BY OWNERSHIP

NEVADA

1985

FOR-PROFIT

HOSPITAL	BEDS	COMMUNITY	COUNTY
Care Unit	50	Las Vegas	Clark
Community, North Las Vegas	163	Las Vegas	Clark
Desert Springs	225	Las Vegas	Clark
Humana	679	Las Vegas	Clark
Raleigh Hills	34	Las Vegas	Clark
Raleigh Hills	34	Sparks	Washoe
Sparks Family	145	Sparks	Washoe
Truckee Meadows	95	Reno	Washoe
Valley Medical	310	Las Vegas	Clark
Women's	61	Las Vegas	Clark
TOTAL HOSPITALS: 10	1,796		

COUNTY

Battle Mountain	16	Battle Mountain	Lander
Carson-Tahoe	116	Carson City	Carson City
Elko General	52	Elko	Elko
Grover C. Dils	7	Caliente	Lincoln
Humboldt General	18	Winnemucca	Humboldt
Lyon Health Center	26	Yerington	Lyon
Mt. Grant General	15	Hawthorne	Mineral
Nye General	21	Tonopah	Nye
Pershing General	24	Lovelock	Pershing
Southern Nevada Memorial	336	Las Vegas	Clark
Washoe Medical Center	537	Reno	Washoe
William Bee Ririe	43	East Ely	White Pine
TOTAL HOSPITALS: 12	1,211		

NON-PROFIT

Boulder City	35	Boulder City	Clark
Churchill Regional	40	Fallon	Churchill
Lakeside Community	29	Incline Village	Washoe
Nathan Adelson Hospice	20	Las Vegas	Clark
St. Mary's	350	Reno	Washoe
St. Rose de Lima	74	Henderson	Clark
TOTAL HOSPITALS: 6	548		

Source: "Licensed and/or Certified Health Facilities", Nevada State Division of Health January, 1985.

STATE

HOSPITAL	BEDS	COMMUNITY	COUNTY
Las Vegas Mental Health	36	Las Vegas	Clark
Nevada Mental Health	110	Las Vegas	Clark
TOTAL HOSPITALS: 2	146		

U.S.

Nellis Air Force Base	133	Nellis AFB	Clark
U.S. Public Health Service	15	Owyhee	Elko
U.S. Public Health Service	14	Schurz	Mineral
Veterans Administration	192	Reno	Washoe
TOTAL HOSPITALS: 4	354		

SUMMARY

OWNERSHIP	HOSPITALS	BEDS	PERCENT OF TOTAL
For-Profit	10	1,796	44.30
County	12	1,211	29.87
Non-Profit	6	548	13.51
State	2	146	3.60
U.S.	4	354	8.72
TOTAL	34	4,055	100.00

Source: "Licensed and/or Certified Health Facilities", Nevada State Division of Health, January, 1985.

TABLE 3

HOSPITALS AND HOSPITAL BEDS BY COUNTY

NEVADA

1985

COUNTY	HOSPITAL	HOSPITAL BEDS	PERCENT OF TOTAL
Carson City	Carson-Tahoe	116	2.86
Churchill	Churchill Regional	40	.99
Clark	Boulder City	35	.86
	Care Unit	50	1.23
	Community, North Las Vegas	163	4.02
	Desert Springs	225	5.55
	Humana	679	16.74
	Las Vegas Mental Health	36	.88
	Nathan Adelson Hospice	20	.49
	Nellis Air Force Base	133	3.28
	Raleigh Hills	36	.84
	St. Rose de Lima	74	1.82
	Southern Nevada Memorial	336	8.29
	Valley Medical	310	7.64
	Women's	61	1.58
	Sub-Total	2,156	53.17
Elko	Elko General	52	1.28
	Owyhee (U.S. Public Health)	15	.37
	Sub-Total	67	1.65
Humboldt	Humboldt General	18	.44
Lander	Battle Mountain	16	.39
Lincoln	Grover C. Dils	7	.17
Lyon	Lyon Health Center	26	.64
Mineral	Mt. Grant General	15	.37
	Schurz (U.S. Public Health)	14	.34
	Sub-Total	29	.71
Nye	Nye General	21	.51
Pershing	Pershing General	24	.59

Source: "Licensed and/or Certified Health Facilities", Nevada State Division of Health January, 1985.

TABLE 3 (CONT.)

COUNTY	HOSPITAL	HOSPITAL BEDS	PERCENT OF TOTAL
Washoe	Lakeside Community	29	.71
	Nevada Mental Health	110	2.71
	Raleigh Hills	34	.83
	St. Mary's	350	8.63
	Sparks Family	145	3.58
	Truckee Meadows	95	2.34
	Veterans Administration	192	4.73
	Washoe Medical Center	537	13.24
	Sub-Total	1,492	36.79
White Pine	William Bee Ririe	43	1.06
	GRAND TOTAL	4,055	100.00

SUMMARY

Clark County	13 Hospitals	2,156 Beds	53.17
Washoe County	8 Hospitals	1,492 Beds	36.79
All Other Counties (11)	13 Hospitals	407 Beds	10.04
TOTAL	34 Hospitals	4,055 Beds	100.00

Note: The following Nevada Counties have no hospitals: Douglas, Esmerelda, Eureka and Storey.

TABLE 4

NUMBER AND PERCENT CHANGE IN HOSPITAL BEDS OF COUNTY HOSPITALS: NEVADA 1978-1984

HOSPITAL	NO. OF BEDS 1978	1984	PERCENT CHANGE
Battle Mountain	16	16	0.00
Carson-Tahoe	77	116	50.64
Elko General	58	52	(10.34)
Grover C. Dils	7	7	0.00
Humboldt General	18	18	0.00
Lyon Health Center	24	26	8.33
Mt. Grant General	23	15	(34.78)
Nye General	21	21	0.00
Pershing General	18	24	33.33
Southern Nevada Memorial	282	336	19.14
Washoe Medical Center	575	537	(4.87)
William Bee Ririe	43	43	0.00
TOTAL	1,162	1,211	4.04

Note: In 1978, Churchill Public Hospital, in Fallon, was a county operated hospital containing 42 beds. Since 1983, it has become a non-profit institution.

Source: "Licensed and/or Certified Health Facilities", Nevada State Division of Health, January, 1985.

TABLE 5

OPERATING REVENUES, EXPENSES, & NET OPERATING INCOME: COUNTY HOSPITALS: NEVADA 1973

RURAL HOSPITALS	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME
Battle Mountain	$278,474	$445,305	$(166,831)
Elko	2,740,216	2,599,740	140,746
Grover C. Dils	133,443	375,779	(242,336)
Humboldt	1,665,671	2,128,430	(462,579)
Lyon	1,082,779	1,108,338	(25,559)
Mt. Grant	822,611	934,692	(112,081)
Nye	3,256,359	4,027,038	(770,679)
Pershing	446,555	568,826	(122,271)
William Bee Ririe	1,302,176	1,401,367	(99,191)
TOTAL	$11,728,284	$13,589,245	$(1,860,961)
URBAN HOSPITALS			
Carson-Tahoe	$7,019,553	$6,744,161	$275,392
So. Nevada Memorial	23,883,631	22,714,925	1,168,706
Washoe Medical Center	37,881,262	34,637,006	3,244,256
TOTAL	$68,784,446	$64,096,092	$4,688,354
ALL HOSPITALS			
GRAND TOTAL	$80,512,730	$77,685,337	$2,827,393

Source: Various Audits filed with the Nevada State Department of Taxation

TABLE C

OPERATING REVENUES, EXPENSES, & NET OPERATING INCOME: COUNTY HOSPITALS: NEVADA 1979

RURAL HOSPITALS	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME
Battle Mountain	$271,429	$439,742	$(168,313)
Elko	3,184,913	2,972,797	212,116
Grover C. Dils	325,750	352,367	(26,617)
Humboldt	1,188,316	1,540,494	(352,178)
Lyon	1,174,741	1,203,884	(29,143)
Mt. Grant	1,034,727	1,104,182	(69,455)
Nye	824,328	1,202,656	(378,328)
Pershing	500,869	629,355	(128,486)
William B. Ririe	1,356,848	1,438,460	(81,612)
TOTAL	$9,861,921	$10,883,937	$(1,022,016)
URBAN HOSPITALS			
Carson-Tahoe	$7,768,183	$7,309,715	458,468
So. Nevada Memorial	25,596,149	25,206,079	390,070
Washoe Medical Center	44,527,726	41,874,466	2,653,260
TOTAL	$77,892058	$74,390,260	$3,501,798
ALL HOSPITALS			
Grand Total	$87,753,979	$85,274,197	$2,479,782

Source: Various Audits filed with the Nevada State Department of Taxation

TABLE 7

OPERATING REVENUES, EXPENSES, & NET OPERATING INCOME: COUNTY HOSPITALS: NEVADA

1980

RURAL HOSPITALS	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME
Battle Mountain	$394,356	$523,699	$(129,343)
Elko	3,554,452	3,502,538	51,914
Grover C. Dils	626,350	643,854	(17,504)
Humboldt	1,610,183	1,910,663	(300,480)
Lyon	1,313,448	1,375,045	(61,597)
Mt. Grant	901,540	1,053,860	(152,320)
Nye	1,019,814	1,251,045	(300,480)
Pershing	712,917	803,432	(231,271)
William Bee Ririe	1,313,320	1,406,844	(93,254)
TOTAL	$11,386,680	$12,471,020	$(1,084,340)
URBAN HOSPITALS			
Carson-Tahoe	$9,851,622	$9,617,408	$234,214
So. Nevada Memorial	32,691,224	32,266,286	424,938
Washoe Medical Center	53,288,850	51,607,397	1,681,453
TOTAL	$95,831,696	$93,491,091	$2,340,605
ALL HOSPITALS	$107,218,376	$105,962,111	$1,256,265

Source: Various Audits filed with the Nevada State Department of Taxation

TABLE 8

OPERATING REVENUES, EXPENSES & NET OPERATING INCOME: COUNTY HOSPITALS: NEVADA

1981

RURAL HOSPITALS	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME
Battle Mountain	$393,234	$581,199	$(187,965)
Elko	4,026,212	4,174,956	(148,744)
Grover C. Dils	865,526	987,921	(122,395)
Humboldt	1,665,671	2,128,430	(462,759)
Lyon	1,431,781	1,543,012	(111,231)
Mt. Grant	1,166,298	1,241,173	(74,875)
Nye	3,256,359	4,027,038	(770,679)
Pershing	1,028,842	1,104,214	(75,372)
William Bee Ririe	1,730,755	1,922,543	(191,788)
TOTAL	$15,564,678	$17,710,486	$(2,145,808)
URBAN HOSPITALS			
Carson-Tahoe	$12,475,125	$11,840,201	$634,924
So. Nevada Memorial	41,153,670	40,097,858	1,055,812
Washoe Medical Center	64,572,622	65,046,683	(474,061)
TOTAL	$118,201,417	$116,984,742	$1,216,675
ALL HOSPITALS	$133,766,095	$134,695,228	$(929,133)

Source: Various Audits filed with the Nevada State Department of Taxation

TABLE 10

OPERATING REVENUES, EXPENSES, & NET OPERATING INCOME: COUNTY HOSPITALS: NEVADA 1983

RURAL HOSPITALS	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME
Battle Mountain	$392,268	$631,715	$(239,447)
Elko	4,938,035	5,323,340	(385,305)
Grover C. Dils	892,376	938,185	(45,809)
Humboldt	2,249,612	2,596,122	(346,510)
Lyon	1,907,759	2,044,057	(136,298)
Mt. Grant	1,734,399	1,813,628	(79,229)
Nye	2,434,231	4,652,747	(2,218,516)
Pershing	1,266,669	1,383,559	(116,890)
William Bee Ririe	2,027,892	2,162,823	(134,931)
TOTAL	$17,843,241	$21,546,176	$(3,702,935)
URBAN HOSPITALS			
Carson-Tahoe	$15,210,483	$14,821,656	$388,827
So. Nevada Memorial	65,699,935	61,123,065	4,576,870
Washoe Medical Center	86,467,918	83,737,918	2,730,000
TOTAL	$167,378,236	$159,682,639	$7,695,697
ALL HOSPITALS	$185,221,577	$181,228,815	$3,992,762

Source: Various Audits filed with the Nevada State Department of Taxation

TABLE 11

OPERATING REVENUES, EXPENSES, & NET OPERATING INCOME: COUNTY HOSPITALS: NEVADA 1984

RURAL HOSPITALS	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME
Battle Mountain	$389,855	$686,003	$(296,148)
Elko	5,435,895	5,688,165	(252,270)
Grover C. Dils	903,891	946,836	(42,945)
Humboldt	2,485,810	2,445,119	40,691
Lyon	2,119,203	2,336,009	(216,806)
Mt. Grant	1,733,019	1,783,818	(50,799)
Nye	2,488,872	3,151,244	(662,372)
Pershing	1,320,272	1,528,040	(207,768)
William Bee Ririe	2,216,186	2,247,893	(31,707)
TOTAL	$19,093,003	$20,813,127	$(1,720,124)
URBAN HOSPITALS			
Carson-Tahoe	$15,785,815	$14,865,522	$920,293
So. Nevada Memorial	61,719,485	67,653,707	$(5,934,222)
Washoe Medical Center	87,048,381	84,405,055	2,643,326
TOTAL	$164,553,681	$166,924,284	$(2,370,603)
ALL HOSPITALS	$183,646,684	$187,737,411	$(4,090,727)

Source: Various Audits filed with the Nevada State Department of Taxation

TABLE 12

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS

BATTLE MOUNTAIN HOSPITAL

1978-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$278,474	$445,305	$(166,831)	(59.90)
1979	271,429	439,742	(168,313)	(62.00)
1980	394,356	523,699	(129,343)	(32.79)
1981	393,234	581,199	(177,965)	(42.25)
1982	421,773	650,965	(229,192)	(54.34)
1983	392,268	631,715	(235,747)	(60.00)
1984	389,855	686,003	(293,338)	(75.20)
TOTAL	$2,540,849	$3,958,636	$(1,440,279)	(56.70)

Source: Various Hospital Audits filed with Nevada State Department of Taxation

TABLE 13

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
ELKO GENERAL HOSPITAL
1973-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$2,740,216	$2,599,470	$140,746	5.13
1979	3,184,913	2,972,797	212,116	6.66
1980	3,554,452	3,502,538	51,914	1.46
1981	4,026,212	4,174,956	(148,744)	(3.69)
1982	4,260,992	4,404,989	(143,997)	(3.37)
1983	4,938,035	5,323,340	(385,305)	(7.00)
1984	5,435,895	5,688,165	(252,270)	(4.64)
TOTAL	$27,185,715	$28,666,255	$(749,610)	(2.75)

Source: Various Hospital Audits filed with the Nevada State Department of Taxa

TABLE 14

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
GROVER C. DILS MEDICAL CENTER
1978-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$133,443	$375,779	(242,336)	(181.60)
1979	325,750	353,367	(26,617)	(8.17)
1980	626,350	683,854	(17,505)	(2.79)
1981	865,526	987,921	(122,395)	(14.14)
1982	880,204	952,048	(187,952)	(21.30)
1983	892,376	938,185	(45,809)	(5.00)
1984	903,891	946,836	(42,945)	(4.00
TOTAL	$4,627,540	$5,196,990	$(685,559)	(14.81)

Source: Various Hospital Audits filed with the Nevada State Department of Taxation

TABLE 15

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
HUMBOLDT COUNTY GENERAL HOSPITAL
1978-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$1,665,671	$2,128,430	$(462,759)	(27.78)
1979	1,188,316	1,540,494	(352,178)	(29.63)
1980	1,610,183	1,910,663	(300,480)	(18.66)
1981	1,665,671	2,128,430	(462,759)	(27.78)
1982	2,166,399	2,533,728	(367,429)	(16.95)
1983	2,249,612	2,596,122	(346,510)	(15.00)
1984	2,485,810	2,445,119	40,691	1.00
TOTAL	$13,031,662	$15,282,986	$(2,251,324)	(17.00)

Source: Various Hospital Audits filed with the Nevada State Department of Taxati

TABLE 16

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
LYON HEALTH CENTER
1973-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$1,082,779	$1,108,338	$(25,559)	(2.36)
1979	1.174,741	1,203,884	(29,143)	(16.67)
1980	1,313,448	1,375,045	(61,597)	(4.68)
1981	1,431,781	1,543,012	(78,875)	(5.50)
1982	1,467,296	1,874,197	(506,901)	(37.07)
1983	1,907,759	2,044,057	(136,298)	(7.17)
1984	2,119,203	2,336,009	(216,806)	(10.23)
TOTAL	$10,397,007	$11,484,542	$(1,054,179)	(10.14)

Source: Various Hospital Audits filed with the Nevada State Department of Taxation

TABLE 17

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
MT. GRANT GENERAL HOSPITAL
1973-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$822,611	$934,692	$(112,081)	(13.60)
1979	1,034,727	1,104,182	(69,455)	(6.71)
1980	901,540	1,053,860	(153,320)	(16.89)
1981	1,166,298	1,241,173	(74,875)	(6.41)
1982	1,360,595	1,485,563	(124,968)	(9.18)
1983	1,734,399	1,813,628	(79,229	(4.56)
1984	1,733,019	1,783,818	(50,799)	(2.93)
TOTAL	$8,753,189	$9,416,916	$(663,727)	(8.56)

Source: Various Hospital Audits filed with the Nevada State Department of Taxa

TABLE 13

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
NYE GENERAL HOSPITAL
1973-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$3,256,359	$4,027,038	$(770,679)	(23.66)
1979	824,328	1,202,656	(378,328)	(45.89)
1980	1,019,814	1,251,085	(231,271)	(22.67)
1981	3,256,359	4,027,038	(770,679)	(23.66)
1982	3,478,208	4,973,338	(1,495,130)	(142.98)
1983	2,434,231	4,652,747	(2,201,721)	(90.44)
1984	2,488,872	3,151,244	(662,402)	(26.61)
TOTAL	$16,758,171	$23,285,146	$(6,210,210)	(37.05)

Source: Various Hospital Audits filed with the Nevada State Department of Taxation

TABLE 19

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
PERSHING GENERAL HOSPITAL
1978-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$446,555	$568,826	$(99,191)	(22.21)
1979	500,869	629,395	(128,526	(25.66)
1980	712,917	803,432	(90,515)	(12.69)
1981	1,028,842	1,104,214	(75,372)	(7.32)
1982	1,166,072	1,288,708	(122,636)	(10.51)
1983	1,266,669	1,383,559	(116,890)	(9.22)
1984	1,320,272	1,528,040	(207,768)	(15.73)
TOTAL	$6,442,196	$7,306,174	$(840,898)	(13.05)

Source: Various Hospital Audits filed with the Nevada State Department of Taxat

TABLE 20

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
WILLIAM BEE RIRIE HOSPITAL
1978-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$1,303,176	$1,401,367	$(99,191)	(7.61)
1979	1,356,848	1,438,460	(81,612)	(6.01)
1980	1,313,320	1,406,844	(93,534)	(7.12)
1981	1,730,755	1,922,543	(191,788)	(11,08)
1982	1,907,097	2,145,537	(238,430)	(12.50)
1983	2,027,892	2,162,823	(134,931)	(6.65)
1984	2,216,186	2,247,893	(31,707)	(1.43)
TOTAL	$11,854,274	$12,725,457	$(871,183)	(7.34)

Source: Various Hospital Audits filed with the Nevada State Department of Taxatio

TABLE 21

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
CARSON-TAHOE HOSPITAL
1973-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$7,019,553	$6,744,161	$275,392	3.92
1979	7,368,183	7,309,715	58,468	0.79
1980	9,851,622	9,617,408	234,214	2.37
1981	12,475,125	11,840,201	639,924	5.12
1982	14,704,555	13,870,705	833,850	5.67
1983	15,210,483	14,821,606	388,827	2.55
1984	15,758,815	14,865,522	893,403	5.66
TOTAL	$82,388,336	$79,069,368	$3,324,078	4.03

Source: Various Hospital Audits filed with the Nevada State Department of Taxati

TABLE 22

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
SOUTHERN NEVADA MEMORIAL HOSPITAL
1973-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$23,883,631	$22,714,925	$1,168,706	4.89
1979	26,596,149	25,206,079	1,390,070	5.26
1980	32,691,224	32,266,286	424,938	1.39
1981	41,153,670	40,097,858	(1,055,812)	(2.56)
1982	54,515,113	52,177,720	2,337,493	4.28
1983	65,699,835	61,123,065	4,576,770	6.96
1984	61,719,485	67,653,707	(5,934,222)	(9.61)
TOTAL	$306,259,107	$301,239,540	$5,019,567	1.63

Source: Various Hospital Audits filed with the Nevada State Department of Taxation

TABLE 23

OPERATING REVENUES, EXPENSES, NET OPERATING INCOME AND PERCENT PROFIT OR LOSS
WASHOE MEDICAL CENTER
1978-1984

YEAR	OPERATING REVENUES	OPERATING EXPENSES	NET OPERATING INCOME	PERCENT PROFIT OR LOSS
1978	$37,881,262	$34,637,006	$3,244,256	8.56
1979	44,527,726	41,974,006	2,553,260	5.73
1980	53,288,850	51,607,397	1,681,453	3.15
1981	64,572,622	65,046,683	(474,061)	(0.73)
1982	79,212,214	79,062,550	149,664	0.18
1983	86,467,626	83,627,918	2,839,708	3.28
1984	87,048,381	84,405,055	2,643,326	3.03
TOTAL	$452,998,681	$440,361,075	$12,637,606	2.79

Source: Various Hospital Audits filed with the Nevada State Department of Taxati

TABLE 24

AMOUNT & PERCENT CHANGE IN OPERATING REVENUES, EXPENSES & NET OPERATING INCOME
FOR
COUNTY HOSPITALS: NEVADA
1978-1984

RURAL HOSPITALS	OPERATING REVENUE	% CHANGE FROM PRIOR YEAR	OPERATING EXPENSE	% CHANGE FROM PRIOR YEAR	OPERATING INCOME	% CHANGE FROM PRIOR YEAR
1978	$11,728,284	-	$13,589,245	-	$(1,860,961)	-
1979	9,861,921	(15.90)	10,883,937	(19.90)	(1,022,016)	(45.08)
1980	11,386,680	15.40	12,471,020	14.58	(1,084,340)	6.09
1981	15,564,678	6.69	17,710,486	42.01	(2,145,808)	97.89
1982	17,008,626	9.27	20,309,063	14.67	(3,300,437)	53.80
1983	17,843,241	4.90	21,546,176	6.09	(3,702,935)	12.16
1984	19,093,003	7.00	20,813,127	(3.44)	(1,720,124)	(58.80)
TOTAL	$102,486,433	62.79	$117,323,054	53.16	($14,836,621)	(14.47)
URBAN HOSPITALS						
1978	$68,784,446	-	$64,096,092	-	$4,688,354	-
1979	77,892,058	13.28	74,390,260	16.06	3,501,798	(25.30)
1980	95,831,696	26.08	93,491,091	25.67	2,340,605	(30.58)
1981	118,201,417	23.34	116,984,742	24.60	1,216,675	(48.01)
1982	148,431,882	25.57	145,110,875	24.04	3,321,007	172.05
1983	167,370,336	12.56	159,682,639	10.04	7,695,697	131.72
1984	164,553,681	(1.70)	166,924,284	4.53	(2,370,603)	(68.80)
TOTAL	$841,073,516	139.23	$820,679,983	118.05	20,393,533	24.24
ALL HOSPITALS						
1978	$80,512,730	-	$77,685,337	-	2,827,393	-
1979	87,753,979	8.99	85,274,197	9.76	2,479,782	(12.29)
1980	107,218,376	22.18	105,962,111	24.26	1,256,265	(4.93)
1981	133,766,095	24.76	134,695,228	27.11	(929,133)	(26.04)
1982	165,440,508	23.67	165,419,938	22.81	20,570	97.70
1983	181,221,577	11.94	181,228,815	9.55	3,992,762	93.14
1984	183,646,684	0.86	187,737,411	3.59	(4,090,727)	(2.45)
TOTAL	$943,559,949	120.00	$938,003,037	140.00	$5,556,912	0.58

Source: Various Hospital Audits filed with the Nevada State Department of Taxation

TABLE 25

EXPENSES PER ADMISSION & PER PATIENT DAY

COUNTY HOSPITALS: NEVADA

1983

RURAL HOSPITALS	ADMISSIONS	PATIENT DAYS	EXPENSES	EXPENSES PER ADMISSION	EXPENSES PER PATIENT DAY
Battle Mountain	284	810	$631,715	$2,224.34	$779.89
Elko	2,462	9,859	5,323,340	2,162.20	539.94
G. C. Dils	192	1,141	938,185	4,886.30	822.24
Humboldt	738	2,013	2,596,122	3,517.78	1,289.67
Lyon	651	4,085	2,044,057	3,139.87	500.38
Mt. Grant	243	1,675	1,813,628	7,463.48	1,082.76
Nye	737	2,425	4,652,747	6,313.08	1,918.65
Pershing	273	2,520	1,383,559	5,067.98	549.03
W.Bee Ririe	1,081	4,398	2,162,823	2,000.76	491.77
TOTAL	6,661	29,466	$21,545,176	$3,234.52	$731.18
URBAN HOSPITALS					
Carson-Tahoe	5,742	23,353	$14,821,656	$2,581.27	$634.67
S. Nev. Memorial	14,875	99,771	61,123,065	4,109.11	612.63
Washoe Medical	19,636	129,258	83,737,918	4,264.50	647.83
TOTAL	40,253	252,382	159,682,639	$3,966.97	$632.70
ALL HOSPITALS	46,914	281,848	181,227,815	$3682.97	$643.22

Source: Financial Data, Various Hospital Audits filed with the Nevada State Department of Taxation
Admission & Patient Day Data, Nevada State Department of Human Resources.

TABLE 26

COUNTY EXPENDITURES FOR MEDICAL INDIGENTS: BY CATEGORY*
1983-1984

(000)

COUNTY	GROUP CARE	CONV. HOME CARE	AMBU-LANCE	BURIALS	IN PATIENT	OUT PATIENT	HOSPITAL SUBSIDY	HEALTH CARE	MENTAL HEALTH	PHAR-MACY	PRIS-ONER CARE	TOTAL
Carson City	$.4	$16.7	$.1	$.6	$49.0	-	-	$13.5	$19.7	$.1	-	$1 1
Churchill	-	45.3	-	5.1	9.4	.9	-	10.0	.6	.4	-	7
Clark	-	-	-	-	147.0	2,579.9	8,574.5	156.5	-	-	-	11,4
Douglas	-	-	-	.7	-	25.0	-	-	-		21.0	46.7
Elko	-	53.3	1.7	5.6	28.6	.6	100.0	10.0	-	-	-	199.8
Esmerelda	-	-	-	.8	-	-	11.4	-	-	.5	2.5	15.2
Eureka	-	12.4	9.8	-	8.8	63.0	-	4.5	-	-	5.3	103.8
Humboldt	-	13.6	27.0	-	59.7	-	333.3	9.0	1.5	-	.6	444.7
Lander	-	16.9	-	-	49.9	9.9	-	6.0	-	-	15.8	98.5
Lincoln	-	13.5	14.1	-	-	-	-	-	-	-	-	27.6
Lyon	-	9.5	-	-	6.0	-	64.0	8.0	-	-	10.0	97.5
Mineral	-	-	-	.6	87.4	-	45.0	6.0	-	-	1.0	140.0
Nye	-	-	1.4	1.4	66.0	-	500.0	8.0	-	2.1	9.6	588.5
Pershing	-	.8	-	1.5	36.5	-	181.4	3.0	2.4	-	-	225.6
Storey	-	-	-	-	-	.9	-	-	-	-	10.0	10.9
Washoe	255.5	198.8	1.8	48.1	2,721.0	800.2	-	-	182.0	20.1	-	4,227.5
White Pine	-	5.3	-	7.2	17.0	.2	28.4	8.4	7.0	6.0	3.6	83.1
Total	$255.9	$386.1	$55.9	$71.6	$3,286.3	$3,480.6	$9,838.0	$242.9	$213.2	$29.2	$79.4	$17,9 1

* Actual Expenditures Only. Does not include costs incurred but not as yet paid, for example, Mineral County has outstanding hospital bills due the State and other counties totalling $184,000.

Source: Oral Reports, Staff of Counties.

TABLE 27

ESTIMATED COUNTY EXPENDITURES FOR MEDICAL INDIGENTS: BY CATEGORY
1984-1985

(000)

COUNTY	GROUP CARE	CONV. HOME CARE	AMBU-LANCE	BURIALS	HOSPITAL IN PATIENT	HOSPITAL OUT PATIENT	HOSPITAL SUBSIDY	HOME HEALTH CARE	MENTAL HEALTH	PHAR MACY	PRIS-ONER CARE	TO
Carson City	$5.0	$20.0	-	$1.5	$45.0	-	-	$13.5	$20.0	.3	-	$105
Churchill	-	55.0	-	5.5	50.6	.3	-	10.0	6.5	.3	2.9	131.1
Clark	-	-	-	-	-	2,610.0	10,372.4	-	-	-	-	12,982.4
Douglas	-	-	-	3.0	-	38.0	-	-	-	-	27.0	68.0
Elko	-	31.6	2.3	6.0	104.0	-	100.0	10.0	5.5	.7	.4	260.5
Esmerelda	-	-	-	.8	-	-	15.0	-	-	.5	3.0	19.3
Eureka	-	15.8	10.4	3.3	29.0	68.0	-	4.5	-	-	8.0	139.0
Humboldt	-	16.0	30.0	-	65.0	-	350.0	9.5	1.6	-	2.5	474.6
Lander	-	-	-	-	50.0	25.0	-	-	6.0	-	31.0	112.0
Lincoln	-	20.0	16.0	-	-	2.0	-	-	-	-	-	38.0
Lyon	-	12.0	1.5	-	10.0	-	-	8.0	-	-	12.0	43.5
Mineral	-	-	-	.7	90.0	-	55.0	6.0	-	-	8.0	159.7
Nye	-	-	2.0	10.0	162.0	-	500.0	8.0	-	3.5	14.0	699.5
Pershing	-	1.0	-	2.0	20.0	1.5	200.0	3.0	3.0	-	1.0	231.5
Storey	-	-	-	-	-	10.0	-	-	-	-	10.0	20.0
Washoe	225.0	350.9	3.2	43.7	2,910.0	878.0	-	-	201.0	35.0	-	4,640
White Pine	-	8.0	-	8.0	20.0	6.0	30.0	9.0	7.0	7.0	4.0	9
Total	$230.0	$530.3	$65.4	$84.5	$3,555.6	$3,638.8	11,622.4	$81.5	$250.6	$47.3	123.8	20,23

Source: Oral Reports, Staff of Counties.

TABLE 28

COUNTY EXPENDITURES FOR MEDICAL INDIGENTS*
ACTUAL: 1982-3 & 1983-4
ESTIMATE: 1984-5

(000)

	Actual 1982-3	Actual 1983-4	Est. 1984-5
Group Care	$88.2	$255.9	$230.0
Conv. Home Care	998.8	386.1	530.3
Ambulance	179.2	55.9	65.4
Burials	210.1	71.6	84.5
Hospital In-Patient	5,061.0	3,286.3	3,555.6
Hospital Out-Patient	1,181.1	3,480.6	3,638.8
Hospital Subsidy	759.4	9,838.0	11,622.4
Home Health Care	286.5	242.9	81.5
Mental Health	723.4	213.2	250.6
Pharmacy	12.0	29.2	47.3
Prisoner Care	222.7	79.4	123.8
Total	$9,722.4	$17,939.1	$20,230.0

* Does not include Administrative Costs nor Unpaid Demand

Source: 1982-3, Survey reports submitted by 10 counties
1983-4 & 1984-5, Oral reports, staff of all counties.

TABLE 28

COUNTY EXPENDITURES FOR MEDICAL INDIGENTS*
ACTUAL: 1982-3 & 1983-4
ESTIMATE: 1984-5

(000)

	Actual 1982-3	Actual 1983-4	Est. 1984-5
Group Care	$88.2	$255.9	$230.0
Conv. Home Care	998.8	386.1	530.3
Ambulance	179.2	55.9	65.4
Burials	210.1	71.6	84.5
Hospital In-Patient	5,061.0	3,286.3	3,555.6
Hospital Out-Patient	1,181.1	3,480.6	3,638.8
Hospital Subsidy	759.4	9,838.0	11,622.4
Home Health Care	286.5	242.9	81.5
Mental Health	723.4	213.2	250.6
Pharmacy	12.0	29.2	47.3
Prisoner Care	222.7	79.4	123.8
Total	$9,722.4	$17,939.1	$20,230.0

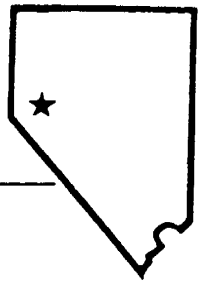
* Does not include Administrative Costs nor Unpaid Demand

Source: 1982-3, Survey reports submitted by 10 counties
1983-4 & 1984-5, Oral reports, staff of all counties.

APPENDIX D

Letter, Dated February 28, 1986, to S.C.R. 34 Subcommittee from Nevada Association of Counties (NACO)

NACO
NEVADA ASSOCIATION OF COUNTIES
308 NORTH CURRY STREET, SUITE 205 • CARSON CITY, NEVADA 89701
(702) 883-7863



February 28, 1986

Chairman Townsend and Members of the Committee to Study State Aid to Medically Indigent (SCR34):

The passage of AB 422 provided Nevada County governments with a safety net to provide a funding mechanism to assist county governments confronted with a mounting statewide medical indigency problem. During the development of the legislation, the Nevada Association of Counties worked with the Assembly Taxation Sub-Committee to develop statistics indicating the need to augment traditional county funding mechanisms to deal with the growing indigent medical care problem. Throughout the legislative process NACO, on behalf of all Nevada Counties, stated that there was an urgent need for additional county funding due to the costly medical indigent cases statewide. The figures developed included not only historical data, but also an estimate of expenditures for 1984-85.

Since the implementation of NRS 428.275, NACO has continued to work with this Committee and the Legislative Counsel Bureau to review and update the original statistics and to provide estimates regarding the funding needs of the seventeen counties for the current 1985-86 fiscal year. In reviewing the actual 1984-85 audited expenditures for indigent medical care, it is clear that the need for the dedicated county medical indigency fund and the Supplemental Fund is well documented. A survey of Nevada Counties conducted this week and attached for your review clearly indicates that <u>county governments continue to experience an increasing medical indigency problem</u>. The survey indicates that ten counties (urban and rural) expect to

utilize the dedicated revenue while at the same time a total of three counties have pending claims against the Supplemental Fund estimated to exceed the $413,000 available. The Supplemental Fund provides a degree of protection against "catastrophic claims" (claims exceeding $25,000) which, as the figures demonstrate, continue to be a serious problem statewide. It is important to note, one medically indigent claim in excess of $25,000 would exceed the total ad valorem revenue available to eight of the seventeen counties, even with the supplemental relief. Multiple claims of a similiar nature would equally impact all counties.

In addition to demonstrating the validity of the original proposal, these estimates are also indicative of the financial accountability of county government in the management of these funds. As can be seen by reviewing the statistics, funds derived from the Ad Valorem levy have been utilized only when traditional county funding has been depleted. In some instances the 3¢ levy will be reduced in FY 1986-87. Thus, the original intent of the law allowing for the fund to float to meet local conditions has been achieved. As previously noted, in many instances, it would only take one to four large claims a year to deplete the local funds. Our contacts with the various counties verify that county governments continue to stress case management and to closely review and monitor all indigent medical cases. Responsible fiscal management combined with access to the dedicated indigent funds has given rise to a well-managed and responsive statewide locally administered program.

The Nevada Association of Counties believes that the statistics support the foresight and leadership which the Nevada Legislature demonstrated in adopting NRS 428.275 during the 1985 Legislative Session. NACO further believes that the two year sunset provision of NRS 428.275 should be deleted by the Legislature in 1987, thus

providing permanent funding to aid the seventeen Nevada Counties in addressing continually increasing indigent medical care costs. Without such a program county governments will suffer serious financial impairment especially when caseloads are increasing and large-scale government cutbacks in federal funding are expected for state and county programs. These programs serve as a vital link in a delicate revenue structure that supports state and county governments.

In Conclusion, we recommend the permanent adoption of the funding mechanism established by NRS 428.275, and support the continuation of the Interim Committee to Study State Aid to Medically Indigent, to monitor the medical indigent problem and to work with county governments to identify potential adjustments if necessary. The Committee has provided a valuable forum for the discussion of indigent medical needs and has contributed to enhanced communications between governmental entities as well as focusing public attention to this matter of mutual concern. This Committee and the Committee to Study Health Care Cost Containment could address the issue of cost containment and restrictions on public hospitals prohibiting them from deriving additional revenue. Supplemental revenue generation by hospitals could increase efficiency and further reduce medical indigent costs, thus helping offset the impact of increasing caseloads.

Your support of this vital program and recommendation for continuation is appreciated and, on behalf of NACO, I thank you for the opportunity to testify in support of NRS 428.275 and a permanent funding mechanism.

NRS 428.275
MEDICAL INDIGENT TAX
FISCAL YEAR 1985-86

County	Ad Valorem Generated by 3¢	Ad Valorem Available to County	Estimated County Expenditure
Carson City	124,395	111,955	111,955
Churchill	42,234	38,011	0
Clark	2,255,450	2,029,905	2,029,905
Douglas	182,380	164,142	82,071
Elko	108,127	97,315	97,315
Esmeralda	10,965	9,868	0
Eureka	21,871	19,683	0
Humboldt	70,924	63,831	31,915
Lander	20,834	18,751	0
Lincoln	14,527	13,074	13,074
Lyon	63,630	57,267	0
Mineral	21,739	19,565	19,565
Nye	93,206	83,886	83,886
Pershing	24,364	21,928	0
Storey	12,886	11,597	0
Washoe	1,044,588	940,129	940,129
White Pine	23,618	21,256	21,256
Total	$ 4,135,738	$ 3,722,163	$3,431,071

Sources: 1985-86 Red Book (Department of Taxation)
County Expenditures reported by County Social Service Department or County Auditor are estimates at this time.

D40: SCR34.2

COUNTY EXPENDITURES FOR MEDICAL INDIGENTS: BY CATEGORY

FISCAL YEAR 1984-85

(000)

COUNTY	Group Care	Conv. Home Care	AMBU-LANCE	BURIALS	IN PATIENT	OUT PATIENT	HOSPITAL SUBSIDY	HEALTH CARE	MENTAL HEALTH	PHAR-MACY	PRIS-ONER CARE	OTHER	TOTAL
Carson City	2.9	28.6	0	2.9	45.1	8.4	0	14.4	23.9	.2	8.1	7.4	141.9
Churchill	0	31.1	0	5.3	36.2	4.0	0	10.0	2.1	1.1	0	0	89.9
Clark	30.1	781.6	28.1	61.9	4150.9	951.4	2500.0	317.3	753.5	0	4.0	327.4	9,906.2
Douglas	0	0	0	2.4	47.1	0	0	0	0	0	25.4	0	74.9
Elko	13.0	45.9	0	4.7	0	0	100.0	12.0	10.1	7.4	6.2	32.0	231.2
Esmeralda	0	0	28.5	0	3.0	0	12.0	1.5	0	0	.3	0	45.3
Eureka	0	0	0	0	8.7	64.7	0	0	0	0	0	1.0	74.4
Humboldt	14.5	0	0	3.4	53.3	0	306.0	9.5	1.8	0	1.7	6.0	396.2
Lander	0	0	0	0	64.2	7.1	0	6.0	0	0	3.0	10.7	91.0
Lincoln	0	0	13.0	0	0	0	0	0	0	7.2	0	0	20.2
Lyon	0	12.0	1.5	0	40.2	0	0	7.0	0	0	12.0	14.0	86.7
Mineral	0	0	0	0	0	0	86.1	0	0	0	0	26.0	112.1
Nye	0	25.0	0	2.3	193.7	0	0	8.0	0	1.8	16.6	11.5	258.9
Pershing	0	113.0	0	0	0	0	0	3.0	0	2.5	1.7	10.5	130.7
Storey	0	0	0	0	0	0	0	0	0	0	0	0	0
Washoe	218.6	252.1	3.5	51.0	2312.1	837.1	0	200.7	0	0	0	458.8	4,333.9
White Pine	43.6	0	0	6.6	6.9	0	0	9.0	3.9	7.5	0	14.6	92.1
TOTAL	322.7	1289.3	74.6	140.5	6961.4	1872.7	3004.1	598.4	795.3	27.7	79.0	919.9	16,085.6

Prepared: 1/30/86 L.S.

ESTIMATED COUNTY EXPENDITURES FOR MEDICAL INDIGENTS: BY CATEGORY

FISCAL YEAR 1985-86

(000)

COUNTY	Group Care	Conv. Home Care	AMBU-LANCE	BURIALS	IN PATIENT	OUT PATIENT	HOSPITAL SUBSIDY	HEALTH CARE	MENTAL HEALTH	PHAR-MACY	PRIS-ONER CARE	OTHER	TOTAL
Carson City	5.0	20.0	0	1.5	45.0	8.4	0	13.5	20.0	.3	10.0	0	123.7
Churchill	0	72.0	0	5.0	65.0	3.0	0	10.0	2.0	0	9.1	0	166.1
Clark	46.6	1800.0	47.5	118.2	7200.0	1800.0	2500.0	384.5	961.6	0	75.0	887.4	15,820.8
Douglas	0	0	0	3.0	43.0	0	0	0	0	0	40.0	0	86.0
Elko	20.0	60.0	0	8.0	0	0	100.0	15.0	20.0	10.0	8.5	138.0	379.5
Esmeralda	0	0	15.0	1.2	0	0	9.0	1.4	0	0	1.0	0	27.6
Eureka	0	0	0	0	30.0	75.0	0	0	0	0	0	5.0	110.0
Humboldt	25.0	0	1.0	3.5	71.2	2.0	0	9.5	2.5	.8	2.5	6.0	124.0
Lander	0	0	0	0	25.0	50.0	0	6.0	0	0	2.8	12.5	96.3
Lincoln	0	0	20.0	0	0	0	0	0	0	18.6	11.5	0	50.1
Lyon	0	12.6	1.5	0	82.4	0	0	8.4	0	0	14.9	15.8	135.6
Mineral	0	0	0	0	95.0	0	0	0	0	0	0	45.0	140.0
Nye	0	25.0	0	2.3	193.7	0	0	8.0	0	1.8	16.6	11.5	258.9
Pershing	0	113.0	0	0	0	0	0	3.0	0	2.5	1.7	10.5	130.7
Storey	0	0	0	0	0	0	0	0	0	0	15.0	0	15.0
Washoe	0	0	0	0	0	0	0	0	0	0	0	4445.1*	4445.1
White Pine	54.0	0	0	6.3	19.5	0	0	9.0	0		0	19.5	108.3
TOTAL	150.6	2102.6	85.0	149.0	7869.8	1938.4	2609.0	468.3	1006.1	34.0	208.6	5596.3	22,217.7

* at this time we were unable to breakdown the individual categories

Prepared: 1/30/86 L.S.
D39

COUNTY EXPENDITURES FOR MEDICAL INDIGENTS
ACTUAL: 1983-84 & 1984-85
ESTIMATE: 1985-86
(000)

	Actual 1983-4	Actual 1984-5	Estimate 1985-6
Group Care	$ 255.9	$ 322.7	$ 150.6
Conv. Home Care	386.1	1289.3	2102.6
Ambulance	55.9	74.6	85.0
Burials	71.6	140.5	149.0
Hosp. In-Patient	3286.3	6961.4	7869.8
Hosp. Out-Patient	3480.6	1872.7	1938.4
Hosp. Subsidy	9838.0	3004.1	2609.0
Home Health Care	242.9	598.4	468.3
Mental Health	213.2	795.3	1006.1
Pharmacy	29.2	27.7	34.0
Prisoner	79.4	79.0	208.6
Other	---	919.9	5596.3
TOTAL	$17,939.1	$16,085.6	$22,217.7

Prepared 1/30/86 L.S.

D39

APPENDIX E

Letter, Dated May 18, 1986, from Senator Raymond D. Rawson, Chairman of the Subcommittee to Study Restraining Costs of Medical Care (S.B. 460)

RAYMOND D. RAWSON
Senator
Clark No. 6
6433 Mecham Avenue
Las Vegas, Nevada 89107
870-6382

COMMITTEES
Member
Human Resources and Facilities
Judiciary
Legislative Affairs

Nevada Legislature

SIXTY-THIRD SESSION

May 8, 1986

Senator Randolph J. Townsend, Chairman
Legislative Commission's Subcommittee
to Study Operation of Program for
State Aid to Medically Indigent
P.O. Box 20923
Reno, NV 89515

Dear Senator Townsend:

As you know, a number of recommendations and concepts concerning uncompensated care have been offered in testimony to the legislative commission's subcommittee to study restraining costs of medical care (S.B. 460).

At its most recent workshop, the subcommittee asked me to write you in order to express their support for continuation of the 3-cent ad valorem tax which was adopted in the 1985 legislative session (Assembly Bill 422, chapter 629). I would appreciate it if you would make your membership aware of our recommendation when you consider this matter.

Please let me know if the members of the S.B. 460 subcommittee or I may be of assistance to you.

Sincerely,

Raymond D. Rawson

Senator Raymond D. Rawson
Chairman, Legislative Commission's
Subcommittee to Study Restraining
Costs of Medical Care

RDR/en
SB460-3:LTR12

APPENDIX F

Report, Alternative Funding Sources for Care of the Medically Indigent by Martha P. King

ONG-TERM CARE HOME HEALTH HOSPICE
ECOND SURGICAL OPINIONS RATE SETTIN
EDICALLY INDIGENT INSURANCE PREVEN
REVENTION CERTIFICATE OF NEED MEDIC
EDICAL MALPRACTICE PREFERRED PRO\
REFERRED PROVIDER ORGANIZATIONS D
IAGNOSTIC-RELATED GROUPS UTILIZATI
TILIZATION ORGAN TRANSPLANTS MEDIC
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ALTERNATIVE FUNDING SOURCES

FOR CARE OF THE MEDICALLY INDIGENT

By

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ALTERNATIVE FUNDING SOURCES FOR CARE OF THE MEDICALLY INDIGENT

Introduction

Squeezed between increasing health care costs and decreasing general fund revenues, state legislatures are tapping new funding sources to finance health care for the medically indigent (MI). More than half the states have considered legislation to raise revenues outside of general fund sources to help fund MI programs. Over a dozen revenue options have been considered, ranging from assessments on hospitals to earmarked lottery proceeds.

This publication provides legislators and legislative staff an overview of funding options. It gives information about alternative financing mechanisms considered by state legislatures, whether adopted or rejected. The bulk of the information appears in a chart, starting on page 10. Listing states alphabetically, the chart focuses on the financing mechanisms and how much money is (or would have been) generated by each. It also shows the status of each proposal, distribution of funds, eligibility requirements, estimated number of patients, as well as covered services and service providers.

Beginning on page 3, this narrative describes each funding option listed in the chart. States that have considered the funding sources are noted in the section about each option.

NCSL conducted a 50-state written survey in the fall, 1985, and later updated those proposals that carried over into the 1986 legislative sessions. The chart, however, does not list all proposals considered by state legislatures in 1986. NCSL appreciates the time and expertise contributed by the legislative staff.

Most state programs for the medically indigent address just part of a larger problem of uncompensated health care. "Uncompensated care" includes both charity care and bad debt. Accounting for roughly one-third of total uncompensated care costs, "charity care" is given to patients without adequate health insurance who are unable to pay. "Bad debt" is generated by those patients who are expected to pay for care but do not. The majority of MI programs compensate providers an amount for "charity" services delivered to persons who meet their state's particular eligibility criteria. A few states with mandatory rate-setting mechanisms address the "bad debt" problem as well as traditional "charity care" by adding an allowance for uncompensated care.

Background

State governments are faced with increasing health care costs for medically indigent persons at the same time that resources are shrinking. States are under pressure from the following areas to find more adequate and equitable means to finance health care for the MI population:

- *Local governments*

  About 30 states require local governments to fully or partially fund indigent care programs. Many towns and counties sponsor public hospitals or contribute toward care for their MI residents who are served through public health programs or by other providers. As health care providers of "last resort," public hospitals bear an increasingly disproportionate share of uncompensated care, accounting for 10 percent of total hospital charges nationwide, but 35 percent of uncompensated charges.1 The burden appears to be growing. Although a marked decline in total hospital use has occurred nationally over the past two years, public hospital use has increased an average of 10 percent over the same period.2 Reflecting a national trend, transfers to Chicago's Cook County Hospital of patients who had no resources to pay their bills increased from 60 to 70 per month in 1983 to over 500 per month by 1985.3

- *Hospitals*

  Nationwide, hospitals reported $6.9 billion in uncompensated care costs in 1984, representing about a 50 percent increase (in constant dollars) since 1980.4 Texas hospitals absorb almost $1 billion annually in uncompensated care. In 1983, five Texas hospitals together funded more uncompensated care than the state's entire Medicaid budget.5 Changing reimbursement mechanisms, increased competition, and pressures from private insurers have forced hospitals to restrain fees, reducing funds available to subsidize the costs of uncompensated care.

- *Businesses*

  National spending for health care has doubled in the past six years, with employers paying about $100 billion annually in health care expenses.6 Business coalitions have been very vocal in addressing the issue of rising health costs. A rough, conservative estimate from a survey of the metropolitan Phoenix area indicates that employers pay an average of $90 to $100 per worker annually in additional health premiums to help cover uncompensated health care.7

- *A declining federal role*

  In 1975, 63 percent of the population near or below the poverty line were eligible for Medicaid; in 1983, the number fell below 50 percent.8 With passage of the Gramm-Rudman-Hollings deficit reduction package, it is unlikely that states can count on any increased financial assistance from Washington to pay for health care of low-income persons.

At the same time that states are under pressure to do something about uncompensated health care costs, many are facing serious budget constraints. In addition to the $16 billion state and local governments spend for Medicaid, several billion dollars also go for uncompensated health care each year. A national survey conducted by the Intergovernmental Health Policy

Project (IHPP) indicates that states and counties paid more than $2.3 billion for MI care in FY 1983. IHPP reports that the figure is low because not all county contributions were available, spending on programs for specific diseases or populations was not included, and funds counties give directly to hospitals to help them offset the cost of uncompensated care are not reflected.9

State lawmakers weighing competing budget needs find it difficult to appropriate additional general fund revenues for uncompensated health care. According to Washington Governor Booth Gardner in an address on the uncompensated care issue in December 1985, states are living in an "era of [the] politics of subtraction," in which a decision to increase the budget in one area inevitably means a decrease in another area. Future federal budget cuts will only aggravate the situation.

In this atmosphere, in addition to seeking ways to control health costs, states are looking for alternative revenue sources to help fund uncompensated care.

Alternative Financing Mechanisms

This section discusses various financing options that lawmakers have used or proposed to fund health care for the medically indigent. Each category lists states that have considered or adopted the revenue source. The chart beginning on page 10 lists states alphabetically and provides details about the programs or proposals.

- *Assessments on hospitals*

  Enacted legislation: Florida, New York, South Carolina, West Virginia, and Wisconsin; pending legislation: Pennsylvania; failed proposals: Alabama, California, Colorado, Georgia, Kentucky, Oregon, Tennessee, Washington, and West Virginia (an alternative to the adopted legislation).

  The most popular alternative revenue source is an assessment on hospitals. Proponents of the assessments point out that they are broad-based taxes that help spread the funding burden more equitably among both providers and consumers, since providers will pass some of the tax on to patients through higher charges. Thus, everyone who pays for health care contributes a share of the costs of funding uncompensated care.

  Opponents of the assessments, most notably the American Hospital Association and the Federation of American Health Systems, argue that it amounts to a "sick tax," which places the burden on providers of care. Michael Bromberg, executive director of the federation, says, "We don't ask private landlords to tax themselves in order to build public housing. We don't ask grocery stores in the rich suburbs to tax themselves to pay for food stamps for poor people in the inner cities."10

  Bromberg supports federal assistance for funding health care for the medically indigent, funded by a tax on employer-purchased health insurance benefits above a specific amount. Dr. Alain

Enthoven of Stanford University estimates that the cost of the tax-free status of health fringe benefits amounts to about $30 billion per year.11

- *Assessments on insurance premiums*

  Enacted legislation: Iowa; pending legislation: Pennsylvania; proposals: New Jersey, Oklahoma, and Tennessee.

  Hospitals finance a large amount of uncompensated care by shifting costs to private third-party payers. This amounts to an informal "cost shifting," with insured patients subsidizing those who do not pay their bills. Dr. Gail Wilensky considers a tax on insurance premiums to be a formalization of this cost-shifting practice.12 Among the advantages Wilensky lists for taxing health insurance premiums are that the tax is broad based and it recovers some of the subsidy provided by the tax exclusion for employment-related insurance. Wilensky says the primary drawback is that self-insured employers would be exempt from state taxation under the federal Employee Retirement Income and Security Act of 1974 (ERISA). ERISA says that federal insurance law supercedes state insurance law for self-insured employers. The exemption may encourage more employers to self-insure, narrowing the revenue base. Since some legal controversy exists about the extent to which ERISA preempts state law, the issue may not yet be closed.

  Several states have proposed assessments on health insurance premiums, but only Iowa has adopted legislation. It assesses a 2 percent tax on all Blue Cross/Blue Shield plans and other nonprofit health service corporation plans. Insurance assessment proposals in New Jersey, Oklahoma, and Tennessee have failed, and a pending Pennsylvania bill would assess health care and accident premiums in addition to hospital revenues.

- *Assessments on other health care providers*

  Pending legislation: Pennsylvania; failed proposal: Washington.

  Two states have considered assessing nonhospital health care providers. A 1985 Washington proposal would have assessed a 1 percent tax on the gross income of "persons engaged in practicing medicine"; a pending Pennsylvania bill would assess uniform surcharges on all provider bills for hospitals and ambulatory surgical facilities, and another Pennsylvania proposal would assess "all health care providers" except physicians 1 percent of gross operating revenues.

- *Minimum care requirements*

  Enacted legislation: Arkansas, California (incentive); existing nonlegislative programs: Georgia, Kentucky; pending legislation: Ohio; failed proposals: Alabama, Kentucky, Nevada, Texas, Washington (incentive), and West Virginia.

  Several programs or proposals require or encourage hospitals to provide a minimum amount of "charity care," which some consider to

be similar to involuntary tax assessments on hospitals. In Arkansas, hospitals must give a specific level of charity care before they can receive reimbursement for additional services to the indigent. Defeated Alabama and Kentucky proposals for minimum charity care levels would have fined hospitals for noncompliance. Proposals in Texas and West Virginia would have required hospitals to provide an amount of charity care as a condition of licensure. A pending Ohio proposal specifies that some hospitals must absorb a share of uncompensated care proportional to their share of compensated care. A defeated bill in Nevada proposed that hospitals give emergency care to indigents. A lease arrangement in Kentucky and executive agency rules in Georgia require the buyers of previously public hospitals to provide specified levels of charity care.

Some proposals encourage, rather than require, health care providers to contribute care to the indigent. After a mandatory "fair share" bill failed in the Kentucky legislature, the provider community established two voluntary programs to encourage both hospitals and physicians to donate their "fair share" of care to indigent persons. A California law encourages hospitals to provide charity care by exempting them from certificate of need requirements if they agree to provide free indigent care over a five-year period worth at least as much as the project. A similar proposal in Washington was defeated.

- *Rate-setting "add-on" mechanisms*

Enacted legislation: Connecticut, Maine, Maryland, Massachusetts, New Jersey, and New York.

Six states provide for uncompensated care costs through their rate-setting programs by adding an allowance to each hospital's rates to help cover uncompensated care costs. This "add-on" mechanism is an explicit form of cost shifting, requiring paying patients to contribute a share of the costs. It is a broad-based revenue source addressing compensation for both medically indigent care and bad debt.

The add-on mechanisms appear to be the most lucrative options, with Massachusetts covering an estimated $200 million in uncompensated care costs in 1985, and Connecticut expecting to cover almost $100 million in 1986. It is important to note that these programs build in compensation for bad debt generated by hospitals, which other programs do not address.

One disadvantage of the all-payer systems is that they cannot exist without regulatory rate-setting structures, which are not politically attractive in many states, especially in an increasingly competitive health care market. In addition, it has become more difficult to obtain a federal waiver allowing states to include Medicare in their all-payer systems. Only Maryland and New Jersey currently have such waivers. New York had a waiver for three years and opted against renewing it. Instead, the legislature chose to assess hospitals 4.5 percent of their Medicare revenues. The Medicare assessment was challenged in court by one

hospital, was ruled invalid for that hospital, and is pending appeal.

Wilensky cites two other drawbacks: the all-payer systems pay for care at whatever hospital individuals use, as opposed to directing them to the most efficient providers; and the systems provide little incentive for competitive innovation.

New York's program may serve as a model to overcome these problems. The state collects its "add-on" revenues and distributes them to eight regional indigent care pools. Funds are allocated to hospitals based on several factors, including whether they have an adequate collection procedure.

o *Employer contributions*

Enacted legislation: Hawaii; developing proposal: Arizona; failed proposals: New Jersey and Oregon.

A few proposals target employers as funding sources, either directly or indirectly. Proposals in Oregon (failed) and Arizona would tax employers directly to help fund MI services and/or subsidize health insurance premiums for qualified persons. Since 1974, Hawaii's Prepaid Health Care Act has required employers to make health coverage available to most employees, an indirect way of tapping employer contributions to minimize the uninsured population. Although the Hawaii approach is not really considered a medically indigent program, an estimated 98 percent of the employed population has health insurance.13 A New Jersey bill would have required larger companies that transfer out of state or terminate operations to contribute a specified amount to help fund the continuation of health and life insurance premiums for affected employees who need it.

Requirements or incentives for employers to offer health insurance to employees could reduce the medically indigent population substantially. An estimated 75 percent of uninsured persons are employed or are dependents of employed workers. About two-thirds of uninsured workers are employed full time and nine out of ten of the employed uninsured cannot obtain insurance through their employers.14

Two obstacles to requiring employers to provide insurance coverage for employees are the exemption of self-insured employers under ERISA and the inability of many small businesses to afford premiums, especially if they are not eligible for group rates. Hawaii is able to require self-insured employers to participate in its program even though the U.S. Supreme Court ruled the state's requirement for self-insured employers invalid in 1981. Congress amended ERISA in 1983 to allow Hawaii to reinstate the requirement.

Small businesses are much less likely to offer health insurance than larger employers. Wilensky cites figures indicating that only 32 percent of firms with fewer than four employees provide health insurance to their workers, compared with over 85 percent of firms having more than 500 employees.15 To address the problem

confronted by small businesses, one option to make health insurance more affordable may be to encourage the formation of "multiple employer trusts"--groups of employers that pool their workers into larger groups to take advantage of lower group rates. Another option is addressed in a pending federal proposal (H.R. 4742). It would allow owners of unincorporated businesses to deduct the cost of their personal insurance as a business expense if they provide comparable coverage for their workers.

o *Other revenue sources*

Several other proposals to fund care for the medically indigent have been proposed, generally using revenue from non-health-related sources.

Both the **cigarette tax** and **motor vehicle fees** are promoted by some as logical funding sources. A significant share of indigent care costs stem from accidents, and smoking contributes to the health care costs for some MI patients. Four states have proposed and rejected increasing excise taxes on cigarettes to help fund MI care: Colorado, Montana, Texas, and Washington. Three of the proposals were tied to the anticipated reduction in the federal excise tax on cigarettes. Ohio is the only state that earmarks a portion of motor vehicle license fees for MI care. A Nevada law targets indigent accident victims through its "accidents fund."

Lottery and **gambling revenues** are tapped in three states. Pennsylvania earmarks approximately $100 million annually from lottery proceeds for pharmaceutical assistance for the elderly. New Jersey appropriates about $70 million from casino gambling taxes for health care for elderly and disabled persons. A Montana law provides that money seized for violation of gambling laws will supplement property tax assessments for MI care.

Oklahoma sponsors a **check-off on the state's income tax form** for persons to donate a portion of their tax refund to the Indigent Health Care Fund. A similar proposal failed in Alabama.

Five percent of the proceeds from offshore oil and gas **severance taxes** in Baldwin County, Alabama, will be earmarked for indigent care costs once oil production begins.

Several programs or proposals require a **contribution from eligible recipients of care**: existing programs in Connecticut, Pennsylvania, South Carolina, and Wisconsin; failed proposals in Colorado, Florida, Georgia, Oregon, and Washington; and a pending proposal in New York.

Arkansas and Minnesota invested **savings from other health-related programs** to help fund care for the indigent. The Minnesota funds will be used as a state match to obtain **private contributions** for alternative health insurance projects.

A failed proposal in Florida would have replaced the assessment on hospitals with an increase in the **sales and use tax**.

Four programs or proposals that use **general fund revenues** (state and/or local) are included in the chart because of their unique features: the Arizona Health Care Cost Containment System is a prepaid capitated health plan; two Colorado proposals would have used funds to help purchase private health insurance for eligible persons; in Nevada, county property taxes fund a state accident pool for injured motorists; and a Texas proposal would have authorized the creation of indigent health care districts with taxing authority.

Exclusions

With a few exceptions, this publication does not list MI proposals or programs that exclusively use general funds, whether from state, county, or federal revenues. The exceptions are those noted above that use the money for innovative delivery systems for MI patients. Proposals to fund the expansion of Medicaid programs to cover portions of the MI population otherwise ineligible for Medicaid also are excluded, unless they use non-general fund revenues. For example, money collected via Florida's hospital assessment law and New Jersey's casino gambling tax is used to fund state Medically Needy programs.

In addition, several other programs that may reduce the amount of uncompensated care are excluded from this publication, unless they tap non-general fund resources. These include approaches that are not primarily targeted at the low-income population, such as catastrophic illness programs and risk-sharing pools for persons who are refused health insurance because of potentially serious or costly health problems. Also excluded are state requirements for health insurance continuation or conversion privileges for laid-off or terminated workers.

Notes

1. *What Legislators Need to Know About Uncompensated Hospital Care* (Denver: National Conference of State Legislatures, 1984).

2. James Morgan, M.D., "Changes in indigent care affect Truman Medical Center," *Metropolitan Hospital* (Chicago: American Hospital Association, fall 1985).

3. Bruce Bernard, M.D., "Poor patients pawned off to public hospitals," *Rocky Mountain News*, October 31, 1985, p. 77.

4. *"Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent"* (Chicago: American Hospital Association, February 1986). (The figure represents charges converted to actual costs.)

5. Larry Gage, President, National Association of Public Hospitals, Presentation to the September 13-14, 1984, conference, "Uncompensated Care in a Competitive Environment: Whose Problem Is It?" Sponsored by the U.S. Department of Health and Human Services and the National Council on Health Planning and Development, Washington, D.C.

6. Sylvia Porter, "Employees feeling pressure to control health-care costs," *Rocky Mountain News*, November 17, 1985.

7. Frank Connell, Greater Phoenix Affordable Health Care Foundation, oral communication, December 1985.

8. Randolph Desonia and Kathleen King, *State Programs of Assistance for the Medically Indigent*, Intergovernmental Health Policy Project (Washington, D.C.: The George Washington University, November 1985), p. viii.

9. Ibid., p. xii.

10. Presentation to the September 13-14, 1984, conference, "Uncompensated Care in a Competitive Environment: Whose Problem Is It?" Sponsored by the U.S. Department of Health and Human Services and the National Council on Health Planning and Development, Washington, D.C.

11. Presentation to the November 28-30, 1984, conference, "Health Care in Colorado." Sponsored by the Gates Foundation, Keystone, Colorado.

12. Gail Wilensky, Ph.D., "Solving Uncompensated Hospital Care: Targeting the Indigent and the Uninsured," *Health Affairs*, winter 1984, p. 54.

13. Emily Friedman, "Mandatory Insurance: A Cure for Indigence?" *Hospitals*, June 5, 1986, p. 46.

14. Wilensky, "Solving Uncompensated Hospital Care," p. 54.

15. Presentation to the Subcommittee on Health, Committee on Ways and Means, U.S. Congress, June 9, 1986.

STATE PROGRAMS/PROPOSALS TO FUND CARE OF THE MEDICALLY INDIGENT

PROGRAM AND LEGAL STATUS/1	FINANCING MECHANISM(S)/2	ESTIMATED REVENUE/3	STATE G.F. CONTRIBUTION/4	ELIGIBLE PATIENTS/5	ESTIMATED NUMBER OF PATIENTS/6	DISTRIBUTION OF FUNDS/7	PROVIDERS AND COVERED SERVICES/8
ALABAMA							
Failed proposal (HB 144, 1985)	Requires all hospitals to provide at least 3% of total hospital gross revenues to medically indigent care. Failure to meet obligation results in a $100,000 fine in addition to full payment of required amount, unless a "good faith" effort is shown. Proprietary hospitals are credited up to 1% for any state or local tax payment. Program supplements county contributions	Unknown	None	Unknown	Unknown	County medically indigent funds are used to reimburse hospitals for medically indigent services, but are limited to those hospitals that have devoted at least 5% of their previous annual gross revenues to indigent care	Providers: Hospitals Services: Hospital services
Failed proposal (HB 491, 1984)	Assesses each hospital $12.50 per bed day. (26,000 beds; 7,134,092 inpatient days,	$88M (FY 1984)	None	Medically indigent	Unknown	Determined by a newly created commission	Providers: Hospitals Services: Unknown
Failed proposal (HB 522, 1984)	Provides for voluntary taxpayer designation of contributions on state income tax return for indigent care	$1 for individual and $2 for joint return	None	Not specified	Unknown	Distributed by State Comptroller to appropriate officials of state governing authority for indigent health care	Not specified

Footnotes
1. Bill number, statutory citation, or source of proposal
2. Revenue sources that are not state general funds
3. Total money generated from the financing mechanism(s) listed in column 2
4. Amount of money contributed from state general funds
5. Persons eligible to receive medical services
6. Number of persons serviced each year
7. Provisions/requirements for the distribution of funds
8. Services for which providers may be reimbursed and providers eligible for reimbursement

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
ALABAMA (con't)							
Code of Ala., 1975, as amended by Act 84-733 and 84-736 (1984)	Allocates 5% of Baldwin County's share of proceeds from offshore oil and gas severance taxes to the Indigent Medical Care Board. (Note: oil and gas production to begin in two or three years; no funding available prior to that)	Unknown	None	Medically indigent residents of Baldwin County	650-700 annually	Determined by the Baldwin Co. Indigent Medical Care Board; maximum per diem rate set annually	Providers: Hospitals Services: Hospital services not including Hill-Burton, educational, or other funds supporting indigent care; excludes physician services
ARIZONA							
Arizona Health Care Cost Containment System (AHCCCS) Ariz. Rev. Stat. Ann. §11-291 and §36-2901 et seq.	Uses existing government appropriations: 25% - counties 25% - federal 50% - state	$255.3M (FY 1984 est.)	$126.5M (FY 1984 est.)	Those eligible for Aid to Families with Dependent Children or Supplemental Security Income and individuals with annual incomes up to $3,200	175,000 (FY 1984)	Distributed on a capitation basis to interested health plans/ organizations submitting bids for care of patients. In FY 1985, the composite capitated fee was $95.07 per month	Providers: Health plans Services: Inpatient hospital services; outpatient services, including dental care, pharmacy services, lab, x-ray, and diagnostic services, eye exams and services for children to age 21
(Maricopa County) Proposal by the Greater Phoenix Affordable Health Care Foundation (a broad-based coalition made up of representatives from business, industry, labor, health care providers, third-party payers, and government)	Taxes employers for each "full time equivalent" employee (FTE): $35/FTE/year for employers who provide a certain minimum level of health insurance benefits to their employees; $1,000/FTE/year for employers who do not provide health insurance to their employees	$100M (FY 1987)	None	Persons in the "notch group" (those who do not qualify for the AHCCCS Program--Arizona's equivalent of Medicaid --and whose income falls below the federal poverty guidelines)	92,000	Funds are collected by the state and administered by a program manager (fiscal intermediary) Funds are used to reimburse participating providers for services provided at a discounted rate The foundation also would serve as a facilitator among employers, particularly smaller employers who don't offer health insurance, to enable them to purchase health insurance at more reasonable rates	Providers: Hospitals, physicians, alternative health care delivery systems Services: Ambulatory care and surgery; emergency services; inpatient care; home-health care; pharmaceuticals; lab, X-ray and other diagnostic procedures; and durable medical equipment

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
ARKANSAS							
Arkansas Indigent Health Care Program Ark. Stat. Ann. §2161 et seq. (PL 97-35, 1985)	Provides for depositing the federal Medicaid rebate to Arkansas for FY 1984 and state appropriations for the medically indigent into the Health Care Trust Fund. Principal and interest payments resulting from investments may be transferred to the Health Care Fund for health services. Hospitals seeking reimbursement for indigent care must provide a level of charity care to be determined by the Department of Human Services and the Indigent Health Care Advisory Council	$11.8M federal rebate (FY 1986) $371,000 from investments (FY 1986) $20M donated by hospitals (FY 1986)	$4.1M (FY 1986)	To be defined by the Department of Human Services and the Indigent Health Care Advisory Council	10,000 (FY 1986)	Funds are distributed according to guidelines established by the Department of Human Services and the Indigent Health Care Advisory Council. Priority for distribution must be given to programs that have the benefit of matching federal funds	Preventive and primary care services must be given highest priority
CALIFORNIA							
Failed proposal (AB 2004, 1985-86)	Assesses health facilities not operated by public entities a portion of their operating revenues to be used to finance an Uncompensated Care Account within the County Health Services Fund	Unknown	None	Persons up to 200% of poverty who are uninsured by any private or public programs and who are unable to use county facilities for enumerated reasons	Unknown	Quarterly distributions made by the Office of Statewide Health Planning to nonpublic health facilities and clinics that provide higher levels of uncompensated care within a health service area	Providers: Health clinics and facilities not operated by public entities Services: Hospital and clinic services
California Health and Safety Code, §437.116 et seq. (1984)	Encourages hospitals to contribute services to indigent patients by exempting them from Certificate of Need requirements	Unknown	None	Uninsured people	Unknown	A hospital would be exempted from Certificate of Need requirements if it agreed to provide free indigent care over a five-year period worth at least as much as the project	Providers: Hospitals Services: Hospital services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
COLORADO							
Failed proposal (SB 29, 1982)	Uses general funds to supplement participant sliding-scale fees for group health insurance (pilot program)	$129,625 (from sliding scale fees)	$404,750 (FY 1983)	Uninsured with income under $11,000 and not covered under existing programs	500 households	Funds used to purchase group health insurance; administered by Department of Social Services	Providers: Hospitals and licensed health care providers Services: hospital and basic health care services
Failed proposal (HB 1380, 1984)	Uses state appropriations to purchase health insurance	$387,253 estimated total savings (FY 1985)	$202,340 estimated G.F. savings (FY 1985)	Categorically needy under $11,000 and not covered by existing programs	27,300 (FY 1985)	State health care certificates are issued to eligible persons to be used for the purchase of health insurance from qualified health providers. Payments would be on the basis of prepaid, capitated contracts awarded by counties as a result of competitive bids	Providers: Same as for Medicaid Services: Same as for Medicaid
Failed proposal (HB 1152, 1985)	Assesses an additional state excise tax on cigarettes to replace the $.08 federal tax scheduled to be repealed. 50% of money would supplement existing medically indigent fund	$14.75M for medically indigent (FY 1986)	Unknown	Persons whose income does not exceed 150% of the poverty level after deducting medical bills and premiums	Not reported	Creates a state Cigarette Tax Fund; a portion of the proceeds would go for research/education about smoking-related illnesses and 50% of proceeds would supplement the current medically indigent program	Providers: Not reported Services: As specified in Article 15, Title 26
Failed proposal (Denver City Council, 1985)	Taxes Denver's private hospitals $2/day/bed to supplement city and state general fund appropriations. (4,586 private hospital beds with 67% occupancy rate)	$2.24M (1986)	Not reported	Medically indigent patients served at Denver General Hospital	Not reported	Not applicable	Providers: Denver General Hospital Services: Hospital services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
CONNECTICUT							
Connecticut Pharmaceutical Assistance Contract to the Elderly ("ConnPACE"--pilot program) 1985 Conn. Acts, P.A. 85-573	Assesses eligible persons a $15 participation fee; provides that 50% of "reasonable cost" of prescription drugs is paid by the state and 50% by eligible participants	Unknown	$2.85M (15 months; begins April 1986)	65 or over with income below: $9,000 single $12,000 couple	60,000 to 90,000 (FY 1986)	State pays 50% of the reasonable cost of prescription drugs dispensed to participants (for the duration of the pilot program, April 1986 to June 30, 1987)	Providers: Participating pharmacies Services: Prescription drugs
Conn. Gen. Stat. §19a-165 to §19a-165q (1984)	Requires hospitals to charge rates to cover a reasonable level of uncompensated care set for each hospital through the state's all-payer prospective reimbursement system (excludes Medicare)	$94.2M from hospital rates (FY 1986)	None	Recipients of uncompensated care at hospitals	Unknown	The Commission on Hospitals and Health Care determines a "reasonable level of uncompensated care" for both inpatient and outpatient services based on number of medical assistance cases, level of bad debt, and socioeconomic characteristics of hospital service areas (e.g., unemployment rate, percent of population on Medicaid or General Assistance)	Providers: Hospitals Services: Inpatient and outpatient
FLORIDA							
Fla. Stat. §395.101(2) (1984)	Assesses hospitals 1% of annual net operating revenues in first year and 1.5% in subsequent years for Public Medical Assistance Trust Fund. Federal government matches state contribution at Medicaid matching rate	$75M raised from hospital assessments $29M from federal funds (FY 1985)	$20M (FY 1985)	Those newly eligible for medical assistance as a result of the state expanding its Medicaid program to include the medically needy program	51,000 (FY 1985)	Same as for Medicaid (Note: a defeated 1986 bill, H.B. 1268, would have expanded the use of revenues to include funding for medically indigent persons. The state would have contributed excess revenues in the fund to county-run capitated programs for the medically indigent. Counties would have contributed 40% of the costs)	Same as for Medicaid

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
FLORIDA (con't)							
Failed proposal (HB 39, 1986)	Imposes a 0.5 percent increase in the sales and use tax to replace the current assessment on hospitals	Not reported	$20M	Uninsured persons whose monthly income is below 150% of federal poverty level	Not reported	Revenues deposited in the Public Medical Assistance Trust Fund are used to fund a state insurance program for the indigent and to finance certain medical services under the Department of Health and Rehabilitative Services. Persons at or below Medicaid financial eligibility standards would receive free care; other qualifying persons would be assessed a co-payment based on ability to pay	Providers: Providers who receive contracts on a competitive basis Services: Emphasis on primary care; a specified amount would be earmarked for wellness programs
GEORGIA							
State Health Planning Agency Rules 272.2-.03(4)(f)2(i) (effective 11/1/84)	Requires the buyer of what was previously a public hospital to agree to devote at least 3% of gross revenues to charity care	Unknown	None	Unknown	Unknown	Not applicable	Providers: Buyer of what was previously a public hospital Services: Hospital care
Failed proposal (HB 556, 1985-86)	Provides for county/state/hospital contributions. Requires hospitals to pay a license fee equal to 5% of their gross revenue (excluding county payment for indigents). Requires counties to pay the greater of either their current payment amounts to hospitals or an amount determined by a property assessment formula. Requires recipients to pay at least 10% of the cost	$155M from hospital license fees (FY 1986) $60M from counties (FY 1986)	$20M (FY 1986)	Those with income no greater than 150% of federal poverty guidelines	Unknown	Funds paid to health care providers on behalf of qualified indigents served	Providers: Hospitals Services: Hospital and physician services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
GEORGIA (con't)							
Failed proposal (HB 811, 1985-86)	Assesses hospitals 2% of gross revenues minus Medicare and Medicaid adjustments and bad debt	Unknown	None	Unknown	Unknown	Expands recipient eligibility under Medicaid	Providers: Hospitals Services: Same as for Medicaid
HAWAII							
Prepaid Health Care Act Hawaii Rev. Stat. Chap. 393 (1974)	Requires employers to make health coverage available to most employees working at least 20 hours per week (not an indigent health care program per se)	Not applicable	None	Most employees working at least 20 hours per week	(See column 7)	Not applicable (Note: employment-based insurance coverage increased from 70% to 78% between 1974 and 1977)	Providers and services covered by health insurance plans or Health Maintenance Organization policies
IOWA							
Iowa Acts, Chap. 239 (H.F. 570, 1985)	Assesses a 2% premium tax on all Blue Cross/Blue Shield plans and other non-profit health service corporation plans	$11M (FY 1986)	None	Certain recipients of Supplemental Security Income	2,670 for 6 months (delay in start to 4/1/86 means fewer will be served)	Provides $1.96M to expand the medically needy program; $8M to be determined by the Iowa General Assembly in 1986	Providers: Excludes mental institutions and facilities for the mentally retarded Services: All services rendered by qualified providers

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
KENTUCKY							
Failed proposal (HB 859, 1984)	Requires all hospitals to provide their "fair share" of indigent care. Fair share is defined as the statewide average percentage of gross patient revenues used by hospitals to provide necessary care to the medically indigent. Hospitals failing to meet their fair share obligations must pay a fine equal to one-and-one-half times the difference between the fair share amount and the amount of indigent care provided	$65M (est.) donated care by hospitals	None	The medically indigent who use hospital services	Unknown	Not applicable	Providers: Hospitals Services: Inpatient hospital services
Voluntary Kentucky Hospital Fair Share Program (initiated by the Health Care Access Foundation in 1984)	Encourages hospitals to sign an agreement saying they will provide at least as much charity care as the average for hospitals in their district up to a maximum of 2.6% of gross patient revenues. 94 of 110 community hospitals have agreed to participate	$65M donated care by hospitals in 1985	None	Recipients of charity care	Unknown	Not applicable	Providers: Hospitals Services: Inpatient hospital services
Voluntary Kentucky Physicians Care Program (initiated by the Kentucky Medical Association, the Kentucky Health Care Access Foundation, and the State Cabinet for Human Resources)	Encourages physicians to agree to accept medically indigent patients referred through the program	Unknown	None	Persons meeting specified guidelines	3,000 (Jan.-Sept. 1985)	Not applicable. Patients are asked to call toll-free hotline for referral to the Cabinet for Human Resources, which determines eligibility and refers participants to physicians	Providers: 2,000 participating physicians Services: out-patient services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
KENTUCKY (con't)							
Lease agreement for private management of University Hospital	Provides for the lease of University Hospital by a private for-profit hospital corporation (Humana, Inc.), which supplements contributions by state, county (Jefferson), and city (Louisville)	$6M Humana, Inc. $2.9M Jefferson County $2.1M Louisville (FY 1984)	$14.8M (FY 1984)	Uninsured patients who meet the poverty guidelines as defined by the federal Hill-Burton program, or who have exhausted their insurance	Est. 35,000 per year	The government's share is put in a "Quality and Charity Care Trust," which the hospital bills at 95% of charges for indigent care. 90% of the trust is earmarked for Jefferson County residents and 10% for non-residents. Indigent care services that exceed the trust amount are absorbed by the hospital. The hospital may stop providing care for the indigent if the respective governments fail to provide funding according to the agreement	Providers: Humana/University Hospital Services: Inpatient hospital services
Failed proposal (SB 62, HB 403, 1986)	Assesses hospitals and long-term care facilities an amount equal to 1% of annual gross operating revenues	Not reported	Not reported	Persons meeting financial requirements of the state	Not reported	Assessments are deposited in the Health Care Assistance Trust Fund. 25% of the fund is used to reimburse hospitals for a proportion of their inpatient charity care, as determined by the Cabinet for Human Resources. The balance of the fund is available for use as matching funds for various medical assistance programs (including nursing home and community-based services) and to support the proposed rate-setting activities of the Health Care Cost Containment Commission	Providers: Hospitals, nursing homes, and other providers under the state's medical assistance programs Services: Hospital services and other services covered under the various medical assistance programs
MAINE							
Me. Rev. Stat. Ann., Chap. 107	Requires all payers (except Medicare) to pay indigent care and bad debt costs in their hospital rates, as determined by Maine's Health Care Finance Commission through its all-payer prospective reimbursement system. The weighted average rate increase for the state's 44 hospitals is 4.76% of total gross revenues for the first payment year	$35.5M (for first full payment year)	None	Recipients of uncompensated hospital care	Unknown	The Health Care Finance Commission adjusts each hospital's revenue limit to compensate for indigent care and bad debt (based on a three-year average)	Providers: Hospitals Services: Hospital services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
MARYLAND							
Health General Article 19-217 (1971)	Requires all third parties to pay indigent care costs in their rates, as determined by Maryland's hospital rate-setting commission (uncompensated care costs averaged 5.7% of gross revenues in FY 1983 and 6.34% of gross revenues in FY 1984)	$142M uncompensated care amount (FY 1984)	None	Charity care and bad debt patients	Not available (case-mix adjusted figure for each hospital)	Hospitals are reimbursed for indigent care costs at the lesser of prior year's actual costs, whatever they request, or whatever the commission deems reasonable	Providers: All hospitals Services: Hospital care
MASSACHUSETTS							
Rate-Setting Law a) Mass. Gen. Law Ann. ch. 6A, §51 (1982, 1985)	Authorizes hospitals to include uncompensated care requirements in their revenue caps ("maximum allowable costs"); requires private payers to reimburse this cost; Medicaid (pending federal approval) pays extra to hospitals with high indigent caseloads; because state opted against renewal of Medicare waiver, private sector will cover $21.5M loss of Medicare funds for free care/bad debt	$220M (total state and private sector payments)	$15M in state Medicaid dollars (plus equal federal match if state plan amendments are approved)	Uncollectable (bad) debt; free care patients (proposed regulations will probably use 200% of Medicaid eligibility)	Not reported	Hospitals increase charges by statewide average for uncompensated care, retain that portion needed for their requirements and remit balance to state administered pool; pool pays hospitals if increase in charges does not meet the need	Providers: Hospitals Services: Hospital inpatient outpatient
b) Mass. Gen. Law Ann. ch. 6A, §5 (1985)	For FY 1986 and FY 1987, increases all hospitals' charges uniformly to recover hospital-specific uncompensated care; provides for the remainder to be deposited in a state "pool" for uncompensated care					For FY 1986 and FY 1987, an uncompensated care "pool" is created to reimburse a hospital's needs if the uniform increase does not meet them	
MINNESOTA							
Rider* to the Omnibus Health and Human Services Appropriations Bill, 1985 Minn. Laws, Chap. 9, Article 1, 1st Special Session *(no force of law; expires after two years)	Allows potential savings from a pilot AFDC alternative health insurance project to be used as a state match to obtain commitments of private contributions for alternative health insurance projects for the uninsured poor	Unknown	Unknown	Uninsured persons with incomes up to 200% of poverty level who are not eligible for public	200 (FY 1986)	To be determined; one proposal under consideration allows the enrollment of eligible persons in a prepaid insurance program	Providers: Unknown Services: To be determined; emphasis on preventive ambulatory services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
MONTANA							
Mont. Code Ann. §23-5-123 and §53-2-322	Provides that money seized or confiscated for violation of the state gambling laws is deposited in the county poor fund, which supplements county property tax assessments of 1.35 mills for indigent care	Unknown from gambling $1.35M from levies (FY 1985)	None	Persons with a "serious medical condition" who are ineligible for other public medical assistance and who meet income requirements	Unknown	Same as under 53-3-103, MCA (which governs general relief medical assistance)	Providers: Hospitals and licensed medical practitioners Services: Same as under §53-3-103
Failed proposal (HB 120, 1985)	Increases the state cigarette excise tax by $0.08	$4.2M (FY 1986)	None	All persons eligible for medical assistance as provided for in Title 53, Chapter 6, Parts 1 and 4	9,380 (FY 1986)	Used to supplement existing medical assistance programs administered by the state	Providers: Hospitals, nursing homes, health care agencies, and other licenced practitioners Services: All services under § 53-6-101
NEVADA							
Accidents Fund 1983 Nev. Stats., Chap. 428	Provides for county property tax levies up to .0075 cents to fund a state accident pool for injured motorists	$965,000 (FY 1985)	None	Indigents having accidents costing more than $4,000	236 (1st 18 months)	Fund pays for services to eligible persons	Providers: All hospitals Services: Hospital services, physician care, ambulance service
Failed proposal (SB 215, 1985)	Requires hospitals to provide emergency medical care to indigent persons	Unknown	None	Not reported	Unknown	Hospitals must provide care until the person can be safely and prudently transported to a county or other designated hospital	Providers: All Hospitals Services: Hospital emergency services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
NEW JERSEY							
Rate-Setting Law N.J. Stat. Ann. §26: 2H-1 et seq. (P.L. 1978, Chap. 83)	Provides that all payers contribute to the cost of care for medically indigent persons. A cost factor is included in all hospital rates under the state's all-payer prospective reimbursement system	$225M (FY 1985)	None	Recipients of uncompensated care at hospitals	Not reported	The Hospital Rate Setting Commission in conjunction with state Department of Health sets rates and includes factors for indigent care	Providers: Hospitals Services: Inpatient and outpatient services
Pharmaceutical Assistance for the Aged and Disabled N.J. Stat. Ann. §30; 4D-20 et seq. (P.L. 1975, Chap. 194)	Allocates revenues from tax on casino gambling, which supplements state funds	$40.1M (FY 1986 est.)	$50.2M	Recipients of Social Security disability who are 65 or older. Annual income limits: $13,250 single; $16,250 married	175,000 (FY 1986 est.)	Distributed by the Division of Medical Assistance and Health Services (Medicaid)	Providers: Pharmacies Services: Prescription drugs insulin, diabetic testing materials
Community Care for Elderly and Disabled (Section 2176 Medicaid Waiver) N.J. Stat. Ann. §30: 4D-1 et seq.	Allocates revenues from tax on casino gambling	$5.9M	None	People with monthly income between $357-$975 and at risk of institutionalization	1,800 (FY 1986 est.)	Distributed by the Division of Medical Assistance and Health Services (Medicaid)	Providers: Home Health Agencies, Homemakers, etc. Services: Home health care, medical transportation, homemaker services, case management, social day care, respite care, medical day care
Medically Needy N.J. Stat. Ann. §30: 4D-1 et seq. (P.L. 1985, Chap. 371)	Allocates revenues from tax on casino gambling	$25M (FY 1987 est.)	None	Senior citizens and disabled Social Security recipients who meet financial	101,000 (FY 1986 est.)	Distributed by the Division of Medical Assistance and Health Services (Medicaid)	Providers: Various health care providers, excluding hospitals and pharmacies Services: Same as for Medicaid

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
NEW JERSEY (con't)							
Failed proposal (via original version of SB 487, 1984-85)	Establishes surcharges on premiums paid by insured for health insurance, not to exceed 5% of premium. (Surcharge proposal was deleted by amendment and replaced with state general fund appropriation; the bill was vetoed)	Unknown	None	Children with catastrophic illnesses not covered by insurance and for which expenses exceed 30% of gross family income or 40% where family income is over $100,000	1,500 to 2,500 (FY 1986)	Determined by state Department of Health	Providers and Services: determined by state Department of Health
Failed proposal (via SB 3024, 1984-85)	Requires companies (with 50 or more employees) that transfer out of state or terminate operations to deposit with the State Treasurer an amount equivalent to six months health and life insurance premiums for all affected employees. (Note: the bill was conditionally vetoed by the Governor, who recommended the creation of a task force to study the issue)	Unknown	Unknown	Persons who lose their jobs because their company moves out state or terminates operations	5,000 (FY 1984)	Creates special state fund to provide continued health coverage to terminated employees who need it	Providers and services are those provided in employee health plans
NEW YORK							
1982 N.Y. Laws, Chap. 536, N.Y. Public Health Law, §2807-a	Provides that each third-party payer adds an allowance to its rate to help cover bad debt and charity care. These allowances (a statewide average of 2.3% in 1983, 3.3% in 1984 and 4.3% in 1985 of total reimbursable inpatient costs) are used to establish eight regional indigent care pools. (Note: this law is no longer in effect)	$175M (1983) $270M (1984) $400M (1985)	None	Persons receiving charity care or who create bad debts	Unknown	Distribution based on type of hospital (whether public or not) and relative need for funds to cover bad debts and charity care. Hospitals must have adequate collection procedures. 0.03 percent set aside for hospitals that, after the above distribution, are still considered "financially distressed"	Providers: Hospitals facing financial hardship as a result of bad debts and charity care Services: Inpatient and outpatient hospital care

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
NEW YORK (con't)							
1985 N.Y. Laws, Chap. 807, N.Y. Public Health Law, §2807-a	For 1986 and 1987, maintains add-ons (4.5% statewide average) to the rates of each third-party payer except Medicare. Also assesses hospitals 4.5% of their Medicare revenue. The add-ons are used to establish eight regional indigent care pools. The 4.5% assessment of Medicare revenue is used to form a statewide pool for the years 1986 and 1987. (Note: the assessment on Medicare revenues is pending court action)	$460M (1986) $485M (1987)	none	Helps pay for charity patients and bad debts	Unknown	Distribution based on type of hospital (whether public or not) and relative bad debt and charity care need. Hospitals must have adequate collection procedures. Approximately 0.05% is set aside for hospitals that, after the above distribution, are still considered "financially distressed"	Providers: Hospitals providing bad debt and charity care Services: Inpatient and out-patient hospital care
1986 N. Y. Laws, Chap. 272	Assesses hospitals 1.9% of total inpatient revenues beginning July 1, 1986. (Note: intended to replace revenue collected from Medicare assessments under Chapter 807, which is pending court action)	$159M (first calendar year)	Same as above	Same as above	Same as above	Same as above	Same as above
Pending proposals: SB 5189 and AB 6342 (1985-86)	Provides for voluntary deductions from unemployment checks	Unknown	None	Persons receiving unemployment checks	Unknown	Creates a health insurance protection plan that offers a basic health plan to persons on unemployment	Providers and services same as for Medicaid
OHIO							
Ohio Rev. Code Ann. 3701.61 - 3701.69 (1985)	Earmarks funds from motor vehicle license tag fees	$4.2M (FY 1985) $4.3M (FY 1986)	None	Indigent motor vehicle accident victims	Unknown	Per diem payments are made to eligible providers	Providers and services to be determined by the Department of Health
Pending proposal (HB 856, 1986)	Requires each hospital in a county with a maldistribution of uncompensated care above a specified threshold level to assume responsibility for a share of the uncompensated care proportional to its share of compensated care	Unknown	None	Unknown	Unknown	The program amounts to a redistribution of the deficits caused by uncompensated care	Providers: Hospitals Services: Hospital services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
OKLAHOMA							
Oklahoma Indigent Health Care Act 56 O.S. Supp. 1985, §57-66	Provides a check-off on the state's income tax form for persons to donate a portion of their tax refund; to supplement state appropriations	Unknown	None	Uninsured persons with income below the poverty level and those with medical expenses exceeding 50% of gross household income	500,000 (FY 1986)	Creates an Indigent Health Care Fund from which the state distributes money to counties. Distribution is made according to a formula based on each hospital's ratio of indigent care to total charges	Providers: Hospitals in counties meeting certain requirements and free-standing clinics in poverty areas certified by the state as hospitals for the purposes of the act Services: Hospital care and some clinic care
Failed proposal Catastrophic Indigent Care Fund (HB 1304, 1985-86)	Assesses a $10 surcharge on each health or life insurance policy issued in the state; used to match federal funds available for catastrophic illness under Medicaid	Unknown	None	Those with a catastrophic injury or illness and those with medical expenses exceeding 50% of gross household income	Unknown	Distributed through Medicaid reimbursements to hospitals for patients with catastrophic injuries or illnesses	Providers: Participating hospitals Services: Hospital care
OREGON							
Failed proposal (SB 431, 1985)	Assesses a flat rate payroll tax on all businesses to supplement state and federal contributions. Also requires eligible persons to contribute enrollment fees and an insurance premium share based on ability to pay	Unknown	Unknown	Requires all state residents to be enrolled in a health plan by Jan. 1, 1989	Total state population	Creates a state Health Financing Fund to purchase insurance from certified health plans and to purchase services on an episodic basis for the itinerant population	Providers: Certified health care plans and participating providers Services: Physician, hospital, mental health, and alcohol and drug addiction services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
OREGON (con't)							
Failed proposal (HB 2032, 1985)	Assesses hospitals an unspecified amount	$18M (FY 1986 est.)	None	Uninsured patients below 150% of federal poverty guidelines	Unknown	Establishes the Hospital Medical Assistance Trust Fund. Money is redistributed to hospitals providing uncompensated care based on their relative share of qualified patient care	Providers: Hospitals Services: Hospital services
PENNSYLVANIA							
Pharmaceutical Assistance Contract for the Elderly P.L. 217, No. 63 (1983)	Earmarks lottery proceeds and requires a $4 co-payment from each participant	$100M from lottery (FY 1985) $22.3M from co-payment (FY 1984)	None	Elderly 65 and older with income below $12,000 (single) and $15,000 (couple) who otherwise don't qualify for public assistance or have private insurance coverage	600,000 (1985)	A private contractor pays providers according to guidelines established by the Department of Aging	Providers: Participating licensed pharmacies Services: Prescription drugs, insulin syringes, and insulin needles
Pending proposal (HB 1164, 1985-86)	Assesses hospitals 1% of gross operating revenue (except that those expending more than 3% of gross operating budget on indigent care receive a $1 credit for every $1 in excess of 3%). Assesses health insurance revenues. The state contributes 80% of the amount hospitals contribute	Unknown	Unknown	Persons with income less than two-thirds of the statewide average weekly wage	Unknown	The Indigent Care Fund is administered by the Health Care Cost Reform Commission, which is to develop a formula for distribution to hospitals that provide a disproportionate share of health care to the medically indigent and that have met all obligations under the Hill-Burton Act	Providers: Hospitals Services: Hospital services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
PENNSYLVANIA (con't)							
Pending proposal (HB 1554, 1985-86)	Applies uniform surcharges to the gross charges on all provider bills for hospitals and ambulatory surgical facilities	Unknown	None	Unknown	Unknown	Regional pools are established to collect and distribute money to needy hospitals to cover uncompensated care on a pro rata basis. Only 75% of uncompensated care expenses are eligible for reimbursement. Total reimbursed uncompensated care expenses may not exceed 5% of gross patient revenues	Providers: Hospitals/ambulatory surgical facilities Services: Hospital services
Pending proposal (HB 1971, 1985-86; and a similar bill, HB 1968)	Assesses health care providers (except physicians) 1% of gross operating revenues. Assesses health care and accident premiums 0.6% of gross revenues	Not Reported	Not Reported	To be determined by the commission	Unknown	Establishes a Health Care Cost Containment Commission to administer a statewide indigent care pool (among other duties)	To be determined by the commissioner
SOUTH CAROLINA							
Medically Indigent Assistance Act S.C. Code Ann. §44-6-5 et seq. (1985)	Assesses all general hospitals and counties at a rate determined by specified criteria. Requires the General Assembly to set an annual funding goal and requires hospitals to contribute 50% of the total. Requires eligible persons to pay fees on a sliding-scale formula	$3.75M each from hospitals and counties (1986-6 months) $7.5M from each group (1987)	$150,000 (1986-6 months)	Persons with income at or below 200% of federal Community Services Administration guidelines who meet other specified criteria	5,750 (1986-6 months) 11,500 (1987)	Creates the South Carolina Medically Indigent Assistance Fund to be administered by the state Health and Human Finance Commission. Funds are distributed to general hospitals as compensation for medically indigent services to eligible persons. Payments are based on prospective payment system	Providers: General hospitals Services: General acute care (inpatient only; no, or limited, psychiatric care)
TENNESSEE							
Failed proposal (SB 536, 1985-86) "Health Equity and Access Act"	Assesses an annual fee on hospitals; taxes health insurance revenues; and requires a $20 per capita levy on counties that don't own and operate a hospital that serves indigents	$31.9M from hospitals $11.6M from insurance companies $33.4M from counties	None	Unknown	330,000 (FY 1985)	Creates the Health Equity and Access Fund, which is used for several purposes including the provision of direct aid to providers who deliver needed care to all persons without regard to ability to pay	Not specified

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
TEXAS							
Failed proposal (SB 789, 1985) "Hospital and Surgical Facility Indigent Care Obligations Act"	Requires all hospitals and licensed ambulatory surgical facilities to provide or fund an amount of uncompensated care equal to 5% of their operating costs. Requirement is a condition of licensure; facilities failing to meet their obligation must make up the deficit in the following year or pay the state an amount equal to the unmet obligation	Unknown	None	Persons with family income less than 200% of federal poverty level; eligibility determined by each facility	Unknown	Creates the Hospital and Surgical Facilities Indigent Care Obligation Fund. The state distributes funds to facilities that exceed their annual uncompensated care requirement	Providers: Hospitals and ambulatory surgical facilities Services: Hospital and ambulatory surgery services
Failed proposal (SJR 29, 1985 -- Constitutional Amendment)	Authorizes the creation of indigent health care districts that would have taxing authority (similar to hospital districts)	Unknown	None	Unknown	Unknown	Indigent health care districts would purchase services from providers	Unknown
Failed proposal (via SB 452, 1985, which passed in different form)	Replaces the proposed $.08 reduction in the federal cigarette tax with a state tax of $.08 earmarked for medically indigent funding (Note: SB 452 passed and was enacted as "The Indigent Care and Treatment Act," Vern. Ann. Civ. Stat. Art. 4438(f), 1985. The excise tax increase was deleted and replaced with state and county general fund revenues)	Unknown	None	Persons who meet AFDC income and resource requirements but are categorically ineligible for AFDC	70,000 (FY 1987)	Payment for services is based on Medicaid payment principles	Providers: Unknown Services: Hospital, rural health clinic, services, lab and x-ray services, family planning, physician services, limited prescription services, limited skilled nursing home services

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
WASHINGTON							
Failed proposal (SB 4403, 1984)	Grants a Certificate of Need to a hospital conditional upon the hospital's meeting or exceeding the regional average level of charity care in the year preceeding the application and in the future	Unknown	None	Unknown	Unknown	Not applicable	Providers: Hospitals Services: Hospital services
Failed proposal (SB 3320, 1985) Prepaid Capitated System	a) Establishes a sliding scale on ability to pay; b) Creates a trust fund from: 1) cigarette tax--4 mill/cig; 2) hospital contribution of 1% gross annual operating costs (less charity care revenue from this program, and revenue from the Department of Social and Health Services); 3) 1% tax on the gross income of persons engaged in practicing medicine; c) Appropriates $1M general fund start-up to be repaid	$60M from trust fund (1986)	$1M "loan"	Enrollees: persons with income less than 200% of the federal nonfarm poverty level	30,000 (first year) 200,000-800,000 est. range for following years	Department of Revenue collects revenue. Washington Basic Health Plan Board manages the trust fund and pays participating "managed health care systems"	Providers: Any provider of health care and insurance approved by the board Services: Determined by the board; emphasis on preventive and primary care; must include prenatal, well-child, and basic health care for children. No major health service may be included unless a tax is levied on that professional group

PROGRAM AND LEGAL STATUS	FINANCING MECHANISM(S)	ESTIMATED REVENUE	STATE G.F. CONTRIBUTION	ELIGIBLE PATIENTS	ESTIMATED NUMBER OF PATIENTS	DISTRIBUTION OF FUNDS	PROVIDERS AND COVERED SERVICES
WEST VIRGINIA							
W.Va. Code §16-29c	Assesses an annual fee on hospitals' net patient revenues to raise an amount equal to the state's contribution	$3M (FY 1986)	$3M (FY 1986)	Medicaid recipients	Unknown	Creates an indigent care fund to be used to finance the reinstatement of recent cuts in Medicaid hospital services	Providers: Hospitals Services: Same as Medicaid
Failed proposals (SB 173, SB 268, 1985)	Imposes a hospital assessment of 1%	Unknown	None	Medically indigent persons	Unknown	Revenues are used to fund both Medicaid and indigent care	Providers: Hospitals Services: Same as Medicaid
Failed proposals (HB 1774, 1984; HB 1062, 1985)	Requires each hospital to provide free or charitable care equal to 5% of gross business as a condition of licensure	Unknown	None	Medically indigent persons	Unknown	Not applicable	Providers: Hospitals Services: Hospital services
WISCONSIN							
1985 Wisconsin Acts 29 (the budget document)	Assesses a fee on hospitals and requires eligible persons to pay fees based on ability to pay	Unknown	None	Those without the means to afford available insurance, including Medicaid recipients	Unknown	Undecided. May be vouchers, direct payment to insurers/HMOs selected by competitive bid, etc. (Note: The act also requires the Insurance Commission to provide information and assistance to employers and employees to facilitate development and awareness of alternative health care delivery systems)	Providers: Those usually covered by health insurance policies. Program would encourage enrollment in prepaid programs Services: Those usually covered by health insurance policies

APPENDIX G

SUMMARY---Makes temporary tax for medical assistance to indigent persons permanent. (BDR S-215)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to indigent persons; making the temporary tax for medical assistance to indigent persons permanent; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Section 16 of chapter 629, Statutes of Nevada 1985, at page 2036, is hereby amended to read as follows:

Sec. 16. This act becomes effective upon passage and approval [and expires by limitation on June 30, 1987.]

Sec. 2. This act becomes effective upon passage and approval.

SUMMARY---Makes various changes in program for medical assistance to indigent persons. (BDR 38-216)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to indigent persons; making various changes in the program for medical assistance to indigent persons; making the temporary tax for medical assistance to indigent persons permanent; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 428.050 is hereby amended to read as follows:

428.050 [1.] In addition to the tax levied pursuant to NRS 428.285, the board of county commissioners of a county shall, at the time provided for the adoption of its final budget, levy an ad valorem tax for the purposes of providing aid and relief to those persons coming within the purview of this chapter. [This levy must not exceed that adopted for the purposes of this chapter for the fiscal year ending June 30, 1971, diminished by 11 cents for each $100 of assessed valuation.

2. No county may expend or contract to expend for that aid and relief a sum in excess of that provided by the maximum ad valorem levy set forth in subsection 1 and NRS 428.285, together with such outside resources as it may receive from third persons, including expense reimbursements, grants-in-aid or donations lawfully attributable to the county indigent fund.

3. No interfund transfer, short-term financing procedure or contingency transfer may be made by the board of county commissioners for the purpose of providing resources or appropriations to a county indigent fund in excess of those which may be otherwise lawfully provided pursuant to subsections 1 and 2 and NRS 428.265,

428.275 and 428.285.] The rate of the tax must be calculated to produce not more than the amount of money allocated pursuant to NRS 428.295.

Sec. 2. NRS 428.295 is hereby amended to read as follows:

428.295 1. For each fiscal year [beginning on or after July 1, 1985,] the board of county commissioners shall, in the preparation of its final budget, allocate money for medical assistance to indigents pursuant to [NRS 428.090.] this chapter. The amount allocated must be calculated by multiplying the amount allocated for that purpose for the previous fiscal year by 104.5 percent.

2. When, during any fiscal year, the amount of money expended by the county to provide assistance to those persons eligible pursuant to [NRS 428.090,] this chapter exceeds the amount allocated for that purpose in its budget, the board of county commissioners may, to the extent that money is available in the fund, pay claims against the county from the fund for that purpose.

3. No interfund transfer, short-term financing procedure or contingency transfer may be made by the board of county commissioners for the purpose of providing resources for medical assistance to indigents in excess of those which may be otherwise lawfully provided pursuant to subsections 1 and 2, except that if the health of the poor is placed in jeopardy and there is a lack of money to provide necessary medical care under this chapter, the board of county commissioners shall declare an emergency and provide additional money for medical care from whatever resources may be available.

Sec. 3. NRS 428.335 is hereby amended to read as follows:

428.335 1. If during any fiscal year the amount of money expended by a county to provide assistance to those persons eligible pursuant to [NRS 428.090] this chapter exceeds the amount available to a county under the provisions of subsections 1 and 2 of NRS 428.295, the board of county commissioners may apply to the board of trustees of the fund for hospital care to indigent persons for reimbursement or partial

reimbursement of unpaid charges for hospital care in excess of $25,000 to any one person which have been incurred by a person certified as indigent by the board of county commissioners pursuant to [NRS 428.090.] this chapter.

2. The board of county commissioners must certify that each person on whose account application is made is indigent and the county has expended 90 percent of the amount of money available to that county pursuant to subsections 1 and 2 of NRS 428.295. The application must be in such form and contain such information as the board of trustees requires.

Sec. 4. Section 16 of chapter 629, Statutes of Nevada 1985, at page 2036, is hereby amended to read as follows:

Sec. 16. This act becomes effective upon passage and approval . [and expires by limitation on June 30, 1987.]

Sec. 5. 1. This section and section 4 of this act become effective upon passage and approval.

2. Sections 1, 2 and 3 of this act become effective on July 1, 1987.