CONSOLIDATION OF STATE AND LOCAL WELFARE PROGRAMS

Bulletin No. 115

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA

September 1974

CONSOLIDATION OF STATE AND LOCAL WELFARE PROGRAMS

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NOTE

The supplement to this report, containing excerpts from federal statutes and regulations on AFDC, AFDC-U, Emergency Assistance and Medicaid, is available upon request in the offices of the Legislative Counsel Bureau, Legislative Building, Carson City, Nevada 89701.

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Legislative Commission

Senator Carl F. Dodge	Assemblyman Keith Ashworth
Senator James I. Gibson	Assemblyman Joseph E. Dini, Jr.
Senator Warren L. Monroe	Assemblyman Lawrence E. Jacobsen
Senator William J. Raggio	Assemblyman Zelvin D. Lowman
Senator C. Coe Swobe	Assemblyman Donald R. Mello
Senator Lee E. Walker	Assemblyman Roy L. Torvinen

Senate Concurrent Resolution No. 26—Committee on Health, Welfare and State Institutions

FILE NUMBER....124

SENATE CONCURRENT RESOLUTION—Directing the legislative commission to conduct a study of the feasibility of consolidating the administration of all welfare programs in the State of Nevada and report recommendations to the next regular session of the legislature.

WHEREAS, Welfare programs, services and facilities in the State of Nevada have become increasingly burdened due to the rapid and ever-increasing growth in the state's population; and

WHEREAS, Any program which is provided to qualified welfare recipients must be efficiently organized and administered in order to provide the most effective economic assistance; and

WHEREAS, These programs place an ever-increasing burden on the counties of this state which results in decreased efficiency in the administration of welfare programs throughout the state and leads to imbalanced and ineffective programs from well-intentioned but overlapping efforts; and

WHEREAS, Consideration should be given to the transfer of all jurisdiction and responsibility for the administration of welfare programs to the State of Nevada for the purpose of relieving the burdens on the several counties and consolidating the administration of welfare programs into one governmental unit; and

WHEREAS, The legislature recognizes the immediate need for a complete study to be conducted of the feasibility of such consolidation; 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 welfare administration in the State of Nevada, including public assistance programs administered by the State of Nevada and the several general assistance programs administered in the various counties; and be it further

Resolved, That the legislative commission, with the assistance of such technical advice as may be required and provided by the department of health, welfare and rehabilitation and the various county departments engaged in the administration of welfare programs or other expert individuals, public agencies or private organizations in the field of welfare administration, shall:

1. Evaluate the existing administrative and organizational structure of the various welfare programs in the State of Nevada with regard to the efficient, economic and effective administration of a comprehensive and adequate program of economic assistance to qualified recipients; and

2. Examine the problems involved in and the advisability of reorganizing and realigning the administrative jurisdiction and authority of welfare programs in the State of Nevada by transferring those programs presently administered by the several counties to the state; and be it further

Resolved, That the legislative commission report the results of such study to the 58th session of the legislature and recommend appropriate legislation for the purpose of providing the most effective and efficient administration of welfare assistance in the State of Nevada.

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REPORT OF THE LEGISLATIVE COMMISSION

TO THE MEMBERS OF THE 58TH SESSION OF THE NEVADA LEGISLATURE:

This report is submitted in compliance with Senate Concurrent Resolution No. 26 of the 57th session (File No. 124, page 1969, Statutes of Nevada 1973) which directed the legislative commission to study welfare administration in the State of Nevada. Senator John P. Foley was designated Chairman of the subcommittee and the following legislators were named as members: Senator Richard E. Blakermore and Assemblymen Marion D. Bennett, M. Kent (Tim) Hafen, Rawson M. Prince, John M. Vergiels and Albert M. Wittenberg.

The attached subcommittee report, containing background information, recommendations and suggested draft legislation, was approved by the legislative commission on September 11, 1974.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

Carson City, Nevada
September 1974

SUMMARY OF RECOMMENDATIONS

The paragraphs below briefly summarize the recommendations of the subcommittee at the conclusion of its deliberations. More detailed discussion on these items can be found in the body of the report beginning at page 43.

The subcommittee recommends:

1. That the basic general assistance function be retained at the county level.

2. That the State Welfare Board be enlarged to nine members with a maximum of three from a single county, and that at least two board meetings a year be held in Clark County. Bill A.

3. That each board of county commissioners be authorized to appoint a five-member county welfare advisory committee or a single county welfare adviser to provide advice and recommendations to the State Welfare Board. Bill B.

4. That the legislature establish a program of state assistance to pay medical costs in cases where nonresident transient indigents are involved in motor vehicle accidents in Nevada. The State Welfare Division would receive claims for such assistance from hospitals which have made diligent efforts to collect on their own behalf and through the district attorney. Bill C.

5. That the legislature take action in 1975 to expand the SAMI program to include the group known as the "medically needy." Bill D.

6. That state supplementation be provided for disabled persons in connection with the SSI program, and that the level of supplementation for the disabled be the same as for the aged. Bill E.

7. That the legislature appropriate sufficient funds to implement fully the chronic renal disease program established in chapter 457A of NRS.

8. That an AFDC-U (Aid to Families with Dependent Children, Unemployed Fathers) program be enacted, with detailed hearings to be held prior to a determination on whether or not those involved in labor disputes should be excluded. Bill F.

9. That the county ad valorem tax levy of 11 cents per $100 of assessed valuation for support of the SAMI program be continued if SAMI is expanded to include the "medically needy," but that the county levy be repealed if the legislature declines to so extend SAMI coverage.

STATE AND LOCAL WELFARE PROGRAMS

Introduction

Senate Concurrent Resolution No. 26, adopted by the Nevada legislature in 1973, directed the Legislative Commission "to study welfare administration in the State of Nevada, including public assistance programs administered by the State of Nevada and the several general assistance programs administered in the various counties." The resolution further directed the Legislative Commission to:

> 1. Evaluate the existing administrative and organizational structure of the various welfare programs in the State of Nevada with regard to the efficient, economic and effective administration of a comprehensive and adequate program of economic assistance to qualified recipients; and
>
> 2. Examine the problems involved in and the advisability of reorganizing and realigning the administrative jurisdiction and authority of welfare programs in the State of Nevada by transferring those programs presently administered by the several counties to the state.

To carry out this assignment, the Legislative Commission appointed a subcommittee composed of the following legislators:

Senator John P. Foley, Chairman	Las Vegas
Senator Richard E. Blakemore	Tonopah
Assemblyman Marion D. Bennett	Las Vegas
Assemblyman M. Kent (Tim) Hafen	Pahrump
Assemblyman Rawson M. Prince	Ely
Assemblyman John M. Vergiels	Las Vegas
Assemblyman Albert M. Wittenberg	Reno

The subcommittee has held four meetings--two in Carson City and two in Las Vegas.

Summary of Meetings

Meeting of October 12, 1973 (Carson City).

For its initial meeting the subcommittee invited representatives from all the counties, the State Welfare Division and the Reno office of the Social Security Administration.

The Consolidation Question. Mr. George E. Miller, State Welfare Administrator, told the subcommittee he was opposed to a state takeover of the counties' welfare functions. He said that county welfare departments are closer to the local situation and are able to handle individual general assistance cases with more flexibility and more economy than would be possible under state administration. He added that local administration would be his preference even for those county general assistance clients who, if transferred to state administered programs, might qualify for federal matching. The federally imposed rules and guidelines which accompany federal matching usually add to the overall cost of a state administered program.

General opposition to consolidation of state and local welfare programs was also expressed by representatives from Churchill, Douglas, Elko, Nye and White Pine counties and Carson City. Correspondence from Lander County also supported this position.

Medical Assistance Funding as Primary Concern. The Lyon County representative reported that the Lyon County Commissioners have great concern over county medical assistance costs and would favor consolidation in order to relieve the county of this excessive burden. The Clark County representative also focused on the problem of medical costs, saying that there would be no need for total consolidation if the state could significantly expand its Medicaid program (State Aid to the Medically Indigent--SAMI), reducing the counties' medical costs and picking up federal matching funds as well. The Washoe County representative agreed that medical expenditures are the biggest problem in county welfare financing.

County hospital practices and budgets were discussed in connection with the medical assistance problem. Treatment of indigents in county hospitals and the provision of medical assistance through county welfare departments are closely interrelated.

References were also made to the counties' dissatisfaction with the results of the imposition in each county of an annual ad valorem tax levy of 11 cents per $100 assessed valuation to help support the state's SAMI program. The counties have been disappointed that the 11-cent levy has not relieved county level medical costs to the extent they had originally expected.

Suggestions were made that possibly the problem of funding medical assistance costs, particularly in Clark and Washoe counties, could be alleviated by state action expanding the SAMI program without completely abolishing all county level general assistance.

Programs for which Federal Matching Might Be Obtained by State. Mr. Miller and his staff mentioned three programs for which federal matching would be available if the state legislature chose to authorize them: Emergency Assistance for Families; Aid to Families with Dependent Children, Unemployed Father (AFDC-U); and the "medically needy" portion of Medicaid. Mrs. Barbara Jones, Director of Clark County Social Services, said that the "medically needy" program would offer counties the most relief, but she also supported adoption of the other two programs. Mr. Miller cautioned that none of these programs should be adopted without thorough study of the effects and overall costs.

The State Welfare Division and the counties all agreed to cooperate with the subcommittee and its staff by providing fiscal and other data on current county welfare programs and the effects of possible new state programs which might qualify for federal matching and shift some of the financial burden away from the counties.

Motor Vehicle Accidents Involving Indigent Transients. Mr. Miller expressed his support for legislation to provide a state reimbursement mechanism for counties incurring medical costs for indigent transients injured in motor vehicle accidents within county boundaries. At the present time the county in which the accident occurred is responsible for hospital and other medical expenses if the injured person cannot pay. This can be a particularly large financial burden for a rural county; yet as an annual county budget item it is unpredictable.

Legislative proposals along this line have received favorable consideration in the past but due to problems with the proposed methods for funding the state's contribution, none has ever become law.

The county representatives present at the meeting were in general agreement regarding the need for and desirability of state funding to relieve the counties of these particular medical costs.

Description and Explanation of New SSI and Food Stamp Programs. Both Mr. Miller and Mr. Arthur Johnson, Director of the Reno office of the Social Security Administration, described various facets of the new Supplemental Security Income (SSI) program for the needy aged, blind and disabled, to be administered through the Federal Social Security Administration.

They explained that preparations were underway to effect a smooth transition to SSI beginning January 1, 1974, and pointed out what the relationships would be between SSI and the state administered Medicaid (SAMI) program. They described how the new program would differ from Nevada's present public assistance for the adult categories and described how individual recipients and applicants might be affected by new SSI provisions. They also discussed the possible financial impact of the changeover on the state and the counties.

In addition, Mr. Miller and his staff gave a brief explanation of the progress of the new food stamp program in Clark and Washoe counties and reported

on the federal requirement that all other counties provide food stamps in lieu of commodity foods by July 1, 1974.

Authorization for Advisory Committees. At the close of the meeting the members of the subcommittee agreed that it would be helpful to appoint advisory committees in different areas of the state to help the subcommittee with its assignment.

Meeting of January 10, 1974 (Las Vegas).

The second meeting of the subcommittee was a joint exploratory meeting with the advisory committee appointed for Clark County. Mr. B. Mahlon Brown III was selected as chairman of this advisory committee.

Clark County's Welfare Program. Following a general briefing on the subcommittee's assignment and a review of the nature of current federal, state and county welfare programs and the problems associated therewith, discussion centered on Clark County's particular problems in the welfare and medical fields.

Mrs. Barbara Jones gave a detailed explanation of Clark County's welfare program, including what it costs, how it operates and whom it serves. She emphasized that there is no federal or state financial assistance for the county's program. It is supported solely from county funds.

Mrs. Jones pointed out a number of problems encountered in the initial stages of the transition to SSI and in county-state relations generally. She repeated the Clark County position in favor of legislation expanding the SAMI program to include the "medically needy." Clark County currently operates its own medically needy program with 100 percent county funding, using its own guidelines and eligibility criteria, but if a similar program were made a part of SAMI, the state could obtain 50 percent federal matching--something not available to the county, she said.

Clark County's Public Hospital System. Dr. Otto Ravenholt, Acting Director of Southern Nevada Memorial Hospital (Clark County's public hospital),

described the financial and administrative framework within which the hospital operates, its services to indigents and the unusual features of the public hospital system as it operates in Clark County.

He explained that, as a condition to serving on the staff of Southern Nevada Memorial, physicians must agree to provide free medical care to the indigent patients of the hospital. With the development in Clark County of a number of proprietary hospitals where the medical staff is not obligated to provide indigent medical care without charge, however, the county can no longer expect that all doctors in the community will be on Southern Nevada Memorial's staff and participate in the obligation to the indigent.

Dr. Ravenholt noted that there is no direct tax subsidy to the hospital from the county for operational expenses. Payments from county welfare for indigent patients constitute about 10 percent of the hospital's total annual budget. Another 10 to 15 percent is classified as "uncollectible" and is absorbed by the hospital, he said.

Although Dr. Ravenholt supported the proposal for a state level "medically needy" program, he stated his feeling that it would be unwise to attempt a complete state takeover of medical assistance without county supplementation. To do so would destroy the diversity and flexibility provided by county level participation in the provision of medical services, he said.

Federal Implementation of SSI. Mr. Hal Foss of the San Francisco Regional Social Security Office described in detail the provisions of the new Supplemental Security Income program for the aged, blind and disabled and reported on the Social Security Administration's progress in implementing the new program. He answered several specific questions about the operation of SSI.

Procedural Questions. Mr. Jack Anderson, Director of Clark County Legal Services, expressed his concern about state level decisionmaking processes in the welfare field. He urged the subcommittee to support procedural changes which would encourage greater communication between the State Welfare Division and Clark

County constituents and officials. He suggested that the Clark County Advisory Committee organize itself for maximum effectiveness and that it work to improve opportunities for public and consumer input in the conduct of state welfare programs.

Statement from State Welfare Administrator. Although Mr. Miller and members of his staff were unable to attend the meeting because of flight cancellations, the subcommittee received Mr. Miller's written statement. In his statement, Mr. Miller suggested that since available funds are limited, priorities should be established for improvements in the state's welfare programs.

The priorities he recommended were: (1) paying 100 percent of need in the Aid to Dependent Children (ADC) program, and (2) adding the program for families with unemployed fathers (AFDC-U). Only after these two programs have been fully implemented should a state level "medically needy" program be considered, the statement said.

Meeting of March 4, 1974 (Las Vegas).

At the third meeting, also joint with the Clark County Advisory Committee, subcommittee members heard further presentations from Mr. Miller and other Welfare Division staff members and from Mrs. Jones. Much of the meeting was devoted to questions and discussion with members of the advisory committee.

Description of State Welfare Division Functions. Mr. Miller's introduction included the following statement:

"The primary objective of the Welfare Division is to protect citizens from poverty and social deprivation through programs which efficiently and effectively aid them in alleviating economic and social need. It is the task of the Division to develop in these dependent people latent skills and abilities, and direct them in a positive manner so they may discover the rewards of achievement, independence and social acceptance."

He then gave a general outline of the financial assistance programs in which the Welfare Division participates--Aid to Dependent Children and the new Supplemental Security Income program for the needy aged, blind and disabled which is primarily administered by the Federal Social Security Administration. He also described the state's Medicaid program and the types of medical services the division provides for those receiving ADC, SSI and Child Welfare.

Continuing, Mr. Miller explained the functions of the Welfare Division in the social services area. Family and children's services involve both Child Welfare (including adoptions and foster homes) and ADC services (including family planning, employment services, child care, health services, protective services for children and services to improve family living). Adult services are provided to SSI recipients and former and potential recipients to maintain maximum independence and self-reliance. These include home management services, homemaker services, protective services, companionship services and services related to health care.

Operation of the Food Stamp Program. Mr. John Downs, State Food Stamp Coordinator, gave a brief description of the new food stamp program administered by the Welfare Division in Clark and Washoe counties. Applications for food stamps are processed at offices established by the Welfare Division. Eligible persons may then purchase their food stamps at distribution centers located at U.S. Postal Services offices and use the stamps to reduce the cost of food purchased at authorized grocery stores. The "bonus value" of the food stamps is 100 percent federally funded through the U.S. Department of Agriculture.

Two different sets of criteria must be used in determining food stamp eligibility--one for public assistance households and another for nonassistance households. Federal matching is available for the Welfare Division's administrative costs in the food stamp program.

State Medical Assistance Program. Mr. Minor Kelso, Chief of Medical Services for the Welfare Division, described Nevada's State Aid to the Medically Indigent (SAMI) program. Federal matching funds are available to Nevada on a 50-50 basis for the full range of medical services currently included in the SAMI (Medicaid) program. Matching funds are available only for "categorically related" persons, primarily those who fit into the ADC and SSI categories. No federal funding can be obtained for medical services to persons who do not qualify as categorically related.

The "medically needy" group is not currently included in the SAMI program, Mr. Kelso said. If SAMI were expanded to include persons now receiving county medical assistance, federal matching would be available only for those who meet the federal definition of "medically needy" and are categorically related. Financial eligibility for the medically needy program would be limited to those having an income, after deduction of medical expenses, below 133 1/3 percent of the ADC grant level, Mr. Kelso reported.

After a lengthy discussion of the proposal for expanding SAMI to include the medically needy, the Welfare Division agreed to conduct a detailed study in Clark County comparing costs and coverage under present county-level medical assistance programs with costs and coverage under the proposed state-level medically needy program which would qualify for 50 percent federal matching.

Clark County's Medical and Direct Assistance. Mrs. Jones again outlined the Clark County welfare program, which includes both medical assistance and direct assistance. Medically needy persons can qualify for county medical assistance under the county's established criteria, she said, but since county programs are not federally matchable, the county pays the entire cost. If medical assistance were under state auspices, federal matching could be obtained.

If the state were to adopt the AFDC-U program, she continued, both the direct and medical assistance burdens of the county would be eased. As it is,

any "intact" family in need of assistance is ineligible for state aid and must turn to the county for help.

In conclusion, Mrs. Jones stated that if the Clark County and Washoe County welfare departments do not receive state assistance for their medical programs they will soon be in serious financial difficulty. She strongly urged the adoption of a state medically needy program or repeal of the state law requiring counties to pay the 11-cent SAMI levy.

Meeting of August 15, 1974 (Carson City).

At its final meeting the subcommittee reviewed a draft report prepared by the staff, received the recommendations of the Clark County Advisory Committee, conferred on several items with State Welfare Division staff members and the Clark and Washoe County welfare directors, and make a series of decisions on final subcommittee recommendations and suggested legislation.

Recommendations of Clark County Advisory Committee. Senator Foley read a summary of the recommendations from the Clark County Advisory Committee. (See Appendix C.) Those present who had attended the final meeting of the advisory committee agreed that the summary accurately reflected the action taken.

County General Assistance. The subcommittee voted to recommend retention of the general assistance function at the county level, but asked that the legislature recognize the counties' need for fiscal relief through state adoption of certain additional programs which would have the effect of transferring some individuals from the county rolls to the state rolls.

State Welfare Board. The subcommittee supported a proposal to enlarge the State Welfare Board to nine members and increase to three the maximum representation from a single county. Also approved was a proposal to require that at least two meetings per year be held in Clark County.

County Welfare Advisory Committees. The subcommittee recommended enabling legislation to permit the county commissioners of any county to appoint a five-member county welfare advisory committee composed of a county commissioner, a county welfare employee, a consumer and two public representatives. In the alternative, the commissioners could appoint a single county welfare adviser. The advisory committee or welfare adviser would be recognized as representing the county's interests and would be empowered to provide advice and recommendations to the State Welfare Board.

Transient Indigents in Highway Accidents. The concept of state assistance to cover county medical costs resulting from accidents involving transient indigents was approved. It was agreed that only motor vehicle accidents and only nonresidents should be covered initially; that the hospital should make diligent efforts to collect the bills before submitting claims to the state; that the district attorney should be responsible for certifying that diligent efforts were made; that the State Welfare Board should make rules and regulations for administration of the program; that the State Welfare Division should utilize the same claim, audit and collection procedures as are used in the SAMI program; and that financing should be from the state general fund.

State Aid to the Medically Indigent (SAMI). The State Welfare Division staff provided statistical information about estimated and actual expenditures for SAMI since its inception and, along with the Clark and Washoe County welfare directors, participated in the subcommittee's discussion of current programs and possible new programs related to SAMI.

Regarding expanded SAMI coverage for institutionalized persons, the subcommittee learned that pursuant to a recent HEW ruling the State Welfare Board has acted to provide SAMI coverage to persons in hospitals, nursing homes and intermediate care facilities who have countable incomes of up to 300 percent of the Supplemental Security Income benefit level and

who otherwise meet SSI eligibility criteria. The coverage will be retroactive to January 1, 1974, and will relieve the counties of a number of their most expensive medical cases.

The subcommittee agreed to recommend that the legislature include the "medically needy" group in the SAMI program unless Congress by 1975 has enacted a comprehensive national health insurance law which would obviate the need for state action in the field.

After reviewing the county ad valorem tax levy of 11 cents per $100 of assessed valuation for support of the SAMI program, the sugcommittee agreed that the levy should be continued if the legislature provides other fiscal relief to the counties in the form of a "medically needy" program. If the counties receive no substantial assistance from the state through the "medically needy" program and other expansions of SAMI coverage, however, the subcommittee said that the legislature should consider repealing the 11-cent levy.

State Supplementation for the Disabled. The subcommittee also recommended that the legislature provide state supplementation for disabled persons under SSI at the same level as is provided for aged SSI recipients. This would make direct grants and SAMI coverage available to additional persons in the disabled category, many of whom have been reliant on the county for general assistance.

Aid to Dependent Children. Senator Foley presented information which had been provided to U.S. Senator Howard W. Cannon from the U.S. Department of Health, Education, and Welfare confirming that there has been a recent downward trend in ADC rolls across the nation. The number of ADC recipients declined 255,000 nationwide during 1973. State Welfare Division staff members noted that while there has been a decrease in the number of individual recipients, the number of cases has increased.

Statistics on estimates and actual figures for ADC caseloads and expenditures in Nevada in past years were provided by the State Welfare Division. The projections for the 1973-75 biennium appear to be high, and there will probably be a sizable reversion to the general fund on July 1, 1975.

The subcommittee recommended the adoption of the "unemployed father" portion of the ADC program. Coverage for families eligible for AFDC-U would include medical assistance under SAMI, as well as grants at the same level as ADC grants. The subcommittee urged the legislature to hold detailed hearings in connection with the proposed AFDC-U program to consider whether the state should utilize the option to exclude strikers from the program.

Consideration was given to the inclusion under the ADC plan of Emergency Assistance to Needy Families with Children. Twenty states include emergency assistance among their public assistance programs. The definition of emergency assistance is found in 42 U.S.C.A. § 606(e). Provision is made for federal matching on a 50-50 basis. (See Part I of the supplement to this report for federal statutes and Part III of the supplement for federal regulations.)

Estimates show that a statewide emergency assistance program in Nevada would serve approximately 100 families per month at an annual cost to the state of approximately $67,000.

The subcommittee noted that emergency services, by their very nature, require flexibility and speed of handling. County general assistance offices are singularly equipped to handle cases of this type without necessity for strict compliance with federal regulations. An emergency assistance program at the state level, on the other hand, would be administratively cumbersome while serving a relatively small clientele. Furthermore, the program is declining in popularity nationwide. The subcommittee decided against including a state emergency assistance program among its recommendations.

The subcommittee considered the ADC standard of need and the level of the ratable reduction, but concluded that these are questions which will be thoroughly considered by the Welfare Division and the legislature during the session when more information is available about the financial situation of the state as a whole. For this reason the subcommittee decided that it was not properly equipped to offer solutions or make recommendations in this area.

Treatment of Renal Diseases. The subcommittee discussed the problems encountered in providing costly renal dialysis for persons suffering from chronic renal diseases but who are financially unable to pay for the treatment. A law enacted in 1971 authorized state assistance in such cases, but the program has never been adequately funded. The subcommittee urged increased funding for implementation of the renal disease law appearing in chapter 457A of NRS.

History and Development of Welfare Philosophy and Administration

A brief review of welfare history shows that many of the issues considered by the subcommittee during the course of this study have been the subject of controversy and debate for years. Questions about governmental responsibility for the poor tend to evoke strong emotional responses from everyone involved.

Even with years of experience and attempts to solve the various problems which surface in programs designed to serve the poor, dissatisfaction with the welfare system remains. Many of the issues are carryovers from medieval England, and still there are no satisfactory answers.

English Origins.

The American public welfare system can be traced back at least as far as England's 12th and 13th century poor laws. Originally the poor laws were administered through the organized church, with each local parish responsible for the care

of its own poor. Priority was given to the aged and sick and widows and orphans, but during this period other persons were also given assistance through the church if they could show evidence of need. No particular stigma was attached to poverty.

As England underwent economic changes in the late Middle Ages, however, it became advantageous to the community to attach penalties to poverty and discourage mobility among the poor. Needy persons requiring assistance were forced to return to their place of birth or settlement, where they were known and relatives and the parish were responsible for their care. An able-bodied man who was poor and needy was likely to be treated as a kind of criminal, regardless of the reasons for his poverty. It was assumed that if he was able to work but not working, his poverty was voluntary and attributable to laziness.

Then, by the time of the Elizabethan Poor Law of 1601, there developed a recognition that, in the wake of economic depression, some unemployment of able-bodied persons might be involuntary. This led to the conclusion that since poverty can be caused by the policies and actions of society as a whole, helping the poor should be, at least in part, a secular responsibility of the entire community.

Under the Elizabethan Poor Law the needy were divided into three groups: the helpless, the involuntarily unemployed and the vagrant. Those classified as vagrants were sent to jail. For the helpless and unemployed, a secular overseer of the poor was appointed and a tax imposed in each parish to support almshouses and provide other means of making work and care available to those in need.

Later, religious and economic thought in England began to place a very high value on work and wealth as a virtue. Conversely, poverty (from whatever cause) was again subjected to community disapproval as a reflection of unwillingness to work--a vice. As a result, public assistance policies became ever more restrictive, with the establishment of workhouses and the enactment in 1662 of a severe Law of Settlement and Removal, which placed great emphasis on domicile and the local community's responsibility for its own poor people.

Development in America.

The Elizabethan Poor Law and the English Law of Settlement and Removal served as models for the first colonial and state laws providing for aid to the poor in the United States. Emphasis on domicile, along with the basic responsibility of the local community and the family, continued as the dominant theme far into the 20th century. This emphasis persists today in the minds of large numbers of people even though durational residency requirements are no longer valid and federalization of public assistance programs is increasing.

In early America each local community (cities and towns in the East and counties in the West and South) assumed responsibility for those of its needy whose relatives were unable to provide support. As in England, secular administrators were assigned the public duty of administering tax funds collected to help support the poor. Assistance to needy persons in the community was granted partly on the basis of eligibility standards such as residency and employability, but cases were also considered on their own individual merits by the administrator, who was viewed as a representative of local taxpayers and acted in accordance with the prevailing sentiment of the community.

In the early 20th century, American state governments became involved to a small extent in welfare activities. Examples of state programs during this era include social insurance (workmen's compensation), pensions for the aged and mothers' aid for widowed mothers with minor children.

State level programs constituted a significant change from solely city or county administered assistance, but the major upheaval began when state and local programs were supplemented by aid from the Federal Government beginning in the 1930's. When widespread poverty during the depression became too much for the states, counties and voluntary agencies to handle, federal participation became a virtual necessity.

Federal grants-in-aid to the states, conditioned on state matching and state compliance with federally imposed regulations, were instituted under the Social Security Act of 1935 for three specific categorical programs: Old Age Assistance, Aid to Dependent Children and Aid to the Blind. In 1950 a fourth category was added--Aid to the Permanently and Totally Disabled.

During the 1960's there was increased federal involvement in the problems of the poor on many fronts. The model cities, economic opportunity, education, manpower, housing and other programs of the so-called "Great Society" represented an ambitious range of efforts to inject innovative federal social policies into the nation's economy, sometimes bypassing state governments to deal directly with newly developing power centers at the community level.

As the Aid to Dependent Children program experienced unprecedented increases in caseloads and costs, Congress attempted to encourage self-help among recipients by establishing work incentive programs and income disregards. In the health care field, the earlier Medical Assistance to the Aged was followed by more comprehensive Medicare and Medicaid programs which made federal participation in the provision of medical care available to the majority of people over 65 and to all persons in the federal-state categorical assistance programs.

Although many of the Great Society programs have been labeled as failures, both by those who felt the Federal Government had gone too far and by those who felt it had not gone far enough, the overall results were not inconsequential. The tone for substantial federal interest and involvement in social programs had been set, and governmental recognition of the organized poor as a potent societal force appeared to be irreversible.

The latest major development in federal participation in welfare programs was in 1972, when the Federal Government instituted a new Supplemental Security Income (SSI) program which federalized the grants for the adult categories, i.e., the needy aged, blind and disabled. These persons had previously been served through state administered categorical programs.

Another program appears ripe for federalization in the next few years. Debate is underway in Congress over national health insurance proposals. It will not be long before some form of national health insurance is a reality.

All of this illustrates that welfare trends in America in the past few decades have been away from the earlier local government programs--first to statewide assistance, then to federal-state partnerships, and now more and more to complete federal administration.

These developments have not been especially welcomed in many parts of the country. Strong preferences for local responsibility and local control were evident in statements made to the subcommittee in the course of this study. Only the anticipation of substantial financial aid from the Federal Government leads state and local officials to consider giving up their responsibility and control in welfare programs. Those who still see the values of grass roots administration object when it is proposed that the counties relinquish control over what remains of their general assistance programs. In light of the Anglo-American welfare traditions of the past, their position in favor of county level administration for general assistance is easily understood.

History of Welfare in Nevada.

In early Nevada, where mining was the primary activity, most people tended to view the state as only a temporary home. They usually planned to leave for California or the East when the Nevada mines stopped producing. This general frame of mind led to a lack of concern for complex governmental structures to provide care and support for the needy.

For widows and orphans, and miners who became sick or disabled, the primary source of assistance was usually a private fraternal organization, a church or a union. Even so, not all of the poor were considered "worthy" of assistance from the private charities. Some were still in need of public assistance. Consequently, the following section was included as section 3 of article 13 of the Nevada constitution in 1864:

> The respective counties of the State shall provide as may be prescribed by law, for those inhabitants who, by reason of age and infirmity or misfortunes, may have claim upon the sympathy and aid of Society.

This constitutional provision, along with implementing legislation for county administered general assistance and county-enforced relative responsibility, remained on the books until 1937, when it became necessary to remove all constitutional obstructions to state level participation in the new grant-in-aid programs made available under the Federal Social Security Act.

Meanwhile, the Nevada legislature had provided in 1913 a state workmen's compensation program and in 1915 a county administered mothers' pension system for women and their minor children, whose husbands and fathers were dead or had deserted their families. In 1923 a law was passed authorizing old age pensions and in 1925 another law authorized aid to the needy blind. The mothers' pensions, old age pensions and aid to the blind were essentially county oriented with only a minimum of state involvement. Relief at the county level was usually in kind rather than cash. There was little uniformity among counties.

When the federal New Deal programs began during the depression, the Federal Government preferred to work with state governments instead of a multitude of local governments. As a step in this direction, the Nevada Emergency Relief Administration was established in 1934 to coordinate the various federal relief programs operating in the state. Shortly thereafter, the State Board of Relief, Work Planning, and Pension Control was created to provide state supervision of all assistance, relief and pension programs.

From that point on, state involvement in welfare programs increased while the counties' welfare autonomy gradually diminished except for medical care and general relief for groups ineligible for assistance under federal-state categorical programs.

In 1937, Nevada entered the federal grant-in-aid programs for Old Age Assistance and Child Welfare. In 1953 Nevada accepted the federally matched program of Aid to the Blind. Aid to Dependent Children, as provided under the Federal Social Security Act, was accepted in 1955 to replace the Nevada mothers' pension. The federal grant program for Aid to the Permanently and Totally Disabled was never adopted by the Nevada legislature, although in the late 1960's state medical assistance was made available to disabled persons. The Medical Assistance to the Aged program was accepted in Nevada in 1960, and in 1967 state participation in the more comprehensive Medicaid program was authorized. In 1973 the state adopted implementing legislation for the federalization of the aged, blind and disabled categories under the Supplemental Security Income program.

Thus, largely due to financial incentives offered from the federal level, responsibility for providing assistance and services to large segments of the welfare population has been shifted away from Nevada's counties and into the hands of state and federal authorities. Nevada has been more reluctant than most

states to make this shift because federal regulations tend to supplant local flexibility and control. In 1974, however, Nevada is participating to some degree in nearly all of the major welfare programs for which federal funding is available. Levels of benefits may not be as high in certain categories as provided by some states, and Nevada may not be utilizing as many options under the programs as are federally matchable, but possibilities for extended grants and services eligible for federal funding are constantly under review by the State Welfare Division, keeping in mind the state's budgetary framework.

General Background on Current Status of State and County Welfare, Medicaid and Supplemental Security Income

State Welfare Division.

The State Welfare Division within Nevada's Department of Human Resources is the state agency designated by the legislature to administer most aspects of the public assistance and related medical assistance programs for which the state obtains federal matching funds. These programs include Aid to Dependent Children (ADC), State Aid to the Medically Indigent (SAMI), child welfare and other social services, and food stamps. Branches of the division are maintained at various locations throughout the state for eligibility determination and provision of services.

The division is responsible for operating ADC and the child welfare system and provides SAMI and social services for the aged, blind and disabled who receive their grants directly through the Social Security Administration under the new federalized Supplemental Security Income (SSI) program.

Funding for the above-mentioned programs of the State Welfare Division comes primarily from state general fund appropriations and federal matching. The counties are financially involved in only two programs. They contribute to SAMI through an annual local property tax levy of 11 cents per $100 of assessed valuation. Additionally, they pay one-third of the foster care costs for children of the county not eligible for the ADC foster care program.

The state's welfare program is limited, for the most part, to the so-called categorical programs for which federal assistance is available. For each program, the Federal Government must approve a detailed state plan implementing federal statutes and regulations. If the state does not comply with the federal requirements, federal matching funds may be lost.

County Welfare.

Not all needy persons are able to meet federal and state eligibility requirements for public assistance under the categorical programs. Included in this group are those who need emergency help or are awaiting processing of their state or SSI applications; intact families with minor children (both parents in the home); persons temporarily unable to work but not technically "disabled"; other needy persons between 21 and 65 without minor children; and those whose income and/or resources are above the financial eligibility level for categorical assistance.

County welfare, sometimes referred to as General Assistance (GA), serves as the residual source of aid for such needy people. It is locally administered and locally financed, with no federal or state matching funds and no federal guidelines. It fills the gaps for those who are unable to obtain assistance through the traditional federal-state programs. It includes some direct assistance and social services, but the main thrust of Nevada's county welfare is in the medical area. The county pays for medical assistance for many of those who are determined to be ineligible for the SAMI program.

It has been suggested that with appropriate adjustments in state laws and budgetary policies, certain federally matched state programs could be expanded, bringing a corresponding reduction in the residual group to be served by the county. An examination of the various programs, the availability of additional federal matching and the ultimate effects of expanded state coverage is needed in order to determine the extent to which state level adjustments might be desirable and whether the utilization of federal matching would result in a net saving to Nevada taxpayers.

Supplemental Security Income.

As a result of the congressional enactment of H.R. 1 (P.L. 92-603) in October of 1972, the Federal Government on January 1, 1974 took over responsibility for administering the welfare grant programs for the so-called adult categories--the aged, blind and disabled. The new program is being run by the Social Security Administration and is known as Supplemental Security Income (SSI). It is a flat grant type of program designed to guarantee a specified minimum monthly income to eligible recipients.

Effect on State Programs. In Nevada prior to the January 1 federalization, there had been Old Age Assistance (OAA) grants and Aid to the Blind (AB) grants which were federally assisted but state administered through the Welfare Division. Nevada had chosen not to participate in the federally assisted Aid to the Permanently and Totally Disabled (APTD) grant program; consequently, whatever public assistance was provided to the needy disabled apart from SAMI came through the county welfare system (and, in the last few months of 1973, the food stamp program in Clark and Washoe counties).

The new flat grants under Supplemental Security Income are replacements for the state's OAA and AB grants which involved a system of budgeting based on the needs of individual recipients. The new SSI program also establishes money grants for the APTD group completely funded with federal dollars.

Uniform federal rules now apply for eligibility and grant determination. SSI applicants and recipients must deal directly with federal Social Security personnel concerning their grants. The state retains responsibility for providing medical and social services to SSI recipients, however, so most SSI recipients need to keep in contact with their Welfare Division offices as well.

Federal Grant Levels and Income Disregards. Under P.L. 92-603, as amended by P.L. 93-66 and P.L. 93-233, the basic SSI grant level (wholly federally funded)

for an eligible aged, blind or disabled individual with no other income is $146 per month ($219 for an eligible couple). The first $20 per month of earned or unearned income, including Social Security or other pension income, is disregarded in computing available income. This establishes, in effect, an eligibility level of $166 per month for an individual and $239 for a couple. (In addition there is a higher disregard for "earned" income.) After the disregards are accounted for, a grant is subject to proportionate reduction according to the recipient's available income.

State Supplementation. Nevada provides "state supplementation" of the federal SSI grants for the aged and blind but not the disabled. The supplemental payment is included as part of the recipient's federal SSI check. With the addition of the state supplement, the grant level in Nevada for an aged individual with no other income is $185 per month; for the blind, $215. For the disabled, the basic grant level is the unsupplemented $146. Income disregards as described above are applicable whether or not there is state supplementation.

State supplementation for the aged and blind is partially funded by the Federal Government under the "hold harmless" provisions of H.R. 1, using a 1972 base.* Since the state had no prior APTD grant program, federal "hold harmless" assistance is not available for the disabled group. If state supplementation were to be provided for the disabled, it would have to be financed solely from state funds.

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* H.R. 1 provided that in cases where states had been paying over the federal grant level, data from calendar year 1972 would be used to establish an "adjusted payment level" (APL). For contributing a fixed sum, the state would be "held harmless" for future costs associated with payment of grants up to the adjusted payment level.

Benefit to Counties. At the beginning of 1974 the State Welfare Division anticipated that the inclusion of disabled persons under the federal SSI program, even at the minimum $146 grant level and lowered eligibility cutoff for SAMI, would result in net savings in county welfare expenditures. First, it was felt that the SSI check would cover the food and shelter requirements of certain needy disabled persons who in the past had to ask the county for help. Second, under the broader federal definition of "disability," estimates were that SAMI coverage would become available to persons whose medical bills had fallen on the county in the past because the state definition (requiring both permanent and total disability) precluded eligibility for SAMI.

However, due to delays at the federal level in implementing SSI for the disabled in Nevada, the expected county savings had not yet occurred by mid-1974. County direct and medical assistance was still necessary for the majority of disabled persons who had applied for SSI coverage.

State Aid to the Medically Indigent.

The state's Medicaid program, known as State Aid to the Medically Indigent (SAMI), is federally matched at 50 percent (the Medicaid percentage applicable to Nevada). It serves recipients of ADC and SSI (known as "categorically needy") and certain others who qualify as categorically related; however, it does not extend to the optional group known as the "medically needy."

Medical Services Provided. For persons determined to be eligible for SAMI under the Nevada state plan, an extensive list of medical services is provided: inpatient hospital services; outpatient hospital services; laboratory and X-ray services; skilled nursing home services for persons over 21, early and periodic screening and diagnosis and treatment for persons under 21, and family planning services; physicians' services; drugs; home health care; outpatient care in clinics; dental and ocular care; podiatry; ambulance and transportation services; physical therapy; prosthetic appliances; mental and tuberculosis hospital care for those over 65; and medical supplies and services of intermediate care facilities.

Coverage Prior to SSI. Nevada's SAMI program has for several years been providing medical care and services for persons receiving ADC, OAA and AB, and also for the permanently and totally disabled who would have been eligible for APTD grants if Nevada had been providing such grants. Most of the adult category SAMI's are now SSI recipients and as such will continue under the SAMI program.

Disabled--Changes in Coverage. In the case of the disabled, it is expected that when the computer problems are overcome an additional group will be declared medically eligible under SSI because of what appears to be a more liberal definition of disability (no longer requiring both permanent and total disability). On the other hand, revisions in the income computation and a lowered financial eligibility cutoff level for the disabled in Nevada apparently destroyed SSI eligibility (and hence SAMI eligibility) for some of those who were previously covered by SAMI as APTD's.

Institutionalized Persons. Some of the most difficult cases in the transition to SSI have involved persons in the disabled category who were previously eligible for SAMI but whose incomes are in excess of the SSI eligibility level (which, as noted above, includes no state supplement in Nevada). For these individuals, ineligibility for SSI has meant being cut off from state SAMI assistance. Among this group are a number of persons who are in hospitals, nursing homes and intermediate care facilities. Since their only recourse for help with their medical costs has been county general assistance, the burden on the counties has been great. Some of the most expensive medical cases were actually transferred from the state back to the county in early 1974 because pensions and other unearned income placed the individuals above the eligibility level.

There is a provision in the federal Medicaid law, added in 1973, which the State Welfare Board has recently utilized to extend SAMI coverage to some of the above-described persons. The law provides

that if a state chooses to include institutionalized persons with incomes up to 300 percent of the SSI benefit level ($438 for a single individual), such persons can be deemed in special need and therefore eligible for Medicaid matching even in the absence of a medically needy program. See 42 U.S.C.A. § 1396b (f) (4) (C), reproduced in Part IV of the supplement to this report.

The State Board action, taken in mid-1974, followed a reinterpretation of the law by HEW, indicating that no additional legislative action would be necessary at the state level to enable Nevada to qualify for federal financial participation in SAMI services provided to the newly eligible group of institutionalized aged, blind and disabled persons. The action will mean that some high medical costs can be transferred from the counties to the state, making such costs eligible for 50 percent federal matching retroactive to January 1, 1974.

Aid to Dependent Children.

Aid to Dependent Children (ADC) is not included in the new federalized SSI program. It remains substantially the same as in recent years--state administered with federal guidelines and federal financial participation. Of the current "average" Nevada ADC grant of $42 per recipient per month, the Federal Government pays $22 and the remaining $20 is covered by state general fund appropriations.

Eligibility and grant determination is a function of the State Welfare Division; the Social Security Administration is not involved. Medical care is available to ADC recipients through the SAMI program described above.

Limitations on Coverage. ADC in Nevada covers needy dependent children (and their caretaker relatives) who are deprived of parental support or care by reason of the death, absence or incapacity of a parent. The optional AFDC-U program (for "intact" families where the father is in the home but unemployed) has not been adopted in Nevada. "Emergency Assistance" for needy families with children is another ADC-related option not included in Nevada's program.

For an intact family or a needy family unable to qualify for ADC under the financial eligibility criteria in Nevada, county welfare is the only source of public assistance apart from food stamps. Medical care for such families frequently must be financed with county funds not eligible for federal matching.

Other Programs.

Food Stamps. The food stamp program replaced the commodity foods distribution program in Clark and Washoe counties in the fall of 1973 and in the other counties of the state beginning July 1, 1974. Food stamps are administered through the State Welfare Division subject to regulations of the U.S. Department of Agriculture in coordination with the U.S. Department of Health, Education, and Welfare. Since the program is relatively new in Nevada, implementation has presented problems for the division. Food stamp eligibility standards are not necessarily the same as those applicable to the public assistance and Medicaid programs. Many of those who are eligible for food stamps are in households ineligible for public assistance.

Social Services. Federal matching is available at 75 percent for the "social services" provided by the State Welfare Division. Similar matching is not available for services provided by county welfare staffs. There has been a great deal of uncertainty about federal policies in the social services area, but the State Welfare Division continues to provide child welfare services and services to ADC and SSI recipients.

State Welfare Statutes and Budgetary Allocations in Nevada

Although there are a number of provisions in the Nevada Revised Statutes dealing with welfare related activities, the subcommittee's review has been limited primarily to the chapters on

State Welfare Administration (chapter 422), Aid to Dependent Children (chapter 425), Indigent Persons (chapter 428) and County Hospitals (chapter 450).

State Welfare Administration.

Under Nevada law the State Welfare Division is one of several divisions in the Department of Human Resources. The chief of the division is known as the State Welfare Administrator. He is appointed by the director of the department with the consent of the Governor and is responsible for the organization and operation of the division, subject to administrative supervision by the director. NRS 232.300, 232.320, 422.060 and 422.160 et seq.

State appropriations to the State Welfare Division for administrative purposes were approximately $2.1 million for fiscal year 1973-74 and $2.3 million for 1974-75. The total estimated costs for administration (including federal matching) were approximately $5.8 million for 1973-74 and $6.2 million for 1974-75. (See Table I.)

In the division there is a seven-member bipartisan State Welfare Board appointed by the Governor from throughout the state. The board formulates all standards and policies and establishes rules and regulations for the administration of the programs for which the division is responsible. The execution and enforcement of board decisions, policies, rules and regulations are delegated to the administrator and the division. NRS 422.070 and 422.140.

Acceptance of federal funds under the Social Security Act is authorized under NRS 422.260 and 422.265:

> 422.260 Acceptance of Social Security Act and federal funds.
> 1. The State of Nevada assents to the purposes of the Act of Congress of the United States entitled the "Social Security Act," approved August 14, 1935, and assents to such additional federal legislation as is not inconsistent with the purposes of this chapter.

Table I--STATE APPROPRIATIONS, ESTIMATED COUNTY PARTICIPATION, AND ESTIMATED FEDERAL PARTICIPATION TO NEVADA STATE WELFARE DIVISION

	1973-74				1974-75			
	State Appropriation	County	Federal Participation	TOTAL	State Appropriation	County	Federal Participation	TOTAL
Administration	$ 2,122,784		$ 3,654,359	$ 5,777,143	$ 2,286,794		$ 3,950,712	$ 6,237,506
ADC	4,716,240		5,187,864	9,904,104	4,952,140		5,447,354	10,399,494
AB[1]	127,590		40,500	168,090	177,420		-0-	177,420
OAA[1]	898,100		885,000	1,783,100	875,800		-0-	875,800
CWS	709,744	$ 122,880	166,656	999,280	741,480	$ 128,000	174,720	1,044,200
WIN	61,248		53,507	114,755	61,248		53,507	114,755
SAMI	6,905,823	2,857,000	9,884,544	19,647,367	7,817,592	3,171,000	11,142,833	22,131,425
Homemaking	58,650		178,131	236,781	65,460		198,935	264,395
Cuban			331,872	331,872			333,694	333,694
Indian Service	-0-		151,780	151,780	-0-		153,966	153,966
Food Stamp[2]	388,632		126,717	515,349	388,632		126,717	515,349
TOTAL	$15,988,811	$2,979,880	$20,660,930	$39,629,621	$17,366,566	$3,299,000	$21,582,438	$42,248,004
Percentage	40.4	7.5	52.1	100.0	41.1	7.8	51.1	100.0

1/ The AB and OAA grants were replaced by federal SSI grants beginning January 1, 1974. State appropriations for these programs after that date cover only the amount for state supplementation. This table does not include the base amount of the federal SSI grants.

2/ Amounts shown for food stamps do not include additional amounts provided by Interim Finance Committee.

Source: Nevada State Welfare Division

2. The State of Nevada further accepts, with the approval of the governor, the appropriations of money by Congress in pursuance of the Social Security Act and authorizes the receipt of such money into the state treasury for the use of the department in accordance with this chapter and the conditions imposed by the Social Security Act.

3. The State of Nevada is authorized to accept, with the approval of the governor, any additional funds which may become or are made available for extension of programs and services administered by the department under the provisions of the Social Security Act. Such money shall be deposited in the state treasury for the use of the department in accordance with this chapter and the conditions and purposes under which granted by the Federal Government.

422.265 Acceptance of increased benefits of future congressional legislation. If, in the future, the Congress of the United States shall pass any law or laws that have the effect of increasing the participation of the Federal Government in the Nevada public assistance or child welfare programs, either as relates to eligibility for assistance or otherwise, the director is authorized to accept, with the approval of the governor, the increased benefits of such congressional legislation; and the board may formulate such standards as are required by the Congress of the United States as a condition of acceptance.

The language of these two sections allows the state's executive branch considerable flexibility in dealing with federal statutes governing public assistance programs and the regulations thereunder issued by the U.S. Department of Health, Education, and Welfare. State legislative control is exercised largely through the purse strings, but in some cases the state laws specify directly the inclusion or exclusion of particular programs or the exercise of particular options.

Aid to Dependent Children.

Chapter 425 of NRS, originally adopted in 1955, contains Nevada's statutes on Aid to Dependent Children (ADC). The legislative

declaration in NRS 425.020 states that it is the purpose of the chapter "to provide assistance for children whose dependency is caused by circumstances defined in subsection 5 of NRS 425.030, and to keep children in their own homes wherever possible."

Subsection 5 of NRS 425.030 states:

> 425.030 Definitions. As used in this chapter:
> * * *
> 5. "Dependent child" means:
> (a) A needy child under the age of 18 years, or under the age of 21 years if found by the department to be regularly attending a school, college or university, or regularly attending a course of vocational or technical training designed to fit him for gainful employment, who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew or niece, in a place of residence maintained by one or more of such relatives as his or their own home; or
> (b) A child removed from the home of a relative designated in paragraph (a) after April 30, 1961, as a result of a judicial determination that continuance in the home of the relative would be contrary to his welfare for any reason, and who has been placed in foster care as the result of such determination, if the child was receiving aid to dependent children in or for the month in which the court action was initiated or would have received aid to dependent children if the application had been made, or who lived with a relative designated in paragraph (a) within 6 months prior to the month in which court action was initiated, and who would have received aid to dependent children in the month court action was initiated if he were still living with the relative and application for assistance had been made, provided the custody of such child has been placed with the welfare division by court order.

Assistance payments are granted to help meet the needs of the dependent child or children and also those of the caretaker relative, if eligibility is based on paragraph (a) and the relative is needy.

The State Welfare Division is responsible for the administration of the ADC program, including the making of rules and regulations and the determination of eligibility for each applicant under the program. NRS 425.020(3) and 425.040 et seq.

Many of the rules relating to eligibility and participation in the ADC program in Nevada are mandated by the Federal Government, either by statute (primarily Title IV-A of the Social Security Act, 42 U.S.C.A. §§ 601 to 610, inclusive, reproduced in excerpted form in Part I of the supplement to this report) or by HEW regulation (primarily 45 C.F.R. § 233.90 and other sections in Part 233).

There is no county level involvement in ADC in Nevada. Program funding has been solely from state and federal sources since 1960, when the requirement for county participation was repealed.* Administration of ADC has always been carried out by state personnel in what is known as a "state administered" system (rather than the "state supervised, county administered" system utilized in a number of states).

The Eligibility and Payments Manual of the State Welfare Division sets forth the state's monthly standard of need for assistance units of various sizes and circumstances. Section 205.1 of the manual states that monthly allowances for "total needs" include food, clothing, recreation, personal incidentals, fuel for heating, cooking and water heating, electricity for refrigeration and lights, household supplies, medical chest supplies and shelter. Section 205.2, which contains the schedule, shows that "total needs" for an ADC mother with three children would be considered to be $329 per month. The monthly grant for such a family (assuming no other income) would be 61 percent of $329, or $201.

* Chapter 254, Statutes of Nevada 1960, repealed NRS 425.180, which had required each county to pay one-third of the non-federal share of ADC costs. The county's share had been raised by an annual ad valorem tax levy of up to 4 cents per $100 of assessed valuation.

State appropriations for the ADC program were approximately $4.7 million for fiscal year 1973-74 and $5 million for 1974-75. At the time this budget was approved by the legislature, the estimated total cost of the ADC program, including federal matching, was $9.9 million for 1973-74 and $10.4 million for 1974-75. (See Table I, page 33.) These estimates were predicated on a projected average of 19,651 recipients per month in 1973-74 and 20,634 in 1974-75 with an average monthly grant of $42 per recipient. Under the federal matching formula for ADC, the state's share of the $42 average monthly grant is computed at $20 and the federal share at $22.

Experience during the first half of the biennium has shown that the actual number of ADC recipients has been lower than projected. There have been approximately 13,500 recipients per month rather than the projected 20,000. As a result, total costs for the ADC program have been lower than anticipated and--in the absence of unusual or unforeseen developments--it appears that the total state expenditure for the biennium will be only approximately $6.5 million instead of the $9.7 million appropriated, leaving an unused appropriation of over $3 million to revert to the general fund at the end of June 1975.

Historical information from the State Welfare Division shows that projections for the ADC program have been difficult to make. Although the number of ADC recipients increased rapidly between fiscal years 1968 and 1971, the caseload did not continue to climb but rather began a slight decrease in fiscal years 1972 and 1973, with an apparent leveling effect in the current biennium. The figures are:

Fiscal Year	No. of ADC Recipients
1968	7,650
1969	8,700
1970	12,000
1971	16,500
1972	15,000
1973	14,500
1974	13,300

County General Assistance.

Chapter 428 of NRS contains most of the statutes relating to county general assistance. The basic provisions setting forth county powers and duties with respect to the indigent appear in NRS 428.010, 428.030 and 428.050:

> 428.010 County aid and relief to indigents; duties of county commissioners.
> 1. To the extent that moneys may be lawfully appropriated by the board of county commissioners for this purpose pursuant to NRS 428.050, every county shall provide care, support and relief to the poor, indigent, incompetent and those incapacitated by age, disease or accident, lawfully resident therein, when such persons are not supported or relieved by their relatives or guardians, by their own means, or by state hospitals, or other state, federal or private institutions or agencies.
> 2. The boards of county commissioners of the several counties are vested with the authority to establish and approve policies and standards, prescribe a uniform standard of eligibility, appropriate funds for this purpose and appoint agents who will develop rules and regulations and administer these programs for the purpose of providing care, support and relief to the poor, indigent, incompetent and those incapacitated by age, disease or accident.

> 428.030 Power of county to give relief to poor person.
> 1. When any poor person meets the uniform standards of eligibility established by the board of county commissioners and does not have relatives of sufficient ability to care for and maintain such poor person, or when such relatives refuse or neglect to care for and maintain such person, then such poor person shall receive such relief as is in accordance with the policies and standards established and approved by the board of county commissioners and within the limits of the funds which may be lawfully appropriated pursuant to NRS 428.050 for this purpose.
> 2. The board of county commissioners may:
> (a) Make contracts for the necessary maintenance of poor persons; or

(b) Appoint such agents as the board may deem necessary to oversee and provide the necessary maintenance of poor persons; or

(c) Authorize the payment of cash grants direct to poor persons for their necessary maintenance; or

(d) Provide for the necessary maintenance of poor persons by the exercise of the combination of one or more of the powers specified in paragraphs (a), (b) and (c) of this subsection.

428.050 Funding of aid to indigents: Budgeting; tax levy; limitations on expenditures.

1. 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. Such levy shall not exceed that adopted for the purposes of this chapter for the fiscal year ending June 30, 1971, exclusive of that required by NRS 428.370.*

2. No county shall expend or contract to expend for purposes of such aid and relief a sum in excess of that provided by the maximum ad valorem levy set forth in subsection 1, together with such outside resources as it may receive from third persons, including, but not limited to, 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, except that if the health of the poor is placed in jeopardy and there is a lack of moneys to provide necessary medical care under this chapter, the board of county commissioners shall declare an emergency and provide additional funds for medical care only from whatever resources may be available.

* NRS 428.370 is the section which imposes the SAMI levy of 11 cents per $100 of assessed valuation.

Not all counties have exercised their authority under NRS 428.010 to establish written policies and uniform standards of eligibility. The only two counties which submitted elaborate written criteria for review by the subcommittee were Clark and Washoe.

The effect of NRS 428.050 is to limit tax levies and expenditures for the direct assistance portion of county general assistance while permitting increases for medical assistance under certain circumstances. Some counties have adapted their bookkeeping to this system by separating the medical assistance fund from the direct assistance (indigent) fund.

Under NRS 428.090, counties are directed to provide medical assistance to nonresident indigents who are not covered by SAMI:

> 428.090 Medical assistance, burial of nonresidents and others.
> 1. When any nonresident or any other person who meets the uniform standards of eligibility prescribed by the board of county commissioners falls sick in the county, not having money or property to pay his board, nursing or medical aid, the board of county commissioners of the proper county shall, on complaint being made, give or order to be given such assistance to the poor person as is in accordance with the policies and standards established and approved by the board of county commissioners and within the limits of funds which may be lawfully appropriated for this purpose pursuant to NRS 428.050.
> 2. If such sick person shall die, then the board of county commissioners shall give or order to be given to such person a decent burial.
> 3. The board of county commissioners shall make such allowance for board, nursing, medical aid or burial expenses as the board shall deem just and equitable, and order the same to be paid out of the county treasury.
> 4. The responsibility of the board of county commissioners to provide medical aid or any other type of remedial aid under this section shall be relieved to the extent of the amount of money or the value of services provided by the welfare division of the department of human resources to or for such persons for medical

care or any type of remedial care under the provisions of NRS 428.150 to 428.370, inclusive.*

This section, along with NRS 450.390 relating to county hospitals, is the basis for the requirement of county payment of medical bills of indigent transients injured in highway accidents within county boundaries.

There is no reliable source of comparative data on county general assistance budgeting and expenditures. Although under NRS 422.270(1)(a) the Department of Human Resources is directed to administer "all public welfare programs of this state, including * * * general assistance * * *", neither the State Welfare Division nor any other division of the department attempts to collect information about county programs or in any way supervises or imposes regulations or uniform standards on the counties. County autonomy prevails in the administration of the general assistance programs.

A review of the latest county budget documents filed with the Nevada Tax Commission, used in conjunction with information provided by the counties themselves, shows that the annual amount for county medical assistance (excluding SAMI) for fiscal years 1972-73 through 1974-75 was approximately $1.4 to $1.8 million in Clark County, $1.0 to $1.6 million in Washoe County and roughly $500,000 to $600,000 in the other 15 counties combined. Statewide totals for county medical assistance were $3.0 to $4.0 million. Amounts for direct assistance were much smaller, never exceeding a total of $1.0 million for all counties of the state.

For the state as a whole, budget information shows that the annual amount for county direct assistance plus salaries and other costs of administering general assistance for fiscal years 1972-73 through 1974-75 was approximately $1.5 to $2.0 million. Over half of this amount ($0.9 to $1.1 million) was in Clark County and about one-eighth ($228,000) was in Washoe County.

* NRS 428.150 to 428.370, inclusive, relate to State Aid to the Medically Indigent (SAMI).

Thus for fiscal 1972-73 through 1974-75, total costs for county general assistance (including medical and direct assistance and administrative costs but excluding the SAMI levy) range from $4.5 to $5.6 million per year statewide, with $2.4 to $2.5 million per year in Clark County and $1.2 to $1.8 million in Washoe County

State Aid to the Medically Indigent (SAMI).

In 1967 the Nevada legislature enacted new legislation directing state participation in the federally matched Medicaid program (Title XIX of the Social Security Act, 42 U.S.C.A. §§ 1396 et seq., excerpted in Part IV of the supplement to this report, and regulations at 45 C.F.R. 248.1 et seq., excerpted in Part V of the supplement). The statutory basis for the Nevada program known as State Aid to the Medically Indigent (SAMI), appears in NRS 428.150 to 428.370, inclusive.

The legislature chose to provide a broad range of medical services under its SAMI program--more than the minimum required by the Federal Government to be eligible for federal matching. The services are listed in NRS 428.210, quoted below. Subsection 7 authorizes the State Welfare Division to add to the items mentioned.

> 428.210 "Medical or remedial care" defined. "Medical or remedial care" means any of the following:
> 1. Inpatient hospital services consisting of the following items furnished to an inpatient in a hospital:
> (a) Bed and board;
> (b) Drugs; and
> (c) All in-hospital services including anesthesia, nursing services, equipment, supplies, laboratory and radiological services, whether furnished directly by the hospital or by contractual arrangements made by the hospital.
> 2. Services of a physician rendered to or in behalf of an inpatient in a hospital or nursing home.
> 3. Skilled nursing-home services consisting of nursing care in a licensed nursing home provided by a registered professional nurse or a licensed practical nurse, which is prescribed by and performed under the general direction of a physician; other medical services related to such skilled nursing care and bed and board in connection with furnishing of such skilled nursing care.

4. Visiting-nurse services consisting of nursing care provided by a registered professional nurse or a licensed practical nurse in the individual's own home under the general direction of a physician and purchased from a public or private nonprofit agency or paid directly to the nurse as the supplier of the service.

5. Drugs prescribed by a physician and provided by a licensed pharmacist for a patient in a nursing home.

6. Outpatient services consisting of the following items furnished to a patient not in a hospital or nursing home, including but not restricted to items furnished in a physician's office, patient's home, hospital emergency room or hospital outpatient clinic:

(a) Drugs prescribed by a physician and provided by a licensed pharmacist;

(b) Services of a physician; and

(c) Laboratory, radiological and other ancillary services requested by a physician and deemed essential for adequate medical care.

7. Other items or services furnished to an individual to preserve health and prolong life, including but not limited to:

(a) Dental services;

(b) Optometric services and glasses; and

(c) Home health services.

The State Welfare Division, under the supervision of the Department of Human Resources, is responsible for administering the state's medically indigent program and is granted authority to establish the property and income requirements for eligibility as a medically indigent person. NRS 428.220 and NRS 428.260. Federally imposed requirements limit the choices a state can make in its Medicaid program and still remain eligible for federal matching. The division attempts to keep abreast of changes in federal statutes and regulations to determine those policies which will be federally acceptable and also of maximum benefit to the State of Nevada.

NRS 428.330 provides that rates and fee schedules for medical or remedial care provided under the program are to be set by the State Welfare Board and are to reflect a "reasonable" cost for providing such care.

Under NRS 428.270(3) the following persons are declared eligible for SAMI beginning on January 1, 1974:

1. Recipients of Aid to Dependent Children.

2. Recipients of Supplemental Security Income, including individuals over 65 in state tuberculosis or mental institutions.

3. Individuals under 21, medically indigent but not eligible for ADC, who belong to a group classification which the State Welfare Board has determined can benefit by medical or remedial care.

The present program in Nevada includes persons described in the federal Medicaid regulations as "categorically needy" but does not extend to those described as "medically needy." The general definitions appear in 45 C.F.R. § 248.1:

> § 248.1
> (a)(1) Categorically needy.
> (i) General. In order to be considered as categorically needy for purposes of title XIX, an individual must in general be receiving financial assistance or sufficiently in need to be financially eligible for financial assistance under title IV-A [ADC] or XVI [SSI] of the Social Security Act, or under a state supplement to title XVI assistance.
> * * *
> (2) Medically needy. (i) An individual is considered to be medically needy if he has income and resources which exceed the amount of income and resources allowed to the categorically needy but which are insufficient to meet the costs of necessary medical and remedial care and services.
> * * *

State appropriations for the SAMI program were approximately $6.9 million for fiscal year 1973-74 and $7.8 million for 1974-75. With the estimated proceeds of the 11-cent county ad valorem tax levy (NRS 428.370) totaling $2.8 million in 1973-74 and $3.1 million in 1974-75, plus the estimated amount from the 50 percent matching provided by the Federal Government under the Medicaid matching formula, the total amount budgeted for SAMI was approximately $19.6 million for 1973-74 and $22.1 million for 1974-75. (See Table I, page 33.)

Historical information provided by the State Welfare Division shows that from fiscal year 1968 to fiscal year 1970 the state's projections for SAMI costs were lower than actual expenditures. In fiscal 1971, 1972 and 1973, however, there were reversions to the general fund of $600,000 to $800,000 per year. Present estimates indicate that the SAMI reversion to the general fund at the end of fiscal year 1975 will approach $2.6 million.

County Hospital Obligations to the Indigent.

The county hospital law (Chapter 450 of NRS) contains provisions relating to hospital care for the indigent.

Subsection (1) of NRS 450.390 provides that every county hospital "shall be for the benefit of such county or counties and of any person falling sick or being injured or maimed within its limits * * *."

The board of county commissioners has the power to determine whether or not patients presented to the county hospital for treatment are "subjects of charity." They are directed to establish by ordinance the criteria and procedures to be used in determining patient eligibility as medical indigents or subjects of charity. NRS 450.420(1).

When the board of hospital trustees fixes charges for occupancy, nursing, care, medicine and attendance, they "shall not include, or seek to recover from paying patients, any portion of the expense of the hospital which is properly attributable to the care of indigent patients." NRS 450.420(2).

Emergency treatment in the county hospital is chargeable to the county under the provisions of subsection (3) of NRS 450.420:

> 3. The county is chargeable with the entire cost of services rendered by the hospital and any attending staff physician or surgeon to any person admitted for emergency treatment, but the hospital and any such attending physician or surgeon shall use reasonable diligence to collect such charges from the emergency patient or any other person responsible for his support. Any amount so collected shall be reimbursed or credited to the county.

Physicians' services in the county hospital are to be provided in accordance with NRS 450.440:

> 450.440 Staff of physicians: Organization; rotation of service; compensation.
> 1. The board of hospital trustees shall organize a staff of physicians composed of every regular practicing physician in the county in which the hospital is located who meets the standards fixed by the rules and regulations laid down by the board of hospital trustees.
> 2. The staff shall organize in a manner prescribed by the board so that there shall be a rotation of service among the members of the staff to give proper medical and surgical attention and service to the indigent sick, injured or maimed who may be admitted to the hospital for treatment.
> 3. No member of the staff nor any other physician who attends an indigent patient shall receive any compensation for his services except as otherwise provided in NRS 450.180* or to the extent that medical care is paid for by any governmental authority or any private medical care program.

The subcommittee received testimony concerning the effect of this provision in Clark County, where the accessibility of proprietary hospitals having no requirement for free services to the indigent has discouraged some physicians from remaining on the staff of the county hospital.

Subsection (3) of NRS 450.240 provides that the county commissioners may levy a tax for the maintenance and operation of the county hospital. Subsection (4) requires that the resolution imposing the tax state the portion of the levy which is necessary to pay for the care of indigent patients. Under subsection (5) there cannot be a levy for the care of indigents in the county hospital unless the levy and its justification are included in the hospital fund budget filed with the tax commission.

* NRS 450.180 empowers the board of hospital trustees to employ physicians, surgeons and internes, either full-time or part-time, and fix their compensation. It also empowers the board to control the admission of such personnel to the staff by promulgating appropriate rules, regulations and standards.

The subcommittee has found that it is difficult to draw distinct lines between those county hospital patients for whom the county will provide general assistance through the county welfare department, those who do not meet the county's requirements for general assistance but are nevertheless unable to pay their bills without a long term payment arrangement with the hospital, and those who might be able to pay the bills but leave the state or otherwise obstruct collection and are therefore categorized as "bad debts" in hospital records.

Chronic Renal Diseases.

Under chapter 457A of NRS, the Health Division of the Department of Human Resources is directed to establish a program for the care and treatment of persons suffering from chronic renal diseases but who are financially unable to pay for such services. The division, with the advice of an 11-member advisory committee, is to develop eligibility standards for such care and treatment and is to "provide financial assistance to persons suffering from chronic renal diseases to enable them to obtain medical, nursing, pharmaceutical and technical services, including the renting of home dialysis equipment, necessary to treat such diseases." NRS 457A.040(4).

It appears that the only state appropriations for this purpose in the current biennium were $6,020 for fiscal year 1974 and $2,620 for fiscal year 1975. These amounts were described in the budget as startup money for the advisory committee, which had been inactive since the law was enacted in 1971 due to a lack of funds for travel expenses and personnel. There has not as yet been an appropriation to provide the financial assistance described in the statute.

The subcommittee received information concerning the plight of some individuals in need of assistance under chapter 457A. Not all renal disease patients qualify for other medical assistance under Medicare or Medicaid or under county general assistance programs.

Specific Problem Areas Considered by Subcommittee

Retention of General Assistance Function at County Level.

Although one of the principal subjects assigned to the subcommittee for study was that of consolidation of state and county welfare programs, it became apparent at the very first meeting that complete consolidation at the state level would receive little support. Testimony before the subcommittee tended to favor the local flexibility and local control made possible by retention of a county level general assistance program to cover those poor people who cannot fit into any of the federally funded categories. Concern during subcommittee deliberations centered primarily on those specific portions of county general assistance which would become eligible for federal matching if transferred to state control.

In the United States as a whole, about one-third of the states have general assistance programs which are completely state administered and state funded. A summary prepared by the U.S. Department of Health, Education, and Welfare in 1970 showed that 17 states had state administered general assistance programs. Of these, 16 programs were fully state financed and one was financed with a combination of state and local funds.

Nevada was among the 17 states listed as having solely locally administered general assistance programs, 15 of which were funded solely with local funds.

Arguments which can be made in favor of consolidation include (1) greater uniformity among counties; (2) improved administrative efficiency; and (3) reduced costs to the counties.

Counterarguments heard by the subcommittee were to the effect that, (1) to impose the rigidities of statewide uniformity in the general assistance program would be to reduce the program's effectiveness in meeting clients' needs quickly on an individual case by case basis; (2) to transfer general assistance to the state level would eliminate the need for welfare personnel at the county level but at the same time would probably necessitate some additional state staff because a new clientele would be added which has not previously been served by the state offices; and (3) there are actions which the state can take, short of total consolidation, which would do much to reduce county costs

without losing the advantages of county involvement in welfare decisionmaking.

With regard to the reduction of county welfare expenditures while retaining the basic general assistance function at the county level, the subcommittee has explored a number of possibilities, many of which are related to expansion of the state's medical assistance program. Several of the sections which follow describe possible state programs to relieve county welfare burdens.

In most of the proposals submitted to the subcommittee for expansion of state level programs, the emphasis was placed on the advantages of obtaining 50 percent federal matching funds which are not available for county administered programs and which would tend to reduce the overall burden to Nevada taxpayers at the state and local levels.

The subcommittee has concluded that total consolidation of state and county welfare programs in Nevada would not be appropriate at this time. Therefore the subcommittee recommends the retention of the basic general assistance function at the county level. At the same time, the subcommittee urges that the state look toward means of reducing the costs of county general assistance by expanding state coverage under the SAMI and ADC programs.

Changes in State Welfare Board.

The subcommittee has received recommendations from its Clark County Advisory Committee regarding changes in present statutes relating to the State Welfare Board. (See Appendix C.) Included were recommendations involving the composition of the board and the scheduling of meetings.

The pertinent sections are NRS 422.070, 422.080 and 422.110:

> 422.070 State welfare board: Creation, composition. There is hereby created in the welfare division a bipartisan state welfare board composed of seven members appointed by the governor. Not more than four of such members shall be members of the same political party.

422.080 Qualifications of members. The members of the board shall be selected on the basis of their recognized interest in and knowledge of the field of public welfare, and so selected on a geographic basis as to give statewide representation. Not more than two members shall be residents of the same county.

422.110 Meetings; quorum; minutes.

1. The members of the board shall meet at such times and at such places as the board, the chairman of the board, the administrator or the director shall deem necessary, but a meeting of the board shall be held at least once each calendar quarter.

2. Four members of the board shall constitute a quorum, and such quorum may exercise all the power and authority conferred on the board.

3. The board shall keep minutes of the transactions of each board session, regular or special, which shall be public records and filed with the welfare division.

After reviewing the advisory committee recommendations for increased representation for Clark and Washoe counties and more meetings in Clark County, the subcommittee has decided to recommend that NRS 422.070 be amended to enlarge the board from seven to nine members; that NRS 422.080 be amended to increase the maximum number of board members representing any one county from two to three; and that NRS 422.110 be amended to require that at least two board meetings be held in Clark County each year. (See Bill A.)

Improved Communication Between State and Local Levels.

Testimony before the subcommittee indicated that there is too little opportunity for meaningful communication about welfare policies and problems between the counties and consumers on the one hand and the State Welfare Division on the other. This appears to be an especially difficult problem in Clark County. It was suggested that the state statutes be amended to provide for some kind of formalized county advisory committee structure, possibly on a local option basis, to encourage and facilitate local input during the policymaking process at the state level.

At the present time the only statutory provision for county advisory boards is NRS 422.300, which permits the judge of the juvenile court in a county to appoint a five-member board to advise the State Welfare Division, the board of county commissioners, the judge, the Governor and the legislature on Child welfare matters.

Before 1963, this section was considerably broader in scope and was in some ways closer to what has been suggested to the subcommittee for enactment in 1975. The pre-1963 version of NRS 422.300 provided that in counties where it was deemed advisable, the State Welfare Administrator, with the approval of the State Welfare Board, could establish three-member county advisory committees to advise the State Welfare Division on local welfare matters generally. Advisory board members were to be appointed by the State Welfare Administrator upon the recommendation of the board of county commissioners, with one of the three members' being a county commissioner.

Among the specific recommendations the subcommittee has received from its Clark County Advisory Committee is one suggesting a new state statute providing that any board of county commissioners may appoint a county welfare advisory committee to consider welfare matters and provide advice and recommendations to the State Welfare Board. (See Appendix C.)

The subcommittee agrees with the concept of authorizing the establishment of an advisory committee in any county where the commissioners deem it desirable, but also recognizes that advisory committees would not be appointed in some of the smaller counties. To provide an alternative system for local input at state board meetings the subcommittee has suggested that counties without advisory committees be authorized to designate single welfare advisers with official status to represent the county commissioners at state board meetings.

Accordingly, the subcommittee recommends the enactment of Bill B, which provides that the board of county commissioners of any county may appoint a county welfare advisory committee composed of one county commissioner, one county employee knowledgeable in welfare matters, one person representing welfare recipients and two persons representing the public at large. If the board of county commissioners chooses not to appoint the full committee, a single county welfare adviser may be designated. The advisory committee or welfare adviser would consider welfare

matters of concern to the county and provide advice and recommendations to the county commissioners and to the State Welfare Board on behalf of the commissioners.

State Assistance to Cover Certain County Medical Costs Resulting from Motor Vehicle Accidents.

For several years there has been legislative interest in proposals whereby the state would appropriate funds to relieve the counties of all or part of the burden of medical costs resulting from motor vehicle accidents inside the county involving nonresident transient indigents.

In 1963 and again in 1965, bills on this subject were passed by both houses of the legislature.* The effectiveness of the 1963 bill was contingent on the passage of a sales tax referendum in June of 1963. Since the referendum failed, the act never became effective.

In 1965, the bill was vetoed by the Governor because the method of financing (a surcharge of $1 to be added to each motor vehicle privilege tax collected) was determined to be unconstitutional. The veto was sustained.

The subcommittee has heard testimony from the State Welfare Administrator and several county representatives supporting another attempt at legislation along these lines. Although there were no specific suggestions from these persons regarding sources of financing, it is the feeling of the subcommittee that general fund appropriations, rather than earmarking of specific revenues, should be the source of funding for any bill proposed in 1975.

The subcommittee, supporting the general concept of state assistance for medical costs resulting from motor vehicle accidents involving indigents, has reviewed various alternative approaches to see which would be best suited to Nevada's needs and current governmental structure. Three of the basic questions are, (1) what state agency should administer the program, (2) how much should the county be involved and (3) to whom should coverage extend?

* Senate Bill 97, appearing as chapter 483, Statutes of Nevada 1963; Senate Bill 174 (1965), veto considered at pp. 33-34 of 1967 Senate Journal.

The 1963 bill provided that only nonresident transient indigents would be covered and claims for reimbursement would be made by boards of county commissioners to the State Board of Examiners. The bill would have allowed a maximum of $10,000 per year toward the claims of each county. The appropriation for the 1963-65 biennium would have been $340,000.

The 1965 bill, however, was much more far-reaching. It covered not only nonresident transients, but all indigents injured in motor vehicle accidents, and provided for the filing of claims by the hospitals (on their own behalf and on behalf of the doctors, nurses and pharmacies who had claims in connection with the case). Claims were to be received and processed by the Nevada Industrial Commission. The bill did not contemplate direct county commissioner involvement in the determination of indigency, the decision to ask the state for reimbursement or the review of providers' fees. The approximate amount which would have been available for the program from the motor vehicle privilege tax surcharge, had it been upheld, is estimated at $850,000 for the 1965-67 biennium.

The subcommittee has concluded that there is no longer a need for all of the elaborate provisions of the NIC program proposed in 1965. Now that Nevada has a mandatory-no-fault motor vehicle insurance law and the State Welfare Division has its own medical care unit equipped to deal with claims for medical assistance to indigents, a more limited program--covering only nonresidents and using established Welfare Division administration and collection procedures--should be adequate to help the counties avoid the budgetary uncertainties and occasional fiscal disasters which have plagued them as a result of state laws placing primary financial responsibility in the hands of the county of injury.

The subcommittee envisions a state "motor vehicle accident indigent assistance" program under which the initial effort to collect would be made by the hospitals providing medical care and services to a nonresident transient injured in a motor vehicle accident. If the hospital has difficulty in collecting, the next step would be the district attorney. If neither the district attorney nor the hospital is able to collect on the bill, the district attorney would certify to the State Welfare Division that diligent efforts have been made at the county level and the bill, or a portion thereof, remains unpaid. The claim to the State Welfare Division would be made by the hospital in

accordance with rules and regulations established by the State Welfare Board. Apart from eligibility criteria, such rules and regulations would closely parallel those which set forth procedures to be used in the SAMI program.

If the patient was a nonresident of Nevada, was injured in a motor vehicle accident and the claim otherwise qualifies for "motor vehicle accident indigent assistance" from the state, the Welfare Division would proceed to make payment to the hospital. Then it would be the responsibility of the state, which is better equipped for the task, to take appropriate action to follow through on collections. If the state's collection efforts are unsuccessful, the loss would be absorbed by the state rather than at the individual county level.

Bill C incorporates the above-described features and the subcommittee recommends its enactment in 1975. The subcommittee also suggests that the legislature consider the possibility of eventually broadening the program to include accidents other than motor vehicle accidents, e.g., airplane, boating and mining accidents.

Expanding SAMI to Include Medically Needy Program.

Under Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396 et seq., excerpted in Part IV of the supplement to this report), federal Medicaid matching is available for state medical assistance programs serving the "medically needy" as well as the "categorically needy."

A "medically needy" individual is one who, but for his income and resources, would be eligible for one of the categorical programs and whose income is insufficient to meet the costs of necessary medical and remedial care and services. See 45 C.F.R. § 248.1 (a) (2) in Part V of the supplement to this report.

Coverage for the medically needy is optional, and less than half the states have undertaken to serve this group. The name given the state medical assistance program in Nevada (State Aid to the Medically Indigent--SAMI) is somewhat misleading in this regard, since SAMI in fact does not include the medically needy. State medical assistance has never reached beyond those who could be classified as categorically needy. What coverage there is for the medically needy comes through county general assistance--primarily in Clark and Washoe counties, where the written criteria include specific guidelines for medical assistance

to persons whose income is insufficient to meet necessary medical costs. The county programs are, of course, financed with county funds and are not eligible to receive federal matching.

The subcommittee has been particularly interested in proposals for the expansion of the state's SAMI program to include the optional program of medical assistance for the medically needy. This is a legal possibility if the legislature adopts enabling legislation and provides the necessary funding. Federal matching for the medically needy would be the same as for the categorically needy--on a 50-50 basis.

The subcommittee has noted that inclusion of the medically needy under SAMI would have considerable fiscal and administrative implications and would involve separate state regulations relating to eligibility and coverage for the new group. To add the medically needy to the state program would be to embark on a new concept of need, bringing in a sizable number of new recipients who are not presently eligible for state medical assistance--potential ADC and SSI recipients who have medical costs which reduce their countable income over a maximum 6-month period to a level below an established minimum which remains "protected for maintenance."

Under the medically needy program, an amount equal to 133 1/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources under the state's ADC plan is the income protected for maintenance. All family income over that amount must be applied toward the payment of medical bills. The state's Medicaid program, with federal matching, then pays the remainder of eligible medical costs.

It would not be necessary to provide the medically needy with the full range of medical services now provided to the categorically needy under SAMI. The federal requirement is that, as a minimum, the medically needy be provided either with the five basic items which are mandatory for the categorically needy (inpatient hospital services; outpatient hospital services; laboratory and X-ray services; skilled nursing home services for persons over 21; early and periodic screening and diagnosis and treatment for persons under 21; and family planning services; and physicians' services) or any seven of the total list of items for which federal matching is available. See 42 U.S.C.A. §§ 1396a(a)(13)(C) and 1396d(a) in, Part IV of the supplement to this report.

At the request of the subcommittee and the Clark County Advisory Committee, the State Welfare Division conducted a statistical study in Clark County in an attempt to determine the approximate cost of a medically needy program at the state level in Nevada. The survey was made on a sample basis using information from the Clark County Social Services Department and the records of Southern Nevada Memorial Hospital. The division, however, cautioned that it was not possible to obtain case information in sufficient detail to make the findings accurate enough to justify very much reliance on them.

Nevertheless, the results of the study are reported in Table II as an indication of the costs that might be expected from adoption of both a medically needy and AFDC-U program. The summary shows that 11 percent (77) of the sample (690 cases in Clark County) were usable cases determined to be potentially eligible for a state medically needy program or medical assistance under an AFDC-U program. The average billing for these cases was $1,142.42.

Projecting these findings, the Welfare Division shows an annual potential medically needy and AFDC-U medical caseload of 1,073 in Clark County, at a potential cost of $1,225,817 for emergency room, outpatient, inpatient and convalescent care.

Adding the estimated cost of physicians' fees and other services covered by Title XIX but not paid by the county under its present program, the total cost for the 1,073 in Clark County was estimated at $1,781,711. The state's share would be 50 percent, or $890,856.

Table II--Clark County Medical Study by State Welfare Division

9,750	Cases on Clark County printout C5760301, dated 3/14/74 covering payments 1/73-2/74.
690	Cases originally selected in sample (7 percent).
-445	Cases discarded as "mental hold" or emergency, or cases for which Clark County had no useful record.
245	Cases (35 percent of original sample) remain after discard.
81	Potential cases remain after examination for potential programs (medical assistance for medically needy and AFDC-U).
-4	Discarded (two records not found, two promissory notes).
77	Cases thoroughly examined (11 percent of original sample).
$1,142.42	Average billing per case (emergency room, outpatient, inpatient, convalescent care). $87,966 total.
1,073	Potential cases in Clark County (11 percent times 9,750).
$1,225,817	Potential cost for above services, which amount to 68.8 percent of average costs paid by Title XIX for these and other services.
$1,781,711	Potential costs for all SAMI services (including physicians' fees) to possible eligibles in Clark County.

Clark County equals 56 percent of state population.

$3,181,627 would be potential cost statewide (50 percent federal, 50 percent state).

Source: Nevada State Welfare Division

NOTE: No subsequent inflation factor in any of above amounts.

Assuming that the same conditions would apply statewide, the potential cost for the state as a whole was estimated at $3,181,627 ($1,590,814 state). Some personnel in the State Welfare Division have indicated that this estimate of statewide costs is low, and that the annual cost to the state would be closer to $2.5 million (one-half of a statewide total of $5 million).

The subcommittee recommends that the legislature take action in 1975 to expand the SAMI program so as to include the medically needy group. Bill D is a suggested starting point for legislative consideration of this recommendation.

The subcommittee is mindful of the numerous problems and proposals with which the legislature will be faced and recognizes the necessity for establishing budget priorities among various welfare proposals. The subcommittee also recognizes that developments at the national level in the field of national health insurance may have resulted in changing perspectives by the time the 1975 legislature convenes.

Nevertheless, the subcommittee strongly urges that the legislature look carefully at the possibilities of a state medically needy program with a view to enacting an adequately funded workable program which is in compliance with federal guidelines and will help relieve the counties' medical assistance burden. If the anticipated reversions from ADC and SAMI on July 1, 1975, materialize, the subcommittee feels such a program would be realistic in terms of the state's budget provided there has been no substantial downturn in the economic health of the state in the next few months.

Including More Disabled Persons Under SSI and SAMI.

Many disabled persons, including those who are not institutionalized, have had their SAMI coverage discontinued since the transfer to SSI. This is a group with high medical bills which have fallen back on the counties.

Under SSI the disabled are in a different situation from the aged and the blind because Nevada had not been providing money grants under the Aid to Permanently and Totally Disabled program prior to the federal takeover. This has meant that Nevada could not qualify for federal "hold harmless" funds to help finance a state supplement over and above the basic SSI benefit

level. In the case of the aged and the blind, state supplements have been provided in Nevada with the use of the federal "hold harmless" funds and the benefit level for those groups was maintained or increased from the Old Age Assistance and Aid to the Blind levels previously in effect.

SAMI eligibility for persons whose income is between the SSI level and the supplemented level has been uninterrupted for the aged and the blind. For the disabled who receive no state supplement, however, income within that range has meant disqualification for SAMI benefits.

It is still true that Nevada cannot obtain "hold harmless" funds for the disabled. It would be possible, however, for the legislature to provide state supplementation for the disabled (comparable to that for the aged or the blind) at 100 percent state expense--thereby increasing grants to the disabled and making more disabled individuals eligible under SSI and SAMI. 42 U.S.C.A. § 1382e.

With federally matchable state Medicaid coverage (at the levels of income for which coverage was available prior to SSI, or higher), the counties would be relieved of some of their high medical bills--possibly making greater services available without substantially increasing the overall cost to Nevada taxpayers. County direct assistance costs would also be reduced because more disabled persons would receive SSI grants.

According to the State Welfare Division, the annual cost to the state of providing state supplementation for the disabled would be something under $500,000. This estimate is based on the assumption that the state supplement for the disabled would bring the basic, SSI level (currently $146 per month for an individual) up to the level provided for the aged (currently $185). It includes both the cost of the additional monthly grants and the state's share of the medical assistance costs for the newly eligible individuals.

The subcommittee feels that the disabled should not be discriminated against in SSI and SAMI eligibility and therefore recommends that state supplementation be provided to the disabled at the same level as to the aged. Bill E is designed as enabling legislation to achieve this result.

Increasing State Funding for Chronic Renal Disease Program.

The subcommittee heard testimony concerning the need for a meaningful level of funding for the chronic renal disease program, including renal dialysis and other forms of care and treatment. Because of the extremely high cost of treatment for those who suffer from chronic renal diseases, and because Medicare and Medicaid do not provide full coverage for such costs, the legislature in 1971 enacted a law to provide financial assistance to persons caught in this situation (chapter 457A of NRS). The subcommittee feels the time has come to follow through with what was envisioned in 1971, and accordingly recommends that the legislature appropriate the state dollars necessary to fully implement the program.

The State Welfare Division has provided estimates of the annual cost of covering "unmet need" among chronic renal disease patients in Nevada through implementation of chapter 457A of NRS. "Unmet need" is that portion of the cost of care and treatment which is not otherwise covered by Medicare, Medicaid, CHAMPUS or the Veterans' Administration.

According to the estimates, there are approximately 35 chronic renal disease patients in Nevada each year. Of these, 27 have some degree of "unmet need."

The "unmet need" for those receiving outpatient dialysis is estimated at $274,700 per year and for those receiving home dialysis, $177,128 per year. Additionally, the estimates show "unmet need" of approximately $60,000 per year for those receiving transplants and $10,000 per year for those not requiring regular dialysis but for whom care and treatment are still necessary. Thus the total annual cost to the state for full implementation of chapter 457A of NRS, chronic renal disease program covering "unmet need" is estimated at $521,828.

Program for Aid to Families with Dependent Children, Unemployed Fathers (AFDC-U).

Several times during the subcommittee's deliberations the subject of AFDC-U (Aid to Families with Dependent Children, Unemployed Fathers) coverage was raised. AFDC-U financial grants and medical assistance would be eligible for federal matching if the Nevada legislature were to exercise its option to authorize coverage for this group (the so-called "intact" family).

(See 42 U.S.C.A. §§ 607 in Part I of the supplement to this report and 1396d(a) in Part IV of the supplement. See also the regulations in 45 C.F.R. §§ 233.100 in Part II of the supplement and 248.1 in Part V). Twenty-two states are currently providing grants to AFDC-U families under their state plans.

Proposals in past legislative sessions to expand Nevada's ADC (Aid to Dependent Children) program to include families with unemployed fathers under the provisions of chapter 425 of NRS have failed. The definition of "dependent child" in NRS 425.-030(5) includes a child who has been deprived of parental support or care by reason of "the death, continued absence from the home, or physical or mental incapacity of a parent," but not by reason of the unemployment of his father.

One of the principal reasons for Nevada's hesitation over adding an AFDC-U program has been the added expense to the state. Even though part of the cost would be borne by the Federal Government, more state dollars would be necessary to cover the state's share of (1) the financial grants and (2) the medical assistance provided to the new recipients.

Estimates of the increased caseload and costs which would be generated by an AFDC-U program in Nevada are shown in Tables III and IV. If eligibility were based on the current 61 percent of the ADC standard of need, the number of new recipients would be approximately 1,080. If eligibility were based on 100 percent of the need standard, the new recipients would number approximately 1,350.

Under the provisions of NRS 428.270(3)(a), State Aid to the Medically Indigent (SAMI) would be available to AFDC-U families if they were added to the ADC program authorized by chapter 425 of NRS. Consequently, medical assistance costs as well as the cost of cash grants and administrative and personnel expenses are included in the annual cost estimates.

Table III--AFDC-U Program at 61 Percent of Need Standard

Est. 8 Percent Increase in No. of ADC Recipients Per Month=1,080 Recipients

Item	Est. State Cost	Est. Federal Matching	Est. Total Annual Cost
Cash Grants ($45.25 ave./mo.)	$293,220	$293,220	$ 586,440
Eligibility Workers (3.6 addtl.)	30,674	30,674	61,348
Social Workers (4.5 addtl.)	22,514	67,540	90,054
Program Administration	7,274	10,912	18,186
Medical Assistance Payments ($40 ave./mo.)	259,200	259,200	518,400
Medical Assistance Admin. (5 percent of payments)	12,960	12,960	25,920
Total Per Year	$625,842	$674,506	$1,300,348

* * * * *

Table IV--AFDC-U Program at 100 Percent of Need Standard

Est. 10 Percent Increase in No. of ADC Recipients Per Month=1,350 Recipients

Item	Est. State Cost	Est. Federal Matching	Est. Total Annual Cost
Cash Grants ($74.00 ave./mo.)	$ 599,400	$ 599,400	$1,198,800
Eligibility Workers (4.5 addtl.)	38,342	38,343	76,685
Social Workers (5.6 addtl.)	28,017	84,050	112,067
Program Administration	9,060	13,590	22,650
Medical Assistance Payments ($40 ave./mo.)	324,000	324,000	648,000
Medical Assistance Admin. (5 percent of payments)	16,200	16,200	32,400
Total Per Year	$1,015,019	$1,075,583	$2,090,602

The subcommittee heard testimony from the State Welfare Administrator that coverage of AFDC-U families under chapter 425 of NRS was high on his list of priorities for recommendation to the 1975 legislature. As in the past, others also urged the adoption of the AFDC-U program to assure that federally matched public assistance, including medical assistance, would be available to needy intact families without necessity for a family breakup in order to establish eligibility. County representatives also pointed out that a state AFDC-U program would relieve county taxpayers of that portion of the current general assistance load attributable to families who would fit the AFDC-U category.

In view of the estimates showing that state costs based on the current 61 percent of the standard of need would be approximately $625,000 per year and would result in the availability of federal matching for both financial and medical assistance covering over 1,000 poor people who have been reliant on county welfare departments for help, the subcommittee recommends that the 1975 legislature enact Bill F, initiating an AFDC-U program in the State of Nevada.

The Federal Government imposes a number of precise requirements for AFDC-U eligibility (see Parts I and II of the supplement to this report). For example, the father must have had six or more quarters of work in the preceding 4 years or unemployment compensation during the preceding year, must have been unemployed for at least 30 days, and cannot have refused a bona fide offer of employment without good cause during such 30-day period. The father must register with the public employment office and must continue to seek work.

One item which concerns the subcommittee is the option provided in the federal regulations to exclude those whose unemployment results from participation in a labor dispute. The regulation reads as follows:

> 45 C.F.R. § 233.100 Dependent children of unemployed fathers.
> (a) Requirements for State Plans. If a State wishes to provide AFDC for children of unemployed fathers, the State plan * * * must * * *
> (1) Include a definition of an unemployed father which * * * must include any father who:
> (i) Is employed less than 100 hours a month; * * * except that, at the option of the State,

such definition need not include a father whose unemployment results from participation in a labor dispute or who is unemployed by reason of conduct or circumstances which result or would result in disqualification for unemployment compensation under the State's unemployment compensation law. (Emphasis added.)

* * *

The subcommittee recommends that the legislature give strong consideration to the inclusion of this option in the state AFDC-U program. Detailed hearings should be held during the session to provide an opportunity for presentation of both sides of the question. The subcommittee is particularly concerned about the potential abuses if the state does not accept the option, and is also aware of the unpredictability of caseload projections and budget requirements if those involved in labor disputes are eligible for AFDC-U benefits.

Continuing the County Ad Valorem Tax Levy for Support of the State's Medical Assistance Program.

County representatives expressed to the subcommittee their dissatisfaction with the results of the county ad valorem tax levy of 11 cents per $100 of assessed valuation required by the state to help pay the nonfederal share of the state's Medicaid (Title XIX) program known as SAMI. NRS 428.370 provides:

428.370 Required payments by counties to state.

1. During each fiscal year, commencing July 1, 1969, each county shall pay to the state a sum of money equal to the amount produced by the county's annual levy of 11 cents ad valorem tax on each $100 of assessed valuation of taxable property in the county.

2. The remittance required by subsection 1 shall be made at least quarterly to the state treasurer, who shall deposit the same in the Title XIX fund.

The law was enacted in its present form in 1969. When the levy was first imposed in 1967, as part of the new Medicaid package in Nevada, expectations were that nearly all county medical assistance costs would be shifted to the state program. Since this has not occurred to the extent anticipated, some of the

counties question whether the 11-cent levy should be continued in the face of the counties' own high medical assistance costs for persons not eligible for SAMI.

In fiscal year 1973 the counties remitted the following amounts to the state's Title XIX program pursuant to the provisions of NRS 428.370:

County	Amount of 11-cent SAMI Levy
Carson City	$ 68,481
Churchill	38,268
Clark	1,321,025
Douglas	82,073
Elko	99,825
Esmeralda	9,360
Eureka	16,917
Humboldt	36,742
Lander	36,681
Lincoln	12,568
Lyon	66,922
Mineral	16,721
Nye	133,525
Pershing	24,707
Storey	6,373
Washoe	598,082
White Pine	46,769
Total (Fiscal Year 1973)	$2,615,039

The county levy provided a total of $2,615,039, approximately 45 percent of the $5,848,918 which constituted the nonfederal share of SAMI costs for the state as a whole in fiscal year 1973; the remaining $3,233,879 was paid from the state's general fund.

Since the SAMI program provides medical services to persons who would otherwise be dependent on the counties for assistance, there are reasons for asking the counties to share in financing the nonfederal share of SAMI costs. Only as the counties' own general assistance expenditures for medical care become increasingly burdensome does it become necessary to consider fiscal relief for the counties, either in the form of SAMI expansion (indirectly reducing county medical

assistance costs) or repeal or reduction of the 11-cent SAMI levy. According to testimony received by the subcommittee, county medical assistance costs have now risen to a point where one of these alternatives is imperative.

Therefore, it is the subcommittee's recommendation that the 11-cent SAMI levy be continued if the legislature takes action to initiate a state medically needy program as recommended earlier in this report. If relief is not provided to the counties by enactment of the medically needy program, however, the subcommittee recommends that the legislature give serious and favorable consideration to the repeal of the SAMI levy so that the counties will have more resources with which to meet their medical assistance obligations.

APPENDICES

Appendix A

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Appendix B

TABLE OF ABBREVIATIONS

AB	Aid to the Blind
ADC, AFDC	Aid to Dependent Children, Aid to Families with Dependent Children
AFDC-U	Aid to Families with Dependent Children, Unemployed Fathers
APL	Adjusted Payment Level (SSI)
APTD	Aid to the Permanently and Totally Disabled
CFR	Code of Federal Regulations
CWS	Child Welfare Services
FNS	Food and Nutrition Service, USDA
GA	General Assistance
HEW	U.S. Department of Health, Education, and Welfare
HMO	Health Maintenance Organization
HR 1	Public Law 92-603, the Social Security Amendments of 1972
ICF	Intermediate Care Facilities
NRS	Nevada Revised Statutes
OAA	Old Age Assistance
OASDI	Old Age, Survivors and Disability Insurance
SAMI	State Aid to the Medically Indigent (Nevada's Medicaid)
SNF	Skilled Nursing Facilities
SRS	Social and Rehabilitation Service, U.S. Department of HEW
SSA	U.S. Social Security Administration
SSI	Supplemental Security Income for needy aged, blind and disabled
Title 16 (XVI)	New SSI portion of Social Security Act
Title 18 (XVIII)	Medicare portion of Social Security Act
Title 19 (XIX)	Medicaid portion of Social Security Act
USCA	United States Code Annotated
USDA	U.S. Department of Agriculture
WIN	Work Incentive Program

Appendix C

RECOMMENDATIONS FROM CLARK COUNTY ADVISORY COMMITTEE

The Clark County Advisory Committee to the Legislative Commission's Subcommittee to Study Consolidation of State and Local Welfare Programs made the following recommendations on July 24, 1974:

1. That the state, by administrative or legislative action as necessary, take over from the counties all welfare programs for which the state can obtain federal matching.

2. That the legislature enact legislation to restructure the State Welfare Board so that membership will be apportioned in accordance with the population distribution of the state.

3. That the legislature enact legislation authorizing each board of county commissioners in the state to appoint a county welfare advisory committee. Any county welfare advisory committee so appointed shall be composed of one county commissioner, one county employee who is knowledgeable in welfare matters, one person representing welfare recipients and consumers and two persons representing the public at large. The State Welfare Administrator shall provide to each such county advisory committee, as soon as practicable before each meeting of the State Welfare Board, a copy of the agenda for such meeting.

4. That the legislature enact legislation to require that meetings of the State Welfare Board be held at least 50 percent of the time in Clark County and also to require that two meetings each year be held jointly with the county welfare advisory committee appointed for Clark County.

PROPOSED BILLS

BILL A

SUMMARY--Enlarges state welfare board and specifies certain counties as meeting place for minimum number of board meetings. Fiscal Note: No. (BDR 38-93)

AN ACT relating to the state welfare board; increasing the membership thereof; revising restrictions on geographic distribution of members; specifying certain counties as meeting place for minimum number of board meetings each year; 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 422.070 is hereby amended to read as follows:

422.070 There is hereby created in the welfare division a bipartisan state welfare board composed of [seven] nine members appointed by the governor. Not more than [four] five of such members shall be members of the same political party.

Sec. 2. NRS 422.080 is hereby amended to read as follows:

422.080 The members of the board shall be selected on the basis of their recognized interest in and knowledge of the field of public welfare, and so selected on a geographic basis as to give statewide representation. Not more than [two] three members shall be residents of the same county.

Sec. 3. NRS 422.110 is hereby amended to read as follows:

422.110 1. The members of the board shall meet at such times and at such places as the board, the chairman of the board, the administrator or the director shall deem necessary, but a meeting of the board shall be held at least once each calendar quarter. Each year at least two meetings of the board shall be held in counties having a population of 200,000 or more, as determined by the last preceding national census of the Bureau of the Census of the United States Department of Commerce.

2. [Four] Five members of the board shall constitute a quorum, and such quorum may exercise all the power and authority conferred on the board.

3. The board shall keep minutes of the transactions of each board session, regular or special, which shall be public records and filed with the welfare division.

BILL B

SUMMARY--Permits appointment of county welfare advisory committees or county welfare advisers. Fiscal Note: No. (BDR 38-92)

AN ACT relating to public welfare; permitting boards of county commissioners to appoint county welfare advisory committees or county welfare advisers; establishing qualifications, powers and duties for such appointees; 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. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. As used in this chapter, "county welfare advisory committee" or "county welfare adviser" means a committee or adviser appointed by a board of county commissioners pursuant to the provisions of section 3 of this act.

Sec. 3. 1. The board of county commissioners of any county may appoint a county welfare advisory committee composed of five members. One member shall be a member of the board of county commissioners, one shall be a county employee knowledgeable in welfare matters, one shall be a person representing

welfare recipients and two shall be persons representing the public at large. The board of county commissioners shall designate one of the members of the advisory committee to serve as chairman. Members shall serve at the pleasure of the board of county commissioners. The county welfare advisory committee shall consider state and local welfare matters of concern to the county and may provide advice and recommendations thereon to the board of county commissioners and to the state welfare board on behalf of the board of county commissioners.

2. In any county wherein no county welfare advisory committee has been appointed pursuant to the provisions of subsection 1, the board of county commissioners may designate a county welfare adviser. Such adviser may be, but is not required to be, a member of the board of county commissioners or an employee of the county. The adviser shall serve at the pleasure of the board of county commissioners. A county welfare adviser may provide advice and recommendations on state and local welfare matters to the board of county commissioners and to the state welfare board on behalf of the board of county commissioners.

Sec. 4. NRS 422.020 is hereby amended to read as follows:

422.020 As used in this chapter, "county boards" means county advisory boards [.] <u>established pursuant to NRS 422.-300 to advise on child welfare matters.</u>

BILL C

SUMMARY--Establishes a state motor vehicle accident indigent assistance program. Fiscal Note: Yes. (BDR 38-102)

AN ACT relating to state motor vehicle accident indigent assistance; providing procedures for hospitals applying for such assistance; prescribing certain duties of district attorneys in connection therewith; providing the powers and duties of the state welfare division in administering the program; establishing a motor vehicle accident indigent fund; 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. Chapter 428 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 16, inclusive, of this act.

Sec. 2. As used in sections 2 to 16, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 11, inclusive, of this act have the meanings ascribed to them in such sections.

Sec. 3. "Applicant" means a hospital which has applied for assistance under sections 2 to 16, inclusive, of this act.

Sec. 4. "Assistance" means state motor vehicle accident indigent assistance.

Sec. 5. "Division" means the welfare division of the department of human resources.

Sec. 6. "Hospital" means an establishment which is staffed and equipped to provide for diagnosis, care and treatment of all stages of human illness and which provides 24-hour medical care.

Sec. 7. "Indigent" means a nonresident of the State of Nevada who has suffered an injury while traveling through the state and who is unable to pay the cost of inpatient hospital care furnished to him by a hospital on account of such injury.

Sec. 8. "Injury" means any personal injury suffered by an individual, and accidentally caused in, by or as the proximate result of the movement of a motor vehicle on a public street or highway within this state, whether the injured person is the operator of the vehicle, a passenger in the vehicle or another vehicle, a pedestrian, or whatever the relationship of the injured person to the movement of the vehicle, and whether or not the vehicle is under the control of an individual at the time of the injury.

Sec. 9. "Inpatient hospital care" means:

1. Inpatient hospital services consisting of the following items furnished to an inpatient in a hospital:

(a) Bed and board;

(b) Drugs; and

(c) All in-hospital services including anesthesia, nursing services, equipment, supplies, laboratory and radiological services, whether furnished directly by the hospital or by contractual arrangement made by the hospital; and

2. Services of a physician rendered to or in behalf of an inpatient in a hospital.

Sec. 10. "Motor vehicle" means every vehicle which is self-propelled but not operated upon rails.

Sec. 11. "State motor vehicle accident indigent assistance" means the payment by the state of part or all of the cost of inpatient hospital care furnished to an indigent as provided in sections 2 to 16, inclusive, of this act and in the rules and regulations of the division.

Sec. 12. In motor vehicle accident cases wherein a non-resident transient individual traveling through the State of Nevada suffers an injury and is furnished inpatient hospital care on account of such injury, the hospital furnishing such

care shall use reasonable diligence to collect the entire cost of such care from the patient or any other person responsible for his support. Any private physician whose services were rendered as a part of such inpatient hospital care may designate the hospital as his agent for collection in the case. If the account or any portion thereof remains unpaid at the expiration of 60 days after the termination of the care, the hospital may request the district attorney for the county in which the hospital is located to make an indigency determination as provided in section 13 of this act.

Sec. 13. 1. A district attorney who receives a request for an indigency determination as provided in section 12 of this act shall proceed forthwith to determine whether the individual qualifies as an indigent as defined in section 7 of this act. An individual is deemed unable to pay the cost of inpatient hospital care if it appears that, upon due and diligent search and inquiry, he, or any other person responsible for his support, cannot be found for service of summons or that, should an action be brought and judgment secured against him, or against any person responsible for his support, for the amount of the unpaid charges, execution thereon would be unavailing.

2. If the district attorney, upon investigation, determines that the individual qualifies as an indigent as defined in section 7 of this act, he shall so certify in writing to the hospital requesting such determination.

Sec. 14. 1. Upon receipt of a certification from the district attorney that the individual qualifies as an indigent, the hospital may apply to the division for assistance in the payment of the cost of inpatient hospital care furnished to such indigent.

2. Each application for assistance shall be in such form and contain such information as the division may require, and shall be accompanied by the certification of indigency submitted by the district attorney.

3. The division may adopt necessary guidelines and regulations to effectuate the provisions of this section and may utilize procedures and fee schedules similar to those established for the administration of NRS 428.150 to 428.370, inclusive.

Sec. 15. 1. Applications for assistance made pursuant to section 14 of this act shall be reviewed by the division and, if approved, payment shall be made to the applicant from the motor vehicle accident indigent fund hereby created in the state treasury.

2. Moneys for the motor vehicle accident indigent fund shall be provided by direct legislative appropriation from the general fund.

Sec. 16. After an application for assistance has been approved for payment, the division may take action to collect the amount due for inpatient hospital care furnished the indigent. Amounts recovered by the division shall be deposited in the motor vehicle accident indigent fund.

Sec. 17. NRS 428.090 is hereby amended to read as follows:

428.090 1. When any nonresident or any other person who meets the uniform standards of eligibility prescribed by the board of county commissioners falls sick in the county, not having money or property to pay his board, nursing or medical aid, the board of county commissioners of the proper county shall, on complaint being made, give or order to be given such assistance to the poor person as is in accordance with the policies and standards established and approved by the board of county commissioners and within the limits of funds which may be lawfully appropriated for this purpose pursuant to NRS 428.050.

2. If such sick person shall die, then the board of county commissioners shall give or order to be given to such person a decent burial.

3. The board of county commissioners shall make such allowance for board, nursing, medical aid or burial expenses as the board shall deem just and equitable, and order the same to be paid out of the county treasury.

4. The responsibility of the board of county commissioners to provide medical aid or any other type of remedial aid under this section shall be relieved to the extent of the amount of money or the value of services provided by the welfare division of the department of human resources to or for such persons for medical care or any type of remedial care under the provisions of NRS 428.150 to 428.370, inclusive [.] or sections 2 to 16, inclusive, of this act.

BILL D

SUMMARY--Extends coverage of state aid to medically indigent to include certain additional individuals. Fiscal Note: Yes. (BDR 38-90)

AN ACT relating to state aid to the medically indigent; extending coverage to certain additional individuals who have insufficient income and resources to meet the costs of necessary medical and remedial care and services; 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 428.270 is hereby amended to read as follows:

428.270 1. State aid to the medically indigent shall be in effect in all of the counties of the state for individuals specified in subsection 2.

2. [Until December 31, 1973, any individual is eligible for assistance who:

(a) Qualified for aid or service under chapters 425, 426 or 427 of NRS, including individuals over 65 years of age in state tuberculosis or mental institutions; or

(b) Would qualify under such chapters except for duration of residence, lien requirements or responsible relative requirements; or

(c) Would qualify for aid or service as totally disabled, pursuant to Title XIV of the Social Security Act (42 U.S.C. §§ 1351-1355), if such a program were in effect in this state; or

(d) Is under the age of 21 years, medically indigent, not eligible for assistance under chapter 425 of NRS, and who belongs to a group classification which the board has determined can benefit by medical or remedial care.

3. Beginning on January 1, 1974, any] Any individual is eligible for assistance who:

(a) [Qualified] Qualifies for aid or service under chapter 425 of NRS ; [and, as]

(b) As the welfare division by regulation may provide [:

(1) Qualified under] , qualifies:

(1) Under Title XVI of the Social Security Act [as amended by section 301 of P.L. 92-603, October 30, 1972,] (42 U.S.C. §§ 1381-1383c), relating to supplemental security income for the aged, blind and disabled, including individuals over 65 years of age in state tuberculosis or mental institutions; or

(2) [Qualified under] Under the standard for medical assistance in effect in this state on January 1, 1972, pursuant to section 209 of P.L. 92-603; [or

(b)] (c) Is under the age of 21 years, medically indigent, not eligible for assistance under chapter 425 of NRS, and belongs to a group classification which the board has determined can benefit by medical or remedial care [.] ; or

(d) Would, except for financial eligibility, qualify for aid or service under chapter 425 of NRS or for supplemental security income benefits pursuant to Title XVI of the Social Security Act (42 U.S.C. §§ 1381-1383c), including state supplementary assistance payments thereunder, and who has insufficient income and resources to meet the costs of necessary medical and remedial care and services. As provided by regulation of the welfare division, an individual has insufficient income and resources to meet the costs of necessary medical and remedial care and services if his family income after deduction or exclusion of allowable deductions does not exceed 133 1/3 percent of the highest amounts ordinarily paid under chapter 425 of NRS to a family of the same size without any income or resources or, in the case of a single individual, if his income does not exceed an income level reasonably related to the amounts ordinarily paid under chapter 425 of NRS to families consisting of two or more individuals without income or resources.

BILL E

SUMMARY--Makes state supplementary assistance payments and state medical assistance available to certain needy disabled persons. Fiscal Note: Yes. (BDR 38-91)

AN ACT relating to public welfare; providing for state supplementary assistance payments to certain needy disabled persons; including persons receiving state supplementary assistance payments as eligible for state medical assistance; 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. Chapter 422 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. State supplementary assistance payments shall be provided to disabled persons who are receiving supplementary security income benefits under Title XVI of the Social Security Act (42 U.S.C. §§ 1381-1383c), or who would but for their income be eligible to receive such benefits. The level of state supplementary assistance payments for disabled persons shall be the same as the state supplement provided to aged persons in equivalent circumstances and shall not be otherwise affected by the availability or nonavailability of federal participation in funding such payments.

2. The department, through the welfare division, may enter into agreements with the Federal Government as necessary to effect the provisions of subsection 1 and shall make rules and regulations for the administration of state supplementary assistance payments for eligible disabled persons.

Sec. 2. NRS 428.270 is hereby amended to read as follows:

428.270 1. State aid to the medically indigent shall be in effect in all of the counties of the state for individuals specified in subsection 2.

2. [Until December 31, 1973, any individual is eligible for assistance who:

(a) Qualified for aid or service under chapters 425, 426 or 427 of NRS, including individuals over 65 years of age in state tuberculosis or mental institutions; or

(b) Would qualify under such chapters except for duration of residence, lien requirements or responsible relative requirements; or

(c) Would qualify for aid or service as totally disabled, pursuant to Title XIV of the Social Security Act (42 U.S.C. §§ 1351-1355), if such a program were in effect in this state; or

(d) Is under the age of 21 years, medically indigent, not eligible for assistance under chapter 425 of NRS, and who

belongs to a group classification which the board has determined can benefit by medical or remedial care.

3. Beginning on January 1, 1974, any] Any individual is eligible for assistance who:

(a) [Qualified] Qualifies for aid or service under chapter 425 of NRS ; [and, as]

(b) As the welfare division by regulation may provide [:

(1) Qualified under] , qualifies:

(1) Under Title XVI of the Social Security Act [as amended by section 301 of P.L. 92-603, October 30, 1972,] (42 U.S.C. §§ 1381-1383c), relating to supplemental security income for the aged, blind and disabled, including individuals over 65 years of age in state tuberculosis or mental institutions [; or

(2) Qualified under] and including individuals for whom the state provides state supplementary assistance payments; or

(2) Under the standard for medical assistance in effect in this state on January 1, 1972, pursuant to section 209 of P.L. 92-603; or

[(b)] (c) Is under the age of 21 years, medically indigent, not eligible for assistance under chapter 425 of NRS, and

belongs to a group classification which the board has determined can benefit by medical or remedial care.

BILL F

SUMMARY--Expands aid to dependent children program to include dependent children of unemployed fathers. Fiscal Note: Yes. (BDR 38-94)

AN ACT relating to aid to dependent children; expanding definition of "dependent child" to include needy child deprived of parental support or care by reason of unemployment of his father; 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 425.030 is hereby amended to read as follows:

425.030 As used in this chapter:

1. "Applicant" means any person who has applied for assistance under this chapter.

2. "Assistance" means money payments with respect to, or medical care in behalf of, or any type of remedial care recognized under state law in behalf of, a dependent child or dependent children, and includes money payments or medical care or any type of remedial care recognized under state law for any month to meet the needs of the relative with whom any dependent child is living if money payments have been made with respect to such child for such month.

3. "Board" means the state welfare board.

4. "Department" means the department of human resources.

5. "Dependent child" means:

(a) A needy child under the age of 18 years, or under the age of 21 years if found by the department to be regularly attending a school, college or university, or regularly attending a course of vocational or technical training designed to fit him for gainful employment, who has been deprived of parental support or care by reason of the death, continued absence from the home, [or] physical or mental incapacity of a parent [,] or unemployment of his father, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew or niece, in a place of residence maintained by one or more of such relatives as his or their own home; or

(b) A child removed from the home of a relative designated in paragraph (a) after April 30, 1961, as a result of a judicial determination that continuance in the home of the relative would be contrary to his welfare for any reason, and who has been placed in foster care as the result of such determination, if the child was receiving aid to dependent children

in or for the month in which the court action was initiated or would have received aid to dependent children if the application had been made, or who lived with a relative designated in paragraph (a) within 6 months prior to the month in which court action was initiated, and who would have received aid to dependent children in the month court action was initiated if he were still living with the relative and application for assistance had been made, provided the custody of such child has been placed with the welfare division by court order.

6. "Director" means the director of the department of human resources.

7. "Recipient" means any person who has received or is receiving assistance.

8. "Welfare division" means the welfare division of the department of human resources.

Supplement to Final Report of the Subcommittee for Study of Consolidation of State and Local Welfare Programs

Bulletin No. 115

Legislative Commission
of the
Legislative Counsel Bureau
State of Nevada

September 1974

Table of Contents

I

FEDERAL STATUTES--AFDC, AFDC-U, EMERGENCY ASSISTANCE

[Excerpts from 42 U.S.C.A. § 601 et seq., amended through 1973--Title IV-A of Social Security Act]

* * *

§ 603. Payment to States; computation of amounts; Federal share of assistance payments; social and supportive services; appropriation; family planning services and supplies; reduction of amounts

(a) From the sums appropriated therefor, the Secretary of the Treasury shall (subject to section 1320b of this title) pay to each State which has an approved plan for aid and services to needy families with children, for each quarter, beginning with the quarter commencing October 1, 1958—

(1) in the case of any State other than Puerto Rico, the Virgin Islands, and Guam, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as aid to families with dependent children under the State plan (including expenditures for premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)—

Federal Matching for ADC Cash Grants--$15 of first $18

(A) five-sixths of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of $18 multiplied by the total number of recipients of aid to families with dependent children for such month (which total number, for purposes of this subsection, means (i) the number of individuals with respect to whom such aid in the form of money payments is paid for such month, plus (ii) the number of other individuals with respect to whom expenditures were made in such month as aid to families with dependent children in the form of medical or any other type of remedial care, plus (iii) the number of individuals, not counted under clause (i) or (ii), with respect to whom payments described in section 606(b) (2) of this title are made in such month and included as expenditures for purposes of this paragraph or paragraph (2)); plus

and

$7 of next $14

(B) the Federal percentage of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds (i) the product of $32 multiplied by the total number of recipients of aid to families with dependent children (other than such aid in the form of foster care) for such month, plus (ii) the product of $100 multiplied by the total number of recipients of aid to families with dependent children in the form of foster care for such month; and

(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to families with dependent children under the State plan (including expenditures for premiums under part B of subchapter XVIII of this chapter for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof), not counting so much of any expenditure with respect to any month as exceeds $18 multiplied by the total number of recipients of such aid for such month; and

(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan—

75 Percent Federal Matching for Social Services

(A) 75 per centum of so much of such expenditures as are for—

(i) any of the services described in clauses (14) and (15) of section 602(a) of this title which are provided to any child or relative who is receiving aid under the plan, or to any other individual (living in the same home as such relative and child) whose needs are taken into account in making the determination under clause (7) of such section,

(ii) any of the services described in clauses (14) and (15) of section 602(a) of this title which are provided to any child or relative who is applying for aid to families with dependent children or who, within such period or periods as the Secretary may prescribe, has been or is likely to become an applicant for or recipient of such aid, or

(iii) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision; plus

50 Percent Federal Matching for Cash Grants

(B) one-half of the remainder of such expenditures.

The services referred to in subparagraph (A) shall include only—

(C) services provided by the staff of the State agency, or of the local agency administering the State plan in the political subdivision: *Provided*, That no funds authorized under this part shall be available for services defined as vocational rehabilitation services under the Vocational Rehabilitation Act (i) which are available to individuals in

need of them under programs for their rehabilitation carried on under a State plan approved under such Act, or (ii) which the State agency or agencies administering or supervising the administration of the State plan approved under such Act are able and willing to provide if reimbursed for the cost thereof pursuant to agreement under subparagraph (D), if provided by such staff, and

(D) under conditions which shall be prescribed by the Secretary, services which in the judgment of the State agency cannot be as economically or as effectively provided by the staff of such State or local agency and are not otherwise reasonably available to individuals in need of them, and which are provided, pursuant to agreement with the State agency, by the State health authority or the State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act or by any other State agency which the Secretary may determine to be appropriate (whether provided by its staff or by contract with public (local) or nonprofit private agencies);

except that services described in clause (ii) of subparagraph (C) hereof may be provided only pursuant to agreement with such State agency or agencies administering or supervising the administration of the State plan for vocational rehabilitation services so approved; and except that, to the extent specified by the Secretary, child-welfare services, family planning services, and family services may be provided from sources other than those referred to in subparagraphs (C) and (D). The portion of the amount expended for administration of the State plan to which subparagraph (A) applies and the portion thereof to which subparagraph (B) applies shall be determined in accordance with such methods and procedures as may be permitted by the Secretary.

(4) Repealed. Pub.L. 90–248, Title II, § 201(e)(3), Jan. 2, 1968, 81 Stat. 880.

50 Percent Federal Matching for Emergency Assistance Program

(5) in the case of any State, an amount equal to 50 per centum of the total amount expended under the State plan during such quarter as emergency assistance to needy families with children.

The number of individuals with respect to whom payments described in section 606(b) (2) of this title are made for any month, who may be included as recipients of aid to families with dependent children for purposes of paragraph (1) or (2), may not exceed 10 per centum of the number of other recipients of aid to families with dependent children for such month. In computing such 10 percent, there shall not be taken into account individuals with respect to whom such payments are made for any month in accordance with section 602(a) (19) (F) of this title.

* * *

§ 606. Definitions

When used in this part—

(a) The term "dependent child" means a needy child (1) who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece, in a place of residence maintained by one or more of such relatives as his or their own home, and (2) who is (A) under the age of eighteen, or (B) under the age of twenty-one and (as determined by the State in accordance with standards prescribed by the Secretary) a student regularly attending a school, college, or university, or regularly attending a course of vocational or technical training designed to fit him for gainful employment;

(b) The term "aid to families with dependent children" means money payments with respect to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, a dependent child or dependent children, and includes (1) money payments or medical care or any type of remedial care recognized under State law to meet the needs of the relative with whom any dependent child is living (and the spouse of such relative if living with him and if such relative is the child's parent and the child is a dependent child by reason of the physical or mental incapacity of a parent or is a dependent child under section 607 of this title), and (2) payments with respect to any dependent child (including payments to meet the needs of the relative, and the relative's spouse, with whom such child is living, and the needs of any other individual living in the same home if such needs are taken into account in making the determination under

section 602(a)(7) of this title) which do not meet the preceding requirements of this subsection, but which would meet such requirements except that such payments are made to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such child or relative, or are made on behalf of such child or relative directly to a person furnishing food, living accommodations, or other goods, services, or items to or for such child, relative, or other individual, but only with respect to a State whose State plan approved under section 602 of this title includes provision for—

(A) determination by the State agency that the relative of the child with respect to whom such payments are made has such inability to manage funds that making payments to him would be contrary to the welfare of the child and, therefore, it is necessary to provide such aid with respect to such child and relative through payments described in this clause (2);

(B) undertaking and continuing special efforts to develop greater ability on the part of the relative to manage funds in such manner as to protect the welfare of the family;

(C) periodic review by such State agency of the determination under clause (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1311 of this title, if and when it appears that the need for such payments is continuing, or is likely to continue, beyond a period specified by the Secretary;

(D) aid in the form of foster home care in behalf of children described in section 608(a) of this title; and

(E) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made;

(c) The term "relative with whom any dependent child is living" means the individual who is one of the relatives specified in subsection (a) of this section and with whom such child is living (within the meaning of such subsection) in a place of residence maintained by such individual (himself or together with any one or more of the other relatives so specified) as his (or their) own home.

(d) The term "family services" means services to a family or any member thereof for the purpose of preserving, rehabilitating, reuniting, or strengthening the family, and such other services as will assist members of a family to attain or retain capability for the maximum self-support and personal independence.

Definition of Emergency Assistance (Optional Program)

(e) (1) The term "emergency assistance to needy families with children" means any of the following, furnished for a period not in excess of 30 days in any 12-month period, in the case of a needy child under the age of 21 who is (or, within such period as may be specified by the Secretary, has been) living with any of the relatives specified in subsection (a) (1) of this section in a place of residence maintained by one or more of such relatives as his or their own home, but only where such child is without available resources, the payments, care, or services involved are necessary to avoid destitution of such child or to provide living arrangements in a home for such child, and such destitution or need for living arrangements did not arise because such child or relative refused without good cause to accept employment or training for employment—

(A) money payments, payments in kind, or such other payments as the State agency may specify with respect to, or medical care or any other type of remedial care recognized under State law on behalf of, such child or any other member of the household in which he is living, and

(B) such services as may be specified by the Secretary;

but only with respect to a State whose State plan approved under section 602 of this title includes provision for such assistance.

(2) Emergency assistance as authorized under paragraph (1) may be provided under the conditions specified in such paragraph to migrant workers with families in the State or in such part or parts thereof as the State shall designate.

AFDC-U Program--Optional Program

§ 607. Dependent children of unemployed fathers; definition

(a) The term "dependent child" shall, notwithstanding section 606 (a) of this title, include a needy child who meets the requirements of section 606(a) (2) of this title, who has been deprived of parental support or care by reason of the unemployment (as determined in accordance with standards prescribed by the Secretary) of his father, and who is living with any of the relatives specified in section 606(a) (1) of this title in a place of residence maintained by one or more of such relatives as his (or their) own home.

(b) The provisions of subsection (a) of this section shall be applicable to a State if the State's plan approved under section 602 of this title—

(1) requires the payment of aid to families with dependent children with respect to a dependent child as defined in subsection (a) of this section when—

(A) such child's father has not been employed (as determined in accordance with standards prescribed by the Secretary) for at least 30 days prior to the receipt of such aid,

(B) such father has not without good cause, within such period (of not less than 30 days) as may be prescribed by the Secretary, refused a bona fide offer of employment or training for employment, and

(C) (i) such father has 6 or more quarters of work (as defined in subsection (d) (1) of this section) in any 13-calendar-quarter period ending within one year prior to the application for such aid or (ii) he received unemployment compensation under an unemployment compensation law of a State or of the United States, or he was qualified (within the meaning of subsection (d) (3) of this section) for unemployment compensation under the unemployment compensation law of the State, within one year prior to the application for such aid; and

(2) provides—

(A) for such assurances as will satisfy the Secretary that fathers of dependent children as defined in subsection (a) of this section will be referred to the Secretary of Labor as provided in section 602(a) (19) of this title within thirty days after receipt of aid with respect to such children;

(B) for entering into cooperative arrangements with the State agency responsible for administering or supervising the administration of vocational education in the State, designed to assure maximum utilization of available public vocational education services and facilities in the State in order to encourage the retraining of individuals capable of being retrained; and

(C) for the denial of aid to families with dependent children to any child or relative specified in subsection (a) of this section—

(i) if, and for so long as, such child's father is not currently registered with the public employment offices in the State, and

(ii) with respect to any week for which such child's father receives unemployment compensation under an unemployment compensation law of a State or of the United States.

(c) Notwithstanding any other provisions of this section, expenditures pursuant to this section shall be excluded from aid to families with dependent children (A) where such expenditures are made under the plan with respect to any dependent child as defined in subsection (a) of this section, (i) for any part of the 30-day period referred to in subparagraph (A) of subsection (b) (1) of this section, or (ii) for any period prior to the time when the father satisfies subparagraph (B) of such subsection, and (B) if, and for as long as, no action is taken (after the 30-day period referred to in subparagraph (A) of subsection (b) (2) of this section), under the program therein specified to refer such father to the Secretary of Labor pursuant to section 602(a) (19) of this title.

(d) For purposes of this section—

(1) the term "quarter of work" with respect to any individual means a calendar quarter in which such individual received earned income of not less than $50 (or which is a "quarter of coverage" as defined in section 413(a) (2) of this title), or in which such individual participated in a community work and training program under section 609 of this title or any other work and training program subject to the limitations in section 609 of this title, or the work incentive program established under part C;

(2) the term "calendar quarter" means a period of 3 consecutive calendar months ending on March 31, June 30, September 30, or December 31; and

(3) an individual shall be deemed qualified for unemployment compensation under the State's unemployment compensation law if—

(A) he would have been eligible to receive such unemployment compensation upon filing application, or

(B) he performed work not covered under such law and such work, if it had been covered, would (together with any covered work he performed) have made him eligible to receive such unemployment compensation upon filing application.

* * *

II

FEDERAL REGULATIONS--AFDC-U

[45 CFR § 233.100]

§ 233.100 Dependent children of unemployed fathers.

(a) *Requirements for State Plans.* If a State wishes to provide AFDC for children of unemployed fathers, the State plan under Title IV—Part A of the Social Security Act must, except as specified in paragraph (b) of this section:

(1) Include a definition of an unemployed father which shall apply only to families determined to be needy in accordance with the provisions in § 233.20 of this chapter. Such definition must include any father who:

(i) Is employed less than 100 hours a month; or

(ii) Exceeds that standard for a particular month, if his work is intermittent and the excess is of a temporary nature as evidenced by the fact that he was under the 100-hour standard for the prior 2 months and is expected to be under the standard during the next month;

except that, at the option of the State, such definition need not include a father whose unemployment results from participation in a labor dispute or who is unemployed by reason of conduct or circumstances which result or would result in disqualification for unemployment compensation under the State's unemployment compensation law.

(2) Include a definition of a dependent child which shall include any child of an unemployed father (as defined by the State pursuant to subparagraph (1) of this paragraph) who would be, except for the fact that his parent is not dead, absent from the home, or incapacitated, a dependent child under the State's plan approved under section 402 of the Act.

(3) Provide for payment of aid with respect to any dependent child (as defined by the State pursuant to subparagraph (2) of this paragraph) when the conditions set forth in subdivisions (i), (ii), and (iii) of this subparagraph are met:

(i) His father has been unemployed for at least 30 days prior to the receipt of such aid.

(ii) Such father has not without good cause, within such 30-day period prior to the receipt of such aid, refused a bona fide offer of employment or training for employment. Before it is determined that a father has refused a bona fide offer of employment or training for employment without good cause, the agency must make a determination that such an offer was actually made. (In the case of offers of employment made through the public employment or manpower agencies, the determination as to whether the offer was bona fide, or whether there was good cause to refuse it, will be made by that office or agency.) The father must be given an opportunity to explain why such offer was not accepted. Questions with respect to the following factors must be resolved:

(*a*) That there was a definite offer of employment at wages meeting any applicable minimum wage requirements and which are customary for such work in the community;

(*b*) Any questions as to the father's inability to engage in such employment for physical reasons or because he has no way to get to or from the particular job; and

(*c*) Any questions of working conditions, such as risks to health, safety, or lack of workman's compensation protection.

(iii) Such father (*a*) has six or more quarters of work (as defined in subdivision (iv) of this subparagraph), within any 13-calendar-quarter period ending within 1 year prior to the application for such aid, or (*b*) within such 1-year period, received unemployment compensation under an unemployment compensation law of a State or of the United States, or was qualified under the terms of subdivision (v) of this subparagraph) for such compensation under the State's unemployment compensation law.

(iv) A "quarter of work" with respect to any individual means a period (of 3 consecutive calendar months ending on

March 31, June 30, September 30, or December 31) in which he received earned income of not less than $50 (or which is a "quarter of coverage" as defined in section 213(a)(2) of the Act), or in which he participated in a community work and training program under section 409 of the Act or any other work and training program subject to the limitations in such section 409, or the work incentive program established under part C of title IV of the Act.

(v) An individual shall be deemed "qualified" for unemployment compensation under the State's unemployment compensation law if he would have been eligible to receive such benefits upon filing application, or he performed work not covered by such law which, if it had been covered, would (together with any covered work he performed) have made him eligible to receive such benefits upon filing application.

(4) Provide for entering into cooperative arrangements with the State agency responsible for administering or supervising the administration of vocational education to assure maximum utilization of available public vocational education services and facilities in the State to encourage the retraining of individuals capable of being retrained.

(5) Provide for the denial of such aid to any such dependent child or the relative specified in section 406(a)(1) of the Act with whom such child is living,

(i) If, and for as long as, such child's father is not currently registered with the public employment offices in the State, and

(ii) With respect to any week for which such child's father receives unemployment compensation under an unemployment compensation law of a State or of the United States.

(6) Provide that within 30 days after the receipt of aid with respect to such children, such unemployed fathers will be certified for participation in the Work Incentive Program, as provided in section 402(a)(19) of the Act and the regulations relating thereto.

(7) Provide, where application for aid with respect to a dependent child (as defined by the State pursuant to subparagraph (2) of this paragraph) is made within 6 months after the effective date of the modification of the State plan in accordance with the provisions in subparagraphs (1) through (6) of this paragraph, that the father of such child will be considered to have met the requirements of subparagraph (3)(iii) of this paragraph if he met such requirements at any time after April 1961 and prior to the date of such application.

(8) Provide, if the approved State plan in effect prior to January 1, 1968, including aid with respect to dependent children of unemployed parents, that for purposes of subparagraph (7) of this paragraph an individual who received such aid under such plan for the last month ending before the effective date of the modification referred to in subparagraph (7) of this section will be considered to have filed application for aid under the plan as modified on the day after such effective date.

(b) *Exception.* Under the law, a State which had in operation an AFDC-Unemployed Parent Program under title IV of the Act at any time during the period October 1–December 31, 1967, is not required prior to July 1, 1969, to include any additional child or family under its approved State plan, by reason of the requirements set forth in paragraph (a) of this section.

(c) *Federal financial participation.* (1) Federal financial participation is available in payments authorized in accordance with the State plan approved under section 402 of the Act as aid to families with dependent children with respect to a child.

(i) Who meets the requirements of section 406(a)(2) of the Act;

(ii) Who is living with any of the relatives specified in section 406(a)(1) of the Act in a place of residence maintained by one or more of such relatives as his (or their) own home;

(iii) Who has been deprived of parental support or care by reason of the fact that his father is employed less than 100 hours a month; or, exceeds that standard for a particular month if his work is intermittent and the excess is of a temporary nature as evidenced by the fact that he was under the 100-hour standard for 2 prior months and is expected to be under the standard during the next month.

(iv) Whose father (*a*) has six or more quarters of work (as defined in paragraph (a)(3)(iv) of this section) within any 13-calendar-quarter period ending within 1 year prior to the application for such aid, (*b*) within such 1-year

period, received unemployment compensation under an unemployment compensation law of a State or of the United States, or was qualified (under the terms of paragraph (a)(3)(v) of this section) for such compensation under the State's unemployment compensation law, or (c) is an individual whose application for aid was made within the period referred to in paragraph (a) (7) or (8) of this section and who by virtue of the requirements in such paragraph (a) (7) or (8) would be considered to have met the conditions in subdivision (iv) (*a*) or (*b*) of this subparagraph; and

(v) Whose father (*a*) is currently registered with the public employment offices in the State, and (*b*) with respect to any week, does not receive unemployment compensation under an unemployment compensation law of a State or of the United States.

(2) The State may not include in its claim for Federal financial participation payments made as aid under the plan with respect to a child who meets the conditions set forth in subparagraph (1) of this paragraph, where such payments were made

(i) For any part of the 30 day period prior to the receipt of such payment, if during such period his father was not unemployed (as defined by the State pursuant to paragraph (a)(1) of this section);

(ii) For such 30-day period, if during such periods his father refused without good cause a bona fide offer of employment or training for employment; and

(iii) For any period beginning with the 31st day after the receipt of such aid, if and for as long as no action is taken during such period to certify his father for participation in the Work Incentive Program as provided in section 402(a)(19) of the Act and the regulations relating thereto.

III

FEDERAL REGULATIONS--EMERGENCY ASSISTANCE

[45 CFR § 233.120]

§ 233.120 Emergency assistance to needy families with children.

(a) *Requirements for State plans.* A State plan under Title IV, Part A, of the Social Security Act, providing for emergency assistance to needy families with children must:

(1) Specify the eligibility conditions imposed for the receipt of emergency assistance. These conditions may be more liberal than those applicable to other parts of the plan. (See paragraph (b)(1) of this section for scope of Federal financial participation.)

(2) Specify if migrant workers with families will be included and, if emergency assistance will not be available to them Statewide, the part or parts of the State in which it will be provided.

(3) Specify the emergency needs that will be met, whether mass feeding or clothing distribution are included, and the methods of providing payments, medical care, and other remedial care.

(4) Specify which of the following services will be provided: Information, referral, counseling, securing family shelter, child care, legal services, and any other services that meet needs attributable to the emergency or unusual crisis situations.

(5) Provide that emergency assistance will be given forthwith.

(b) *Federal financial participation.* Beginning with the effective date of approval of the amendment to the State plan for AFDC which provides for emergency assistance to needy families with children pursuant to section 406(e) of the Act:

(1) Federal financial participation is available for emergency assistance to or on behalf of a needy child under the age of 21 and any other member of the household in which he is living if—

(i) Such child is (or, within 6 months prior to the month in which such assistance is requested, has been) living with any of the relatives specified in section 406(a)(1) of the Act in a place of residence maintained by one or more of such relatives as his or their own home,

1972 Amendment to Statute Reduced Matching to 50 Percent

(ii) Such child is without resources immediately accessible to meet his needs,

(iii) The emergency assistance is necessary to avoid destitution of such child or to provide living arrangements for him in a home, and

(iv) His destitution or need for living arrangements did not arise because he or such relative refused without good cause to accept employment or training for employment.

(2) The rate of Federal financial participation in expenditures during a quarter as emergency assistance in accordance with the provisions of an approved State plan is:

(i) 50 percent of the total amount of such expenditures which are in the form of money payments, payments in kind, or such other payments as the State agency specifies, including loans and vendor payments, or medical or remedial care recognized under State law, with respect to or on behalf of individuals described in subparagraph (1) of this paragraph; and 50 percent of the total amount expended for administration, including costs incurred in determining eligibility, in the payment process, and for other related administrative activities;

(ii) 75 percent of the total amount of such expenditures which are for the following services provided to individuals described in subparagraph (1) of this paragraph, directly by staff of the agency, or by purchase from other sources: Information, referral, counseling, securing family shelter, child care, legal services, and any other services that meet needs attributable to the emergency or unusual crisis situations.

(3) Federal matching is available only for emergency assistance which the State authorizes during one period of 30 consecutive days in any 12 consecutive months, including payments which are to meet needs which arose before such 30-day period or are for such needs as rent which extend beyond the 30-day period. Another condition for Federal participation is that the State has a reasonable method of determining the value of goods in kind or services provided for emergency assistance.

IV

FEDERAL STATUTES--MEDICAID

[Excerpts from 42 U.S.C.A. § 1396a et seq., amended through 1973--Title XIX of Social Security Act]

§ 1396a. State plans for medical assistance—Contents

Statewideness

(a) A State plan for medical assistance must—

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

* * *

Single State Agency

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter.

* * *

(10) provide—

Categorically Needy

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

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

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

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

Medically Needy--
Optional Program

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

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

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

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);

* * *

Mandatory Care and Services

Categorically Needy

Medically Needy

(13) provide—

(A) for inclusion of some institutional and some noninstitutional care and services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1396d(a) of this title, and

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

(i) the care and services listed in clauses (1) through (5) of section 1396d(a) of this title or

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

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1320a—1 of this title, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services for purposes of subchapter XVIII of this chapter; and

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

Fees and Charges

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

Categorically Needy

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

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in clauses (1) through (5) and (7) of section 1396d(a) of this title, will be imposed under the plan, and

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and

Medically Needy

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

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

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

* * *

Standards for Eligibility and Coverage

Consideration of Income and Resources

Medically Needy--Consideration of Medical Costs

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

* * *

§ 1396b. Payments to States--Computation of Amount

* * *

Limitation on Federal participation in medical assistance

(f) (1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

Medically Needy--Maximum Federal Financial Participation

(B) (i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of subchapter IV of this chapter.

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

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

Medical Costs Excluded in Computing Income

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

(3) For purposes of paragraph (1) (B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of subchapter IV of this chapter shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan (without regard to section 608 of this title) provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

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

Institutionalized--Income Up to 300 Percent of SSI Benefit Level

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, but only if the income of such individual (as determined under section 1382a of this title, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title.

at the time of the provision of the medical assistance giving rise to such expenditure.

* * *

§ 1396d. Definitions—Medical assistance

For purposes of this subchapter—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentist's services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

Medical Assistance can extend to AFDC-U and Emergency Assistance to Needy Families

(i) under the age of 21,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child, except for section 606(a)(2) of this title, is (or would, if needy, be) a dependant child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

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

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter, or

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter,

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

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

(2) outpatient hospital services;

(3) other laboratory and X-ray services;

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

Physicians' Services are included in Mandatory Group

(5) physicians' services furnished by a physician (as defined in section 1395x(r) (1) of this title), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

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

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

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

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

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

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1396a(a) (31) (A) of this title, to be in need of such care;

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

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

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

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

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

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

Federal medical assistance percentage; State percentage

Federal Medicaid Matching Never Below 50 Percent

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1301(a)(8) of this title.

* * *

V

FEDERAL REGULATIONS--MEDICAID

[Excerpts from 45 CFR 248.1 et seq.]

§ 248.1 State plan requirements and options for coverage under the medical assistance program.

The provisions of §§ 248.1 through 248.4 do not apply to Guam, Puerto Rico and the Virgin Islands, with respect to which §§ 248.10, 248.11, and 248.21 apply.

(a) *General provisions governing eligibility for medical assistance.*—(1) *Categorically needy.*—(i) *General.* In order to be considered as categorically needy for purposes of title XIX, an individual must in general be receiving financial assistance or sufficiently in need to be financially eligible for financial assistance under title IV–A or XVI of the Social Security Act, or under a State supplement to title XVI assistance.

Categorically Needy

(ii) *States limiting coverage by returning to earlier Medicaid standard.* (A) In a State which covers both the categorically needy and medically needy under its title XIX plan, and in addition has exercised its option under section 209(b) of P.L. 92–603 to limit Medicaid coverage of aged, blind, and disabled individuals, an individual who meets the more restrictive eligibility criteria through having his title XVI payment (if any) and incurred medical expenses deducted from income is considered as categorically needy if he is eligible for a cash payment under title XVI of the Social Security Act or a State supplementary payment which meets the conditions specified in § 248.2(d).

(B) In a State which covers only the categorically needy under its title XIX plan, and in addition has exercised its option under section 209(b) of P.L. 92–603 to limit Medicaid coverage of aged, blind, and disabled individuals, all individuals establishing eligibility for medical assistance by deducting their title XVI payments (if any) and incurred medical expenses from income will be considered categorically needy regardless of whether their income would allow them to qualify for cash assistance.

Medically Needy

(2) *Medically needy.* (i) An individual is considered to be medically needy if he has income and resources which exceed the amount of income and resources allowed to the categorically needy but which are insufficient to meet the costs of necessary medical and remedial care and services.

(ii) In determining whether an individual's income is above the medically needy level, medical expenses are not deducted from income. However, in determining eligibility for medical assistance, incurred medical expenses must be deducted from income for a medically needy individual.

Categorically Needy--Mandatory Coverage

(b) *Required coverage of the categorically needy.* A State plan under title XIX of the Social Security Act must specify what groups of individuals are covered as categorically needy for Medicaid. These groups must, as a minimum—

(1) In the case of families and children, include: (i) All individuals receiving aid under the State's approved plan under title IV-A;

(ii) All individuals under 21 who are (or would be, except for age or school attendance requirements) dependent children under the State's approved AFDC plan; and

(iii) All families which were receiving assistance under the State's plan under title IV-A in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such assistance because of increased hours of, or increased income from, employment. As long as a member of the family is employed, such families will continue to be eligible for medical assistance, for a period of 4 calendar months beginning with the month in which such family became ineligible for assistance under title IV-A because of increased hours of employment, or increased earnings, to the same extent and under the same conditions as it is furnished to the categorically needy under the title XIX plan in effect during such months.

(2) In the case of the aged, blind and disabled, include one of the groups listed in paragraph (b)(2)(i), (ii) or (iii) of this section, and in addition, those listed in paragraph (b)(2)(iv), (v) and (vi) of this section:

(i) Individuals receiving a benefit under title XVI (for purposes of the regulations in this part, the phrase "individuals receiving a benefit under title XVI" includes the eligible spouses of such individuals), or

(ii) Individuals receiving a benefit under title XVI or a State supplementary payment which meets the conditions specified in § 248.2(d), or

(iii) Individuals who meet the eligibility criteria used for medical assistance on January 1, 1972 (or any other criteria which are less restrictive than the January 1, 1972 criteria but no less restrictive than the comparable criteria under title XVI or for a State supplementary payment which meets standards described in § 248.2(d)), after the amount of the title XVI payment and State supplementary payment (if any) and incurred medical expenses are deducted from income;

(iv) All individuals who receive a State supplementary payment mandated pursuant to section 212 of P.L. 93-66;

(v) All individuals who in December 1973 were eligible as essential spouses under the State title XIX plan which for such month provided for medical assistance to individuals described in section 1905(a)(vi) of the Social Security Act, provided that:

(A) The individual with whom such an essential spouse is living continues to meet the December 1973 criteria for aid or assistance under one of the State plans under titles I, X, XIV or XVI as in effect in such month.

(B) The essential spouse continues to be the spouse of and to live with such individual, and under the State plan approved under title I, X, XIV or XVI as in effect in December 1973, would still be considered to be essential to the well being of such individual, and such spouse's needs would be taken into consideration in determining the amount of aid or assistance furnished to such individual under such State plan.

(vi) All individuals who, for all (or any part of) the month of December 1973:

(A) Were eligible under the State title XIX plan as inpatients or residents in institutions qualified for reimbursement under title XIX of the Act; and

(B) (*1*) Would (except for being an inpatient or resident in such institution) have been eligible to receive aid or assistance under a State plan approved under title I, X, XIV, or XVI of such Act; or

(*2*) Were, on the basis of need for care in such institution, considered to be eligible for aid or assistance under a State plan under title I, X, XIV or XVI for purposes of determining their eligibility for medical assistance under a State plan approved under title XIX of the Act (whether or not such individuals actually received aid or assistance under a State plan under title I, X, XIV or XVI) provided that:

(i) Such individuals continue to be (for all of any month after December 1973) inpatients or residents in such an institution and would (except for being inpatients or residents in such institution) continue to meet the conditions of eligibility to receive aid or assistance under such plan (as such plan was in effect for December 1973), and

(ii) Such individuals are determined (under the utilization review and other professional audit procedures applicable to State plans approved under title XIX of the Act) to be in need of care in such an institution.

(3) With respect to both families with children and aged, blind, or disabled individuals include:

(i) Any individual who would be eligible for aid under title IV-A of the Act or benefits or supplementary payments under title XVI (as may be applicable) except for any eligibility condition or other requirement that is specifically prohibited in a program of medical assistance under title XIX.

(ii) for any month prior to July 1, 1975, any individual;

(A) Who, for the month of August 1972, was receiving or eligible for financial assistance under the State's plan approved under title I, IV-A, X, XIV, or XVI of the act and who was also entitled to monthly insurance benefits under title II of the act for the month of August 1972, and

(B) Who, except for the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92-336, would have been eligible for financial assistance for the current month. Under this requirement:

(1) An individual qualifies as receiving or eligible for financial assistance for August 1972 if, with respect to such month:

(i) He was receiving financial assistance; or

(ii) He met all conditions of eligibility for financial assistance under title I, IVA, X, XIV, or XVI as in effect in August 1972 but had not applied, provided the State title XIX plan included such individuals as categorically needy in August 1972; or

(iii) He was in a medical facility or interminate care facility, and had he left, would have been eligible for financial assistance, provided the State title XIX plan included such individuals as categorically needy in August 1972.

(2) An individual is considered as though he were eligible for financial assistance for the current month (after August 1972 and prior to July 1, 1975) if with respect to such month, except for the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92-336:

Categorically Needy--Optional Coverage

(i) He would meet all conditions of eligibility for financial assistance (however, he need not file an application). In such case he is eligible under the current title XIX plan to the same extent as individuals who are receiving financial assistance; or

(ii) He is in a medical or intermediate care facility and, if he left, would be eligible for financial assistance, provided the State title XIX plan includes such individuals as categorically needy. In such case he is considered as though he were categorically needy and is eligible under the title XIX plan to the same extent as other categorically needy individuals in such a facility. Countable income for categorically needy individuals in such a facility does not include the amount specified as a pass-along in sections 306 of P.L. 92-603 and 1007 of P.L. 91-172.

(c) *Options for coverage of categorically needy.* A State may at its option also cover additional groups of individuals as categorically needy provided they are so specified in the plan. These groups may include any of the following:

(1) Individuals who meet all the conditions of eligibility, including financial eligibility, for aid under title IV-A, benefits under title XVI or State supplementary payments (provided such supplementary payments meet standards specified in § 248.2(d), and the State plan approved under title XIX specifies that recipients of such payments are treated as categorically needy) but have not applied for such assistance. If such group is included in the plan, it must also include all individuals who meet the financial criteria and who:

(A) Although they were not actually receiving cash assistance, in December 1973 met all the conditions of eligibility, including financial eligibility, for aid under a State plan approved under title X, XIV, or XVI of the Act (by reason of their having been previously determined to meet the criteria for blindness or disability established by such a State plan) and

(B) they were eligible under the State title XIX plan in effect in that month if, for each consecutive month after December 1973 such individuals continue to meet the criteria for blindness or disability, and the financial criteria, established by the State plan, approved under title X, XIV or XVI as it was in effect for December 1973.

AFDC-U

(ii) Individuals in a facility eligible for reimbursement for services rendered under title XIX who, if they left such facility would be eligible for aid under title IV-A, benefits under title XVI or State supplementary payments (provided such payments meet standards specified in § 248.2(d), and the State plan approved under title XIX specifies that recipients of such payments are treated as categorically needy). This includes individuals who have enough income to meet their personal needs while in the facility, but not enough to meet their needs outside the facility according to the applicable program.

(iii) Individuals who would be eligible for financial assistance under the State public assistance plan approved under title IV-A except that the State plan imposes eligibility conditions more stringent than, or in addition to, those required under the Social Security Act. For example, individuals who would be eligible for AFDC if the State's program covered families with children deprived of parental support or care to the full extent permitted under title IV-A of the Act, including AFDC for families with unemployed fathers.

(iv) All individuals under 21 who qualify on the basis of financial eligibility, but do not qualify as dependent children under a State's AFDC plan; or groups of such individuals if based on reasonable classifications. Children in foster homes or private institutions, or in subsidized adoptions, for whom public agencies are assuming financial responsibility, in whole or in part, constitute a reasonable classification. The additional inclusion of children placed in foster homes or private institutions by private, nonprofit agencies would also be considered reasonable. Individuals under age 21 who are in intermediate care facilities or in psychiatric hospitals, also constitute a reasonable classification.

(v) Caretaker relatives enumerated in section 406(a)(1) of the Act who have in their care one or more children under 21 who, except for age or school attendance requirements, would be dependent children under the State's AFDC plan.

(vi) Individuals who would be eligible for financial assistance if their work-related child care costs were paid out of earnings rather than as a service expenditure by the agency, provided the State plan for financial assistance otherwise recognizes child care costs in determining the amount of the payment.

Medically Needy--Coverage

(d) *Coverage of the medically needy.* If the State opts to include medically needy individuals under title XIX, the State plan must specify that it covers all medically needy groups that correspond to the categorically needy groups covered in the plan; except that this requirement will not apply with respect to individuals required to be covered pursuant to paragraph (b)(1)(iii), (2)(iv), (v), and (vi), and (3)(ii) of this section. Included as medically needy are all individuals who are financially eligible under the standard for medical assistance in effect and who, for the month of December 1973, were eligible as medically needy persons by reason of their having been previously determined to meet the criteria for blindness or disability established by a State plan approved under title X, XIV, or XVI of the Act, if, for each consecutive month after December 1973, such individuals continue to meet the criteria for blindness or disability so established by the State plan (as it was in effect for December 1973), and continue to meet the financial criteria established under the title XIX plan as in effect for December 1973.

(e) *Conditions of eligibility.* The State plan must specify all conditions of eligibility that must be met by members of all optional groups included in the plan.

§ 248.2 Conditions for State plan approval.

(a) All groups the State elects to include in the program are based on reasonable classifications that do not result in arbitrary or inequitable treatment of individuals or groups and are not otherwise inconsistent with the broad objectives of title XIX of the Act.

(b) Except for financial eligibility, the conditions of eligibility that are imposed on elective groups

(1) In the case of families and children, are not more stringent or more numerous than those imposed on families and children receiving aid under the approved State title IV-A plan, and

(2) In the case of aged, blind, or disabled individuals, are not more stringent or more numerous than those imposed on such individuals receiving benefits under title XVI (except for individuals receiving a State supplementary payment as provided in paragraph (d) of

this section, or individuals who become eligible for medical assistance as provided in § 248.1(b)(2)(iii)).

(c) No age, residence, citizenship, or other requirement is imposed that is prohibited by title XIX of the Act.

(d) If individuals who receive only a State supplementary payment (but no title XVI payment) are covered as categorically needy, the supplementary payment meets the following standards. It is

(1) Regular, in cash and based on need;

(2) Made to some reasonable classification of aged, blind, and disabled individuals who, except for the level of their income, would be eligible for benefits under title XVI; such reasonable classifications are limited to any of the following, or any combination thereof:

(i) The aged, or the blind, or the disabled;

(ii) The aged, or the blind, or the disabled who:

(A) Are in domiciliary facilities or other group-living arrangements as defined in title XVI regulations;

(B) Are receiving a supplemental payment which is administered by the Federal government in accordance with an agreement made pursuant to Section 1616(a) of the Social Security Act, provided, however, that such payment meets conditions specified in paragraph (d)(3) and (4) of this section;

(iii) Other additional classifications as may be specified by the Secretary;

(3) Available to the reasonable classifications of individuals covered on a Statewide basis, and any variations in level of payment by political subdivision are demonstrated to the satisfaction of the Secretary to be based on cost-of-living differentials; and

(4) Equal to the difference between income and the financial standard used to determine eligibility for the supplement. The income allowed under such standard, before application of any disregards applied under title XVI, may not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act, except for those persons required to be covered pursuant to § 248.1(b)(2)(vi) or persons receiving a mandatory supplement under section 212 of P.L. 93-66.

(e) Notwithstanding the provisions specified in paragraph (d) of this section, if a State plan provides that persons who would be eligible except that they are in a medical institution (or intermediate care facility) are covered as categorically needy, the financial standard applied to determine eligibility for such persons who are aged, blind, or disabled may not exceed that standard which will allow income, before application of any disregards applied under title XVI, of up to 300 percent of the SSI benefit rate established by section 1611(b)(1) of the Social Security Act, even though a State supplementary payment might not actually be made. The State plan must specify the financial eligibility standard for such persons.

§ 248.3 State plan requirements on financial eligibility for medical assistance programs.

Categorically Needy

(a) With respect to the categorically needy, a State plan under title XIX of the Social Security Act must:

(1) Specify the financial eligibility conditions that apply to the covered categorically needy groups.

(i) In the case of families and children, the financial eligibilty conditions of the State plan approved under title IV-A shall be applied.

(ii) In the case of aged, blind and disabled individuals, either:

(A) If the State plan provides for categorically needy coverage only for individuals receiving or eligible for a benefit under title XVI, the financial eligibility conditions of title XVI shall be applied;

(B) If the State plan provides for categorically needy coverage for all individuals receiving or eligible for a benefit under title XVI and in addition provides for coverage of defined classifications of persons receiving a State supplementary payment, (1) the financial eligibility conditions of title XVI shall be applied for individuals who are receiving or eligible for only a title XVI benefit and are not eligible for a State supplementary payment, and (2) the financial eligibility conditions of the State supplementary

payment program shall be applied to individuals receiving such payments, provided that the financial standard for the supplementary payment program does not allow income, before application of any disregards applied under title XVI, which exceeds 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (except that these conditions will not apply to individuals in institutions required to be covered pursuant to § 248.1(b)(2)(vi) or individuals receiving a mandatory State supplement under sec. 212 of P.L. 93-66); or

(C) If the State plan limits coverage by applying any eligibility requirement as restrictive as or less restrictive than those in its January 1, 1972 medical assistance plan but more restrictive than the eligibility criteria for title XVI or supplementary payment recipients, financial eligibility criteria must be specified. These criteria may be: (*1*) As low as those of the January 1, 1972 medical assistance standard, or (2) up to or as high as the standards which would be allowed for title XVI beneficiaries, or for recipients of State supplementary payments as specified in paragraph (a)(1)(ii)(B) of this section.

(2) Provide for the application of income first to maintenance costs, except that this does not preclude imposition of copayments or deductibles pursuant to § 249.40 of this chapter.

Both Categorically and Medically Needy

(b) With respect to both the categorically needy and, if they are included in the plan, the medically needy, a State plan must:

(1) Provide that only such income and resources as are actually available will be considered and that income and resources will be reasonably evaluated.

(2) Provide that financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for spouse and of parents for children under age 21, or blind, or disabled.

(3) Specify the extent to which the financial responsibility of any such relatives is taken into account.

(4) Provide that a lower income level for maintenance shall be used for individuals not living in their own homes but receiving care in hospitals, skilled nursing facilities, intermediate care facilities, and institutions for tuberculosis or mental diseases which are covered under title XIX. This lower income level must be reasonable in amount for clothing and personal needs for such individuals, and

(i) For aged, blind, and disabled individuals, such income level must be at a minimum of $25.00 per month;

(ii) For others, States may establish reasonable standards different from that specified in subdivision (i), provided they are based on a reasonable differential in personal needs.

When such an individual's home is maintained for a spouse or other dependents, the appropriate income level for such dependents, plus the individual's income level for maintenance in a long-term care facility, shall be applied. A higher level of maintenance may also be applied for a temporary period, not to exceed six months, to allow an individual to apply his income and resources to maintenance of a home if a physician has certified that such individual is likely to return to the home within such temporary period.

(5) Provide, for individuals in long-term care facilities specified in paragraph (b)(4) of this section, for the application of income first to personal needs, and for the medically needy only, to the title XIX enrollment fee, premium or similar charge imposed under section 1902(a)(14)(B) of the Act, and provide for the application of the remainder to the cost of medical or remedial care.

(6) Provide that, with respect to an aged, blind, or disabled individual receiving a benefit under title XVI or a State supplemental payment, who is not eligible for medical assistance unless he can meet additional eligibility criteria from the January 1972 standard, the amount of such individual's title XVI benefit and State supplemental payment will be disregarded in determining eligibility for medical assistance.

Medically Needy

(c) With respect to the medically needy, the State plan must:

(1) Provide levels of income and resources for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance. Under this requirement:

(i) Such income levels must be comparable as among individuals and families of varying sizes;

(ii) Except as specified in paragraph (c)(1)(iii) of this section, the income levels for maintenance must be, as a minimum, at the higher of the levels of the payment standards generally used as a measure of financial eligibility in the money payment programs, that is:

(A) In the case of families of three or more, at the level of the payment standard of the State plan approved under title IV-A generally applied;

(B) In the case of individuals, or families (including families with children) of two persons, at the higher of:

(*1*) The payment standard of the State plan approved under title IV-A generally applied, or

(2) The highest level of payment which is generally available to individuals in any of the three groups (aged, blind and disabled) who are (or would be, except for income) eligible for benefits under title XIX;

except that this subparagraph (B) shall not be construed to require the provision of medical assistance to any aged, blind or disabled individual who would not be eligible under the medical assistance standard in effect in such State for January 1972.

(iii) The income levels for maintenance may be less than those specified in paragraph (c)(1)(ii) of this section if the level for which Federal financial participation available pursuant to § 248.4 (b)(4) is less, but if so, not lower than the Federal financial participation level.

(iv) Resources which may be held must, as a minimum, be at the higher of the levels allowed under the State plan approved under title IV-A or allowed in the supplemental security income program established under title XVI of the Social Security Act, and the amount of liquid assets which may be held must increase with an increase in the number of individuals in a family (except that a State may allow to aged, blind or disabled individuals only the level of resources allowed in the January 1972 medical assistance standard, if this is not less than the State allows the categorically needy). There must be separate levels established for resources.

(2) Provide that there will be a flexible measurement of available income which will be applied in the following order of priority:

(i) First, for maintenance, so that any income in an amount at or below the established level will be protected for maintenance, except that this does not preclude imposition of the enrollment fee, premium or similar charge, or of copayments or deductibles pursuant to § 249.40 of this chapter;

(ii) Next, income will be applied to costs incurred for medical insurance premiums (including the enrollment fee, premium or similar charge imposed under section 1902(a)(14)(B) of the Act), for any copayments or deductibles imposed under such section, and for necessary medical or remedial care recognized under State law and not encompassed within the State plan for medical assistance. States may set reasonable limits on such medical services for which excess income may be applied. Any medical resource of an individual in the form of insurance or other entitlement will also be applied to such costs. (See also § 250.31 of this chapter regarding third party liability.);

Federal Matching

(iii) All of the remaining excess income and medical resources in the form of insurance or other entitlement will be applied to costs of medical assistance included in the State plan. Once such income and resources are exhausted, the full amount, duration and scope of care and services provided by the plan are available.

(3) Provide that all income and resources will be considered in establishing eligibility, and for the flexible application of income to medical costs not in the plan, and for payment toward the medical assistance costs. In considering all income and resources when establishing eligibility, the State plan must provide for:

(i) In the case of families and children, consideration of all disregards applicable to income and resources which are utilized when determining eligibility, or setting aside for future needs under the State's approved title IV-A plan;

(ii) In the case of the aged, blind, or disabled, the highest of:

(A) The disregards applied in title XVI, or

(B) The disregards applied in the State supplementary payment program which are available to all individuals who are or would be (except for their income level) eligible for a title XVI benefit,

except that in a State which has limited coverage of the categorically needy by applying eligibility requirements which are the same as or at a level between those in its January 1, 1972 plan and those under title XVI, disregards which similarly fall within January 1, 1972 and title XVI levels, provided that they are at least the same as those allowed to the aged, blind, and disabled categorically needy.

(4) Provide that only such income and resources will be considered as will be "in hand" within a period, not in excess of six months ahead, including the month in which medical services which are covered under the plan were rendered.

§ 248.4 - Federal financial participation.

(a) *Administrative costs.* Federal financial participation is available in the administrative costs of providing medical care and services to all individuals covered under the plan, in the cost of whose medical care and services the Federal government shares.

(b) *Medical assistance.* (1) Except for the exclusion in paragraph (b)(2) of this section, and subject to the provisions of paragraphs (b)(3) and (4) of this section and of Part 250 of this chapter, Federal financial participation is available in payments for medical care and services provided under the State plan to any financially eligible individual who is:

(i) Under the age of 21 (or under age 22 and receiving inpatient psychiatric hospital services pursuant to § 249.10(b)(16) of this chapter); or

(ii) A parent or other caretaker relative specified in section 406(a)(1) of the Act (see § 233.90(c)(1)(v)(a) of this chapter) with whom a child under the age of 21 is living, if such relative is eligible or would, except that the child is not regularly attending school or a course of vocational training, and except for need, be eligible to receive payments within the scope of Federal financial participation under title IV-A of the Act. Only one such parent or other caretaker relative, plus the spouse of such parent or caretaker relative who meets the conditions specified in section 406(b)(1) of the Act (see § 237.50(b)(3) and (4) of this chapter), are within the scope of Federal financial participation under title IV-A of the Act; or

(iii) An aged, blind, or disabled individual, as specified in section 1614 of the Social Security Act.

(2) Federal financial participation is not available for care or services provided to any individual who is an inmate of a public institution (except as a patient in a medical institution or a resident in an intermediate care facility), or who is under age 65 and a patient in an institution for tuberculosis or mental diseases (see exception in paragraph (b)(1)(i) of this section for individuals under age 22). See § 248.60.

(3) Federal financial participation is available in payments made on behalf of individuals specified in the plan as categorically needy, subject to the condition, in respect to aged, blind or disabled individuals receiving State supplementary payments, that the State's eligibility standard for the supplementary payment does not allow income, before application of any disregards applied under title XVI, which exceds 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act, except for those individuals required to be covered pursuant to § 248.1(b)(2)(v) of this chapter or individuals receiving a mandatory supplement under section 212 of P.L. 93-66.

(4) Payments in behalf of medically needy individuals are subject to Federal financial participation only to the extent that they are made for a member of a family which has annual income within the following levels:

(i) 133⅓ percent of the amounts specified in paragraph (b)(4)(ii) of this section. Any total yearly income levels established by applying the above percentage which are not multiples of $100 shall be rounded to the next higher multiple of $100. Federal financial participation is available for an individual whose annual income exceeds this level to the extent that medical expenses exceed the income excess (see paragraph (b)(4) subdivision (ii)(C) of this section).

(ii) The amounts to be applied in calculating the income levels referred to in paragraph (b)(4)(i) of this section are the highest money payments which would ordinarily be made to a family of the same size without any income or resources, under the State's approved AFDC plan, subject to the following modifications:

(A) In the case of a single individual the amount of the income level shall be reasonably related to the amounts payable under such plan to families consisting of two or more individuals who are without income or resources.

(B) If the amounts established under such plan are subject to a maximum family limit, the income level for families which exceed such limit will be determined by adding an amount for each member of the family to such limit. The amounts to be added shall be reasonably related to those established under the plan for families which are within the maximum family limit.

(C) In computing a family's or individual's income for purposes of paragraph (b)(4)(i) and (ii) of this section, there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family or individual for medical care or for any other type of remedial care recognized under State law, provided that such costs are not subject to reimbursement by a third party.

(5) Federal financial participation is available in medical assistance provided to individuals who were eligible therefor in the month in which the medical care or services were provided, except that this does not apply to costs incurred for medical care by families and individuals in process of establishing eligibility for medical assistance through the incurment of medical expenses which are deducted from income. (See § 206.10(a)(6) of this chapter for retroactive entitlement.)

(6) Federal financial participation is available in medical assistance for individuals, in accordance with the State plan, during a temporary period through the second month following the month in which eligibility ceases, or for the period of time during which financial assistance is received, while the effects of certain eligibility conditions such as blindness, disability, continued absence or incapacity of a parent, or unemployment of a father are being overcome.

(7) Federal financial participation will be available in medical assistance for individuals during a reasonable period of time from the effective date an aged, blind, or disabled individual is no longer eligible for title XVI benefits (in order for the State to determine whether he is still eligible for Medicaid and to allow for notification by the State to such individual of his ineligibility for medical assistance). If the notice is received from the Social Security Administration on or before the 10th of the month, such period may not extend beyond the end of that month, unless the recipient has timely requested a hearing; if the notice is received from the Social Security Administration after the 10th of the month, it may not extend beyond the end of the next month, unless the recipient has timely requested a hearing. The State must take the necessary steps promptly upon receipt of notice from the Social Security Administration.

(8) Notwithstanding any other provision of this section, Federal financial participation is available in medical assistance provided to individuals in groups listed in § 248.1(b)(1)(iii); (2) (iv), (v), and (vi); and (3)(ii); and for persons included within sections 248.1(c)(1) and (d) except for the definition of disability established by title XVI, as specified in those sections.

(c) *Limitation.* If a State furnishes medical assistance on the basis of income levels which are higher than those specified in this section, the State agency must submit to the Department of Health, Education, and Welfare for its approval income levels which are calculated on the basis provided in this section, and must establish procedures to assure that claims for Federal financial participation are limited accordingly.

(d) *Agreement for supplementary payments.* No Federal financial participation is available under title XIX for any given quarter in which the State does not have in effect in such quarter an agreement with the Secretary for State supplementary payments as specified in section 212 of P.L. 93-66. This provision does not apply with respect to any State which meets the conditions specified in section 212(f) of P.L. 93-66 or to Puerto Rico, Guam, and the Virgin Islands.

§ 249.10 Amount, duration, and scope of medical assistance.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

(1) Specify that at least the first five items of medical and remedial care and services, set forth in paragraph (b) (1) through (5) of this section, will be provided to the categorically needy.

(2) Specify that, if the plan includes the medically needy, at least the following items of medical and remedial care and services will be provided to the medically needy:

(i) The first five items set forth in paragraph (b) (1) through (5) of this section; or

(ii) (*a*) Any seven of the items set forth in paragraph (b) (1) through (14) of this section; and

(*b*) If the plan includes inpatient hospital services or skilled nursing home services, physicians' services to eligible individuals when they are patients in a hospital or skilled nursing home, even though physicians' services as defined in paragraph (b)(5) of this section are not otherwise included for the medically needy.

(3) In carrying out the requirements in subparagraphs (1) and (2) of this paragraph with respect to the item of care set forth in paragraph (b)(4)(ii) of this section, provide:

(i) For establishment of administrative mechanisms to identify available screening and diagnostic facilities, to assure that individuals under 21 years of age who are eligible for medical assistance may receive the services of such facilities, and to make available such services as may be included under the State plan;

(ii) For identification of those eligible individuals who are in need of medical or remedial care and services furnished through title V grantees, and for assuring that such individuals are informed of such services and are referred to title V grantees for care and services, as appropriate;

(iii) For agreements to assure maximum utilization of existing screening, diagnostic, and treatment services provided by other public and voluntary agencies such as child health clinics, OEO Neighborhood Health Centers, day care centers, nursery schools, school health programs, family planning clinics, maternity clinics, and similar facilities;

(iv) That early and periodic screening and diagnosis to ascertain physical and mental defects, and treatment of conditions discovered within the limits of the State plan on the amount, duration, and scope of care and services, will be available to all eligible individuals under 21 years of age; and that, in addition, eyeglasses, hearing aids, and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health, will be available, whether or not otherwise included under the State plan, subject, however, to such utilization controls as may be imposed by the State agency. If such screening, diagnosis, and such additional treatment are not available by the effective date of these regulations to all eligible individuals under 21 years of age, the State plan must provide that screening, diagnosis, and such additional treatment will be available to all eligible children under 6 years of age, and must specify the progressive stages by which screening, diagnosis, and such additional treatment will be available to all eligible individuals under 21 no later than July 1, 1973.

(4) Effective July 1, 1970, provide for the inclusion of home health services for any eligible individual who, under the plan, is entitled to skilled nursing home services.

(5) Specify the amount and/or duration of each item of medical and remedial care and services that will be provided to the categorically needy and to the medically needy, if the plan includes this latter group. Such items must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Effective July 1, 1970, specify that there will be provision for assuring necessary transportation of recipients to and from providers of services and describe the methods that will be used.

(6) Provide that the medical and remedial care and services made available to any categorically needy individual included under the plan will not be less in amount, duration, or scope than those made available to other individuals included under the program, except that:

(i) Skilled nursing home services may be limited to persons 21 years of age or older;

(ii) Services to persons in institutions for tuberculosis or mental diseases may be limited to persons 65 years of age or over;

(iii) Benefits under part B of title XVIII of the Social Security Act made available to individuals 65 years of age or over through a "buy-in" agreement or payment of the premiums, or the payment of part or all of the deductibles, cost sharing or similar charges under part B, may be limited to such individuals; and

(iv) Early and periodic screening and diagnosis for individuals, and treatment of conditions found, as provided in section 1905(a)(4)(B) of the Act, may be limited to individuals under 21 years of age.

(7) Provide that the medical and remedial care and services made available to a group (i.e., either the categorically needy or the medically needy) will be equal in amount, duration, and scope for all individuals within the group, with the permissible exceptions specified in subparagraph (6) of this paragraph.

(8) Include a description of the methods that will be used to assure that the medical and remedial care and services are of high quality, and a description of the standards established by the State to assure high quality care.

(9) Provide for broadening the scope of the medical and remedial care and services made available under the plan, to the end that, by July 1, 1975, comprehensive medical and remedial care and services will be furnished to all eligible individuals.

(10) If the State plan includes medical and remedial care and services in relation to family planning, as defined in paragraph (b)(15)(ii) of this section, provide that there shall be freedom from coercion or pressure of mind and conscience, and freedom of choice of method, so that individuals can choose in accordance with the dictates of their consciences.

(b) *Federal financial participation.* Subject to the limitations in paragraph (c) of this section, Federal financial participation is available in expenditures for medical or remedial care and services under the State plan which meet the following definitions:

(l) *Inpatient hospital services (other than services in an institution for tuberculosis or mental diseases).* "Inpatient hospital services" are those items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases and which is licensed or formally approved as a hospital by an officially designated State standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation; and which has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under title XIX of the Act.

(2) *Outpatient hospital services.* "Outpatient hospital services" are those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution which is licensed or formally approved as a hospital by an officially designated State standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

(3) *Other laboratory and X-ray services.* The term "other laboratory and X-ray services" means professional and technical laboratory and radiological services ordered by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law, and provided to a patient by, or under the direction, of a physician or licensed practitioner, in an office or similar facility other than a hospital outpatient department or a clinic, and provided to a patient by a laboratory that is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

(4) (i) *Skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older.*— "Skilled nursing facility services" means those items and services furnished by a skilled nursing facility maintained primarily for the care and treatment of inpatients with disorders other than tuberculosis or mental diseases which are provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law. A "skilled nursing facility" is a facility, or a distinct part of a facility, which meets the following conditions; the term also includes any institution which is located on an Indian reservation and is certified by the Secretary as being a qualified skilled nursing facility by meeting the requirements of section 1861(j) of the Social Security Act:

(*a*) The facility is constructed, equipped, maintained, and operated in compliance with all applicable State and local laws and regulations affecting the health and safety of the patients and their protection against the hazards of fire and other disaster, and there is a written, rehearsed disaster plan.

(*b*) The administrator is qualified by training and experience for successful operation of a nursing home and has the necessary authority and responsibility for management of the facility.

(*c*) The facility employs staff sufficient in number and qualifications to meet the requirements of the patients accepted for care or remaining in the facility for care.

(*d*) Food is prepared and served under competent direction, at regular and appropriate times. Professional consultation is available to assure good nutritional standards and that the dietary needs of the patients are met.

(*e*) Patient care is provided in accordance with written policies formulated with the advice of one or more professional registered nurses.

(*f*) Constructive care directed toward restoring and maintaining each patient at his best possible functional level is provided, including activities designed to encourage self-care and independence provided as a part of the patient's treatment program.

(*g*) Patients in need of nursing care are admitted to a facility only upon recommendation by a physician of the need for the level of care provided by that facility. The care of such patients is continuously under the supervision of a physician; and the facility maintains arrangements that assure that the services of a physician who can act in case of emergency are continuously available.

(*h*) The facility has been determined by the single State agency to meet all of the standards established under section 1902(a)(28) of the Act, as evidenced by an agreement between the single State agency and the facility for the provision of skilled nursing home care and the making of payments under the plan; except that, effective July 1, 1972, with respect to skilled nursing home services furnished on or after such date by a skilled nursing home whose provider agreement expired or was otherwise terminated on or after such date, the State agency may continue to claim Federal financial participation in payments on behalf of eligible individuals for such services furnished by such home during a period not to exceed 30 days starting with the date of expiration or other termination of its provider agreement, but only if such individuals were admitted to the home before the date of expiration or other termination of its provider agreement, and if the State agency makes a showing satisfactory to the Secretary that it has made reasonable efforts to facilitate the orderly transfer of such individuals from such home to another appropriate facility.

(*i*) All drugs and medications are prescribed, handled, stored, and administered in accordance with accepted professional practices.

(*j*) An individual record is maintained for each patient covering his medical, nursing, and related care in accordance with accepted professional standards.

(*k*) Effective arrangements are maintained through which services required by the patients but not regularly provided within the facility can be obtained promptly when needed. This includes laboratory, X-ray, and other diagnostic services, and regular and emergency dental care. It includes, also, provisions for recognition of need for social services and for prompt reporting of such need to the local welfare department or other appropriate source.

(*l*) Effective July 1, 1968, the facility is licensed or formally approved as a nursing home by an officially designated State standard-setting authority and has not been determined by such authority not to meet fully all requirements of the State for licensure as a nursing home except as provided in the next sentence. Payments to a nursing home which formerly met fully all requirements of the State for licensure as a nursing home, but is currently determined not to meet fully all such requirements, may be recognized for a period specified by the State standard-setting authority, if during such period such home promptly takes all necessary steps to again meet such requirements.

(*m*) The facility (including a facility operated by a governmental agency) meets all requirements which are applied for licensure or formal approval as a nursing home to the same type of facility in any other ownership category (i.e. governmental, non-profit or proprietary) within the State.

(ii) *Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.* Early and periodic screening and diagnosis of individuals under the age of 21 who are eligible under the plan to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Federal financial participation is available for any item of medical or remedial care and services included under this section for individuals under the age of 21. Such care and services may be provided under the plan to individuals under the age of 21, even if such care and services are not provided, or are provided in lesser amount, duration or scope to individuals 21 years of age or older.

(5) *Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere.* "Physicians' services" are those services provided, within the scope of practice of his profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

(6) *Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.* This term means any

medical or remedial care or services other than physicians' services, provided within the scope of practice as defined by State law, by an individual licensed as a practitioner under State law.

(7) *Home health care services.* "Home health care services" in addition to the services of physicians, dentists, physical therapists, and other services and items available to patients in their homes and described elsewhere in these definitions, are any of the following items and services when they are provided on recommendation of a licensed physician to a patient in his place of residence, but not including as a residence a hospital or a skilled nursing home:

(i) Intermittent or part-time nursing services furnished by a home health agency;

(ii) Intermittent or part-time nursing services of a professional registered nurse or a licensed practical nurse under the direction of the patient's physician, when no home health agency is available to provide nursing services;

(iii) Medical supplies, equipment, and appliances recommended by the physician as required in the care of the patient and suitable for use in the home;

(iv) Services of a home health aide, who is an individual assigned to give personal care services to a patient in accordance with the plan of treatment outlined for the patient by the attending physician and the home health agency which assigns a professional registered nurse to provide continuing supervision of the aide on her assignment. The term "home health agency" means a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

(8) *Private duty nursing services.* "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse, under the general direction of the patient's physician, to a patient in his own home or in a hospital, skilled nursing home, or extended care facility when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital, nursing home, or extended care facility.

(9) *Clinic services.* "Clinic services" are preventive diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients.

(10) *Dental services.* "Dental services" are any diagnostic, preventive, or corrective procedures administered by or under the supervision of a dentist in the practice of his profesion. Such services include treatment of the teeth and associated structures of the oral cavity, and of disease, injury, or impairment which may affect the oral or general health of the individual. The term "dentist" means a person licensed to practice dentistry or dental surgery.

(11) *Physical therapy and related services.* "Physical therapy and related services" means physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, and the use of such supplies and equipment as are necessary.

(i) "Physical therapy" means those services prescribed by a physician and provided to a patient by or under the supervision of a qualified physical therapist. A "qualified physical therapist" is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, or its equivalent, and where applicable, is licensed by the State.

(ii) "Occupational therapy" means those services prescribed by a physician and provided to a patient and given by or under the supervision of a qualified occupational therapist. A "qualified occupational therapist" is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and is engaged in the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

(iii) "Services for individuals with speech, hearing, and language disorders" are those diagnostic, screening, preventive or corrective services provided by or under the supervision of a speech pathologist or audiologist in the practice of his profession for which a patient is

referred by a physician. A speech pathologist or audiologist is one who has been granted the Certificate of Clinical Competence in the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience necessary for such a certificate, or who has completed the academic program and is in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

(12) *Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.* (i) "Prescribed drugs" are any simple or compounded substance or mixture of substances prescribed as such or in other acceptable dosage forms for the cure, mitigation, or prevention of disease, or for health maintenance, by a physician or other licensed practitioner of the healing arts within the scope of his professional practice as defined and limited by Federal and State law. With respect to "prescribed drugs", Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act. When dispensing, the practitioner must do so on his written prescription and maintain records thereof.

(ii) "Dentures" are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by, or according to the directions of, a dentist.

(iii) "Prosthetic devices" means replacement, corrective, or supportive devices prescribed for a patient by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law for the purpose of artificially replacing a missing portion of the body, or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.

(iv) "Eyeglasses" are lenses, including frames when necessary, and other aids to vision prescribed by a physician skilled in diseases of the eye, or by an optometrist, whichever the patient may select, to aid or improve vision.

(13) *Other diagnostic, screening, preventive, and rehabilitative services.* (i) "Diagnostic services", other than those for which provision is made elsewhere in these definitions, include any medical procedures or supplies recommended for a patient by his physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law, as necessary to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in the patient.

(ii) "Screening services" consist of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify suspects for more definitive studies.

(iii) "Preventive services" are those provided by a physician or other licensed practitioner of the healing arts, within the scope of his practice as defined by State law, to prevent illness, disease, disability and other health deviations or their progression, prolong life and promote physical and mental health and efficiency.

(iv) "Rehabilitative services", in addition to those for which provision is made elsewhere in these definitions, include any medical remedial items or services prescribed for a patient by his physician or other licensed practitioner of the healing arts, within the scope of his practice as defined by State law, for the purpose of maximum reduction of physical or mental disability and restoration of the patient to his best possible functional level.

(14) *Inpatient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.* For purposes of this subparagraph:

(i) "Inpatient hospital services" are those items and services ordinarily furnished by the hospital to inpatients, which are provided to an inpatient in the institution or to a patient who is receiving care in the institution under a day-care or a night-care plan, and which are furnished under the direction of a physician to a patient in an institution for tuberculosis or an institution for mental diseases.

(ii) "Skilled nursing home services" are those items and services given in a skilled nursing home, as defined in subparagraph (4)(i) of this paragraph, when these items and services are furnished to patients who would not have been discharged from, or would be admitted to, an institution for tuberculosis or mental diseases if skilled nursing home services were not available to them.

(iii) An "institution for tuberculosis", qualified to carry out the provisions of the Act in respect to the care and treatment of individuals 65 years of age or over is one that (*a*) meets the requirements for a tuberculosis hospital under title XVIII, section 1861(g), of the Social Security Act; or (*b*) effective only until July 1, 1969, is licensed, or formally approved, by an officially designated State standard-setting authority as a hospital or medical institution operated primarily to provide diagnosis, treatment and rehabilitation to inpatients with tuberculosis.

(iv) An "institution for mental diseases", qualified to carry out the provisions of the Act in respect to the care and treatment of individuals 65 years of age or over is one that (*a*) meets requirements for a psychiatric hospital under title XVIII, section 1861(f), of the Social Security Act; or (*b*) effective only until July 1, 1970, is approved by appropriate State standard-setting authorities as a hospital established for the care of the mentally ill and as being physically safe and as having staff adequate in number and qualifications to carry out an active program of diagnostic, treatment and rehabilitative services for its patients; and specifically provides psychiatric supervision, medical services, including 24-hour nursing services under the supervision of a registered nurse, and the social services necessary to assure a continuous plan of treatment and care for all of its patients. Effective October 1, 1969, in the case of any institution for mental diseases which qualifies for Federal Financial Participation through subdivision (*b*) the single State agency must have on file a written plan which describes the steps which the institution will take for meeting the requirements of title XVIII, section 1861(f) of the Act by July 1, 1970.

(15) *Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.* This term includes the following items in those States in which they are recognized under State law and under the circumstances, and to the extent to which, they are so recognized:

(i) Transportation, including expenses for transportation and other related travel expenses, necessary to securing medical examinations and/or treatment when determined by the agency to be necessary in the individual case. "Travel expenses" are defined to include the cost of transportation for the individual by ambulance, taxicab, common carrier or other appropriate means; the cost of outside meals and lodging en route to, while receiving medical care, and returning from a medical resource; and the cost of an attendant to accompany him, if medically or otherwise necessary. The cost of an attendant may include transportation, meals, lodging, and salary of the attendant, except that no salary may be paid a member of the patient's family.

(ii) Family planning services, including drugs, supplies, and devices, when such services are under the supervision of a physician.

(iii) Services of Christian Science nurses who are listed and certified by the First Church of Christ Scientist, Boston, Mass., when these services have been requested by the patient and are provided (*a*) by, or under the supervision of, a Christian Science visiting nurse organization listed and certified by the First Church of Christ Scientist, Boston, Mass.; or (*b*) as private duty services to an individual in his own home or in a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass., when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the sanatorium.

(iv) Care and services provided in Christian Science sanatoria operated by, or listed and certified by, the First Church of Christ Scientist, Boston, Mass.

(v) Skilled nursing home services, as defined in subparagraph (4)(i) of this paragraph, provided to patients under 21 years of age.

(vi) Emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services, even though the hospital does not currently meet the conditions for participation under title XVIII of the Social Security Act, or definitions of inpatient or outpatient hospital services set forth in subparagraphs (1) and (2) of this paragraph.

(vii) Personal care services in a recipient's home rendered by an individual, not a member of the family, who is qualified to provide such services, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse.

(c) *Limitations.* Federal financial participation in expenditures for medical and remedial care and services listed in paragraph (b) of this section is not available with respect to any individual who is an inmate of a public institution (except as a patient in a medical institution), or any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

(d) *General provisions.* (1) In all the items listed in paragraph (b) of this section, the following definitions apply, except to the extent the context otherwise requires:

(i) "Patient" is an individual who is in need of and receiving professional services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or alleviation of disability or pain.

(ii) "Inpatient" is a patient who has been admitted to a hospital, skilled nursing home, or other medical institution on recommendation of a physician or dentist and is receiving room, board, and professional services in the institution on a continuous 24-hour a day basis.

(iii) "Outpatient" is a patient who is receiving his professional services at an organized medical facility, or distinct part of such facility, which is not providing him with room and board and professional services on a continuous 24-hour-a-day basis.

(2) Nothing in the Social Security Act or Federal policies thereunder will be construed to require any State to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under its approved State plan if such person objects, or in the case of a child, his parent or guardian objects, to such care on religious grounds. An individual may not be found eligible unless he undergoes such physical examination as is necessary to establish his eligibility, e.g., an examination must be made of an individual applying for medical assistance on the basis of his disability (as disabled under the AFDC, AB, APTD, or AABD program).