Federal Participation in Vendor Payments for Medical Care

by VIVIAN NORMAN *

For many years the States have been meeting some of the costs of the medical services supplied to recipients of public assistance through payments from assistance funds made directly to the suppliers of the services, but not until the adoption of the 1950 amendments to the Social Security Act was Federal participation in these payments possible. By June 1952, fifteen States were reporting vendor payments made under plans approved by the Social Security Administration or under plans that had been submitted for approval. The extent of Federal participation in the vendor payments made in that month is reported in the following pages.

ONE of the changes in the Social Security Act made by the 1950 amendments permits the States, beginning October 1950, to obtain Federal matching funds for the payments made by the public assistance agencies directly to doctors, hospitals, and other suppliers of medical services to assistance recipients. Such participation is now available to the extent that the total of the money payment and of payments made to vendors for medical care does not exceed the maximums on individual monthly payments specified in the Federal act. Before the amendments the Federal Government participated in the cost of medical care only if an amount to cover the cost was included in determining the amount of the money payment to the assistance case within the established maximums. Thus the States now have greater flexibility than they formerly had in arranging and paying for medical services with Federal financial participation.[1]

The 1950 amendments established $50 as the maximum on individual payments in which the Federal Government can share for old-age assistance, aid to the blind, and aid to the permanently and totally disabled and, for aid to dependent children, $27 for the first child in the family, $27 for the needy adult relative with whom the child is living, and $18 for each additional child in the family.[2] For Puerto Rico and the Virgin Islands, the maximums under both the 1950 and 1952 amendments are $30 for old-age assistance, aid to the blind, and aid to the permanently and totally disabled and, for aid to dependent children, $18 for the first child and $12 for each additional child; the Federal share within these maximums is 50 percent.

By June 1952 (21 months after the effective date of the amendment) only 15 States were reporting vendor payments for medical services made under approved plans or under plans that had been submitted to the Social Security Administration for approval (table 1). Four additional States with plans submitted did not report vendor payments under those plans in June. These States are New Mexico and West Virginia, with plans that have been approved, and Hawaii and Ohio, which have submitted plans on which action is pending. New Mexico started to claim Federal participation in vendor payments in July 1952. While West Virginia has an approved plan, the date when the State will begin operations under the plan is uncertain.

Additional States may develop plans for claiming Federal participation in vendor payments for medical care, but the effect of the amendment probably will continue to be limited. Some States may not amend their plans to include vendor payments for medical care or to request Federal participation in such payments. States that lack sufficient resources to meet maintenance needs on a relatively adequate basis, for example, usually provide little medical assist-

Table 1.—*Amount of vendor payments for medical care in States claiming Federal participation and the amount of Federal participation, June 1952*

Program	Number of States	Amount of vendor payments for medical care	Vendor payments subject to Federal participation		Estimated Federal share		
			Amount	Percent of total	Amount	Percent of—	
						Total vendor payments	Vendor payments subject to Federal participation
Total	15	$6,342,944	$1,509,002	23.8	$836,757	13.2	55.5
Old-age assistance	14	4,886,440	1,225,687	25.1	670,374	13.7	54.7
Aid to the blind	9	110,830	28,786	26.0	16,042	14.5	55.7
Aid to dependent children	11	652,068	97,911	15.0	58,512	9.0	59.8
Aid to the permanently and totally disabled	10	693,606	156,618	22.6	91,829	13.2	58.6

* Division of Program Statistics and Analysis, Bureau of Public Assistance.

[1] For information on medical care paid for by the States before the 1950 amendments, see the *Bulletin*, August 1952, pp. 7–12, and June 1950, pp. 3–7.

[2] The 1952 amendments provided for an increase in maximums to $55, $30, and $21, respectively; this provision became effective in October 1952 and is scheduled to terminate at the end of September 1954.

Table 2.—*Federal participation in vendor payments for medical care, by State,* [1] *June 1952*

State	Programs [2]	Amount of vendor payments for medical care	Vendor payments subject to Federal participation				Estimated Federal share			
			Amount	Percent of total	Payments for—		Total		For cases with vendor payments only	For cases with money and vendor payments
					Cases receiving money payments	Cases receiving vendor payments only	Amount	Percent of total vendor payments		
Total		$6,342,944	$1,509,002	23.8	$900,081	$608,921	$836,757	13.2	$386,573	$450,184
Connecticut	A B C	132,699	48,274	36.4	48,274	0	24,136	18.2	0	24,136
Illinois	A B C D	1,822,245	569,836	31.3	375,787	194,049	310,859	17.1	122,966	187,893
Indiana	A B C	330,247	90,919	27.5	75,368	15,551	48,468	14.7	10,785	37,683
Louisiana	B C D	5,116	2,714	53.0	2,714	0	1,358	26.5	0	1,358
Massachusetts	A C D	640,127	109,081	17.0	71,255	37,826	58,450	9.1	22,823	35,627
Michigan [3]	A B D	101,824	60,408	59.3	4,379	56,029	35,809	35.2	33,619	2,190
Minnesota [4]	A B C	824,570	129,359	15.7	110,625	18,734	66,807	8.1	11,494	55,313
Nebraska	A	205,829	69,953	34.0	53,923	16,030	36,802	17.9	9,840	26,962
Nevada	A	2,489	2,479	99.6	2,008	471	1,330	53.4	326	1,004
New Hampshire [5]	A B C D	74,240	34,884	47.0	34,884	0	17,585	23.7	0	17,585
New York	A B C D	2,151,424	368,801	17.1	105,592	263,209	223,189	10.4	170,393	52,796
North Carolina [4]	A C D	19,716	14,200	72.0	14,200	0	7,101	36.0	0	7,101
North Dakota	A C D	24,694	1,542	6.2	1,003	539	887	3.6	385	502
Rhode Island [3]	A B D	7,654	6,482	84.7	0	6,482	3,941	51.5	3,941	0
Virgin Islands	A C D	70	70	100.0	69	1	35	50.0	1	34

[1] States with vendor payment plans for medical care approved or pending approval.
[2] A signifies old-age assistance; B, aid to the blind; C, aid to dependent children; and D, aid to the permanently and totally disabled.
[3] Plan not yet approved.
[4] Data for May.
[5] Excludes $197 paid from other than pooled fund.

ance and are not likely, under the present Federal law, to expand their programs. In three jurisdictions—the District of Columbia, Maryland, and Washington—medical assistance programs are administered by public health agencies, and in Hawaii the public health agency is responsible for providing hospital care for needy persons. The local governments carry the responsibility in a number of States for providing medical care for the indigent. New State legislation or appropriations would usually be required before these States could develop plans for making vendor payments for medical care with Federal participation. Moreover, States with a relatively large proportion of money payments at or above the Federal maximums can obtain Federal participation in only a small share of their vendor payments.

In June 1952 the 15 States reporting on the program made vendor payments for medical services amounting to $6.3 million. Only $1.5 million, or not quite 25 percent of the total, fell within the Federal maximums on individual payments (table 1). The Federal share in these vendor payments has been estimated at $837,000, or about 13 percent of the $6.3 million. In old-age assistance, aid to the blind, and aid to the permanently and totally disabled, Federal funds represented from 13 percent to 14 percent of vendor payments for each program. The Federal share for aid to dependent children was 9 percent.

For purposes of this estimate, it has been assumed that, in applying the usual matching formula,[3] Federal funds are used to participate in the money payment first. If an old-age assistance recipient, for example, received a money payment of $40 and his medical bill of $30 was paid for him, it was assumed that there was Federal participation in the $40 money payment and in $10 of the vendor payment. Since in June 1952 $50 was the maximum old-age assistance payment in which the Federal Government could share, under the 1950 amendments, the $20 balance above this maximum would be met wholly from State and/or local funds. In such a case (for an individual receiving both money and vendor payments) an estimate of the Federal share in the vendor payment was arrived at by applying only the second half of the Federal matching formula—that is, by considering that the Federal share was half the matchable portion of the vendor payment. The estimated Federal share in the case cited would be $5.

For an individual who did not receive a money payment—one for whom only a vendor payment was made—the Federal share was determined in the usual manner. If, for example, a $100 medical bill was paid for a recipient of old-age assistance who did not receive a money payment, the Federal Government would participate up to the specified maximum of $50 and the Federal share would be $30.

At the June 1952 rate of expenditure and under the matching provisions in effect in that month, the estimated Federal share of vendor payments for medical services would amount to only $10 million a year. In general, vendor payments are reported for the month in which the medical bills are paid rather than for the month or months in which the services were authorized or received. Any cumulative lag in payment of bills may distort the figures for a given month. Such a lag has occurred in Illinois. Since this State accounted for one-third of the Federal share of expenditures for medical care in the

[3] In June 1952, the Federal Government paid three-fourths of the first $20 plus half the balance up to $50. Under the 1952 amendments, effective October 1952–September 1954, the Federal share is four-fifths of the first $25 plus half the balance up to $55.

15 States in June, there is considerable inflation in the June figures and in the estimate of annual expenditures at the June rate. If the Illinois figures were reduced to represent a more nearly normal monthly rate of expenditure, the Federal share at the June rate may not have exceeded $9 million a year for the 15 States.

Not all the Federal expenditures represent additional Federal costs resulting from the amendment, because some medical expenses now being met by vendor payments were previously met by including the necessary amount in money payments to recipients. Nor does the total represent all Federal participation in medical costs, since in several States part of the cost of medical care was met through money payments to recipients.

A number of circumstances affect the share of total vendor payments met from Federal funds in each State (table 2). In general, States in which a large proportion of the money payments are less than the Federal maximums will have a relatively large share of vendor payments for medical services met from Federal funds. The Federal share of total costs is also likely to be high in States that limit the use of the vendor-payment method to a few medical care items or to inexpensive services. The association of these two factors accounts for the relatively large share of these payments met from Federal funds in Louisiana, North Carolina, and the Virgin Islands. Louisiana limits its vendor payments to expenditures made for eyeglasses, refractions, and eye treatment; North Carolina makes vendor payments only for hospitalization, but a part of the charge is met from other than assistance funds and is not included in this report.

In most of the other reporting States a smaller proportion of total vendor payments for medical care were met by Federal funds because the States made such payments for a wide range of services or had a relatively small percentage of money payments below the Federal maximums. In general, these two circumstances explain the extent of Federal participation in vendor payments. The results for some States were also affected, however, by data for cases receiving only vendor payments for medical care. The Federal share of vendor payments for these cases is, of course, higher than for cases that also receive a money payment. Eleven States were making vendor-only payments in June 1952, as shown below.

State	*Number of cases*
Total	16,105
Illinois	5,144
Indiana	594
Massachusetts	781
Michigan	1,121
Minnesota	421
Nebraska	365
Nevada	18
New York	7,497
North Dakota	23
Rhode Island	140
Virgin Islands	1

Probably a high proportion of the vendor payments made for recipients receiving no money payment is made on behalf of recipients who are patients in medical institutions. Such payments are also made, however, for persons living outside institutions who have sufficient resources to meet their maintenance needs but are unable to meet their medical care costs.

Illinois, Indiana, Massachusetts, Michigan, Minnesota, and New York reported a substantial number of vendor payments only. In New York the 7,500 vendor-payment-only cases account for about three-fourths of the estimated Federal share in vendor payments in that State. In contrast the 5,100 cases in Illinois that received only vendor payments for medical care account for two-fifths of the Federal share in vendor payments in that State. The Federal share in vendor payments for cases receiving both types of payment was higher in Illinois than in New York since a larger proportion of the money payments were below the Federal maximums. As a result of the various factors, Federal funds met 17 percent of the cost of vendor payments in Illinois and 10 percent in New York. Together these two States account for $534,000 of the $837,000 spent by the Federal Government as its share of the cost of the vendor payments made by the 15 States in June 1952. If the Illinois figures were adjusted to represent a more normal rate of expenditure, the Federal funds for vendor payments for medical care for the two States would still represent half the total for all States combined.

The Federal share of total vendor payments was relatively high in Michigan because a large share of expenditures represented the cost of hospitalization for cases not receiving a money payment. In June, Federal participation in vendor payments was claimed by the Rhode Island agency only for 140 cases that did not receive a money payment. Since July 1, Rhode Island has been operating under a "pooled fund" and paying vendors for a wide range of services.

Pooled Fund

In June 1952, Connecticut and New Hampshire were operating with "pooled funds" from which payments were made to suppliers of the medical services provided to recipients. A "pooled fund" has been defined by the Bureau of Public Assistance as a "fund established, maintained, and operated by the public assistance agency as a prepayment arrangement to meet the cost of medical services for public assistance recipients, and into which fixed payments are made each month in behalf of each public assistance recipient covered by the fund. The monthly payments into the fund are made as assistance expenditures in behalf of recipients and must constitute irrevocable payments to the fund."

When States pay for medical care out of a pooled fund, it is the payment into, rather than out of, the fund that constitutes the assistance payment. Under this type of plan the Federal share tends to be relatively high because the cost of medical care is spread among all recipients and there is Federal participation in the premium for all cases that receive money payments in amounts less than the Federal maximums. The data used therefore represent "pooled fund" deposits rather than actual expenditures during the month.

New Hampshire makes a monthly payment into the fund of $8 for each recipient of old-age assistance and aid to the permanently and totally disabled, $7 for each recipient of aid to the blind, and $11.50 for each

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Employment

NATIONAL COMMITTEE ON SHELTERED WORKSHOPS AND HOMEBOUND PROGRAMS. *Sheltered Workshops and Homebound Programs: A Handbook on Their Establishment and Standards of Operation.* New York: The Committee, 1952. 71 pp. $1.

Designed as a guide for programs for rehabilitation of the handicapped.

U. S. DEPARTMENT OF LABOR. WOMEN'S BUREAU. *The Outlook for Women as Physical Therapists.* (Medical Service Series, Bulletin No. 203–1, rev.) Washington: U. S. Govt. Print. Off., 1952. 51 pp. 20 cents.

Points out the need for physical therapists in the program for crippled children and the vocational rehabilitation program.

Public Welfare and Relief

AKANA, PAUL. "Toward a Diagnosis of Public Attitudes Regarding Confidentiality of Assistance Records." *Social Work Journal,* New York, Vol. 33, Oct. 1952, pp. 191–195 f. $2.

GREAT BRITAIN. NATIONAL ASSISTANCE BOARD. *Report for the Year Ended 31st December, 1952.* (Cmd. 8632.) London: H. M. Stationery Office, 1952. 47 pp. 1s.6d.

KASAI, YOSHISUKE. "The Development of the Public Assistance Program in Japan." *Public Aid in Illinois,* Chicago, Vol. 19, July 1952, pp. 1–4 f., and Aug. 1952, pp. 6–10.

QUINLAN, LUCILE. "A Short History —15 Years of Public Welfare in Minnesota." *Minnesota Welfare,* St. Paul, Vol. 8, Aug. 1952, pp. 16–18 ff.

SHOSTROM, EVERETT L., and BRAMMER, LAWRENCE M. *The Dynamics of the Counseling Process.* New York: McGraw-Hill Book Company, Inc., 1952. 213 pp. $3.50.

Designed to help in developing and improving a counseling program.

Maternal and Child Welfare

BLACKWELL, GORDON W., and GOULD, RAYMOND F. *Future Citizens All.* Chicago: American Public Welfare Association, 1952. 181 pp. $2.

A study, made with the cooperation of 38 States, the District of Columbia, and the Territory of Alaska, that gives extensive information on more than 6,500 families for whom payments under aid to dependent children were terminated in late 1950 and early 1951. The study was designed to "throw new light upon the environmental and familial situation of approximately one and one-half million children in low-income families in this country who are currently being assisted through the Aid to Dependent Children program."

HESELTINE, MARJORIE M. "Feeding of Mothers and Children under Emergency Conditions." *Public Health Reports,* Washington, Vol. 67, Sept. 1952, pp. 872–875. 45 cents.

By the chief of the Nutrition Section, Division of Health Services, Children's Bureau. Discussion of the special problems associated with feeding this group.

SCHNEIDERS, ALEXANDER A. *The Psychology of Adolescence: A Factual and Interpretive Study of the Conduct and Personality of Youth.* Milwaukee: Bruce Publishing Co., 1951. 550 pp. $4.

VIRTUE, MAXINE BOORD. "Public Services to Children: A Study in Confusion." *Journal of the American Judicature Society,* Ann Arbor, Vol. 36, Aug. 1952, pp. 46–49. Free.

Discusses Michigan's public services for children.

WEINER, HYMAN. "Group Work with Children in a Medical Setting." *Child Welfare,* New York, Vol. 31, Oct. 1952, pp. 8–9. 35 cents.

Describes the group work in the Blythedale Hospital and Rehabilitation Center in Westchester County, New York.

Health and Medical Care

AMERICAN MANAGEMENT ASSOCIATION. *Significant Developments in Special Coverages.* (Insurance Series, No. 95.) New York: The Association, 1952. 52 pp. $1.25.

Includes a paper by A. M. Wilson on experience with coverage for catastrophic illness.

Health Security by Union Action: A Report on the Sidney Hillman Health Center of New York. New York: New York Joint Board, Amalgamated Clothing Workers of America, May 1952. 62 pp.

MERRILL, A. P. "Hospitals for the Chronically Ill." *New York State Journal of Medicine,* New York, Vol. 52, Oct. 1, 1952, pp. 2393–2396. 50 cents.

Points out that the care of the chronically ill and aged sick person is the number one public health problem today.

NEW YORK STATE JOINT HOSPITAL SURVEY AND PLANNING COMMISSION. *Improving Hospital Service through Community Planning.* (Legislative Document (1951) No. 16.) Albany: The Commission, 1951. 73 pp.

The annual report for 1950–51.

RAPPORT, SIDNEY M. "The Role of the Psychiatrist in Vocational Service." *Jewish Social Service Quarterly,* New York, Vol. 28, June 1952, pp. 375–377. $2.

VENDOR PAYMENTS

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family receiving aid to dependent children. In Connecticut the payments are $6 for each recipient of old-age assistance and for each family receiving aid to dependent children; the payments amount to $5 for each recipient of aid to the blind.

The Federal share of total vendor payments in June was 18 percent in Connecticut; it was 24 percent in New Hampshire. Because the proportion of money payments below the Federal maximums is higher in New Hampshire than in Connecticut, a larger proportion of the payments into the pooled fund in New Hampshire could be included within the Federal maximums.

Plans approved for two of the States not reporting in June—New Mexico and West Virginia—also provide for a pooled fund.