U. S. DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE

MEDICAID HEARING

SAN FRANCISCO, CALIFORNIA

DECEMBER 27, 1968

# SAN FRANCISCO PUBLIC HEARING ON MEDICAID

## U. S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Board of Supervisors' Chambers
San Francisco City Hall

Friday, December 27, 1968

HEARING OFFICER: Dr. Philip R. Lee
Assistant Secretary of HEW for
Health and Scientific Affairs

PANEL MEMBERS: Charles H. Shreve
Regional Director
Department of Health, Education,
and Welfare

Miss Faustina Solis

Reported by:

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...The San Francisco Public Hearing on Medicaid, U.S. Department of Health, Education, and Welfare, was called to order at 9:10 a.m., December 27, 1968, by Charles H. Shreve, Regional Director, Department of Health, Education, and Welfare...

MR. SHREVE: As Regional Director for the Department of Health, Education and Welfare, it is a pleasure for me to call this Hearing to order.

Before introducing the Hearing Officer to you, I want to make a couple of announcements. I also want to introduce to you another member of our Panel. I will explain a little bit about how we are going to operate today.

You have our tentative schedule. Those of you who have telephoned, written or wired us and have asked for time have all been assigned a starting time and a limited amount of time to make their presentations. The statements they are making will be recorded by a stenographer, and if any of them wish to have a transcript, they may leave their name and address with the young lady with the green dress, just inside the railing, who is taking the transcripts. It will be available at 40 cents a page from Schiller's Reporting Service.

We are going to try to follow the schedule as closely as possible. We left two periods of 40 and 30 minutes, respectively, in the middle of the morning and the middle of the afternoon. If we run behind, we'll use part of those open periods, the balance will be used for those who have come and wish to make a statement,

but who made no advance arrangements to do so.

At the beginning, I would like you to know Miss Faustina Solis, who is one of the members of our Panel here, and a very distinguished Mexican-American social worker. Miss Solis is a member of the Medical Assistance Advisory Council, appointed by Secretary Wilbur J. Cohen of the Department of Health, Education and Welfare.

In her spare time, she is also a Project Director of the Farm Workers Health Service of the California Department of Public Health, she is on the faculty of the School of Public Health and the School of Social Welfare of the University of California, Berkeley.

Her activities have been recognized by many as those of a person dedicated to the welfare of her fellowman. In 1965, she received the Koshand Award through the California Health and Welfare Conference, given to the outstanding social worker of the year in the State of California.

During the same year, she received an award of the outstanding Mexican-American Woman of the Year; and in 1966, the Ethel H. Wise Award was presented to her by the Columbia University Alumni of the School of Social Work.

We are very happy to have Miss Solis with us, and her task as a member of the Panel will be to ask any questions of those testifying, to clarify their position for the record.

And now, it is my pleasure to present to you the Hearing

Officer for these hearings in San Francisco who really needs no introduction to a Californian or even a national audience: The Honorable Dr. Philip R. Lee, Assistant Secretary of Health, Education and Welfare for Health and Scientific Affairs. He comes from the distinguished ~~Colorado~~ California Lee family of doctors of whom we all know, and it is a privilege and a pleasure to have worked with him over the past several years and to have such a distinguished leader in the country as our Hearing Officer today.

HEARING OFFICER LEE: Thank you very much, Mr. Shreve.

I would just like to say a word about the purpose of these hearings, and also, welcome those of you who are here already, and those of you who will be coming to testify.

Secretary Cohen has actually called for these public hearings in nine different cities of the country in order to obtain really grass roots opinions about the Medicaid Program from recipients or from people who've been served by the program, from the administrators, from medical groups, from hospitals, from professional associations, from health and welfare agencies and from interested citizens. And the hearings are being held in Atlanta, Boston, Chicago, Columbus, Ohio; Dallas, New Orleans, New York, Washington, D. C., and here in San Francisco. I think that we are very fortunate in the number of people who have asked to testify at these hearings.

Our first witness will be Mr. Spencer Williams, who is the Secretary of Human Resources for the State of California; and

is, I think, well known to everyone in this audience.

Mr. Williams.

MR. WILLIAMS: Miss Solis, Mr. Shreve, Dr. Lee, I appreciate the opportunity to appear before this distinguished Committee to express our views and our Medicaid program referred to in California as Medi-Cal, and have made certain recommendations that we have inserted in the program.

Last September, in this very same room, I addressed the Advisory Commission on Intergovernmental Relations Hearing on the subject of Medicaid, Tittle XIX of the Social Security Act.

At that time, I and ~~Carroll Koyer~~ Conrad Mallett, my Director of Health Care Services made various recommendations for improvement in the Medicaid programs. Those recommendations are still valid.

California adopted its program in November, 1965, during a special session of the Legislature. It became effective on March 1, 1966, and it soon was apparent that insufficient time and planning had been allowed for the massive job of financing near-comprehensive care for well over a million individuals in California.

When the current Administration took office, it found payments lagging, controls virtually nonexistent and expenditures threatening to outstrip budget resources. A businessman's task force lent its efforts to the task of bringing order to the chaos and made a number of recommendations, nearly all of which have been implemented. Controls have been instituted, the data

collection system has been improved; thanks to the cooperation of responsible leadership in the provider organizations considerable improvement has been brought about, although much more remains to be done. A complete professional survey of the entire system has been contracted out of which additional recommendations are expected within the next several months. But a rising dependency rate plus continuing cost escalation pose a real threat to the State's ability to balance the 1969-1970 budget.

A major difficulty faced by states operating Medicaid programs is the 1975 goal of comprehensive medical care for all medically indigent persons. Is this goal realistic in terms of other obligations imposed upon our tax dollars in the areas of national defense, education, urban problems, agriculture, employment, and many others.

Is it realistic in terms of the present formula for Federal sharing in Medicaid programs in view of the fact that Federal matching is available only for the "categorically linked" and not for thousands of other individuals whose need is equally urgent and whose potential for a creative contribution to our society is frequently greater?

Is it realistic in view of the near success of the Long amendments which would have materially reduced Federal sharing for the medically needy in the last session of Congress and the near certainty that such amendments will be reintroduced in 1969?

No action has been taken by the Federal Government to

extend Federal financial participation in medical care for those persons who do not fit the present Federal aid categories: the aged, the blind, certain dependent families, and the permanently and totally disabled.

In fact, in January, 1968 Federal sharing in money payments and medical care was cancelled for those family groups in which the family breadwinner was unemployed and receiving unemployments payments -- no matter how small the payment received.

In addition, there is no Federal participation in medical care of: one, childless persons whose disability is total but not permanent; two, marginally employed families. These features work a particular hardship on migrant farm labor.

I have some recommendations that I think will offer proof to the following program:

First, modification of the 1975 goal provision: Unless there is Federal financial participation for all medically needy, including the non-categorically linked, many states will be unable to assume the financial burden imposed by this requirement by 1975.

Second, modification of comparability of services requirements. This would allow states to adopt a professionally developed priority system for the expenditure of limited funds and, for instance, give special emphasis to dental or vision care for children, rather than offering services uniformly for those who are qualified.

Third, leave the determination of medical indigency level to the states, as was the case prior to the 1967 amendments, and provide Federal sharing for care given in connection with catastrophic accidents and illnesses.

The financial eligibility standard imposed by the 1967 amendments is not realistic. This standard, 140 percent of the AFDC cash grant payment level commencing January first of 1969, will drop to 133 percent of the AFDC cash grant payment level on January 1, 1970. This can force medically needy aged and disabled persons to spend down to this level prior to receiving medical assistance programs, and force them to apply -- or encourage them to apply for cash categorical aid payments.

Also, there is no medical assistance available to the taxpayer with a moderate income who suffers a catastrophic accident or illness until that person has spent down to a poverty level. Federal sharing in medical assistance for catastrophic illnesses or accidents would tend to allow these persons to maintain a moderate living standard and would allow them to return more quickly to a taxpaying status in our society.

Fourth, rescind provisions that no minimum length-of-residence requirements may be imposed. With the present disparity of medical benefits between states potential medical care recipients are encouraged to move to states offering more liberal benefits. This becomes more pronounced as durational residence requirements are abolished for cash categorical aid payments.

Normally, those attracted are persons who need the more expensive types of care: long term nursing home care, costly surgery, childbirth, and others. And we have indication that this immigration is happening in the State of California.

Fifth, modification of hospital payment method. The present "Principles of reimbursement for provider costs" developed by the Social Security Administration for hospital reimbursement were made applicable to Title XIX by the Secretary of HEW. These principles do not, by and large, set limits on costs so that as a result the system contains no incentive for economy, efficiency, or cost effectiveness. Some hospitals provide comfort services which are not essential to good quality medical care. I strongly believe that the Federal law should be amended to permit states to refuse reimbursement for costs resulting from unessential construction or operation and to limit Title XIX participation to those hospitals which operate within certain reasonable cost maxima and which cooperate with organizations created for the orderly planning of health facilities.

Sixth, I would suggest we allow copayment for some medical benefits. An anomaly of the law, as interpreted by HEW, permits a state to exclude drugs entirely from its program but prohibits a program feature which would pay for prescriptions on condition that a patient make a small contribution, such as 25 cents for a prescription. And, this is truly a nominalism.

It is not unreasonable to require a beneficiary with up

to, say, $1,200 in the bank to make some token payments toward his medical care. This is part of the mainstream concept, I think, by those receiving the subsistence.

Seven, you have them set a proper priority of the use of their resources with their personal health board. States should have more freedom with respect to liens and responsible relatives.

Title XIX does not allow liens, and relative responsibility is restricted to parent for minor child and spouse for spouse. Allowing the states more freedom with respect to liens and relative responsibility would add to the financial resources which can be utilized for the purchase of care.

Eight, remove the requirement for mandatory use of declaration form of application. States should be encouraged to use the declaration form of application when they find such use is feasible, but there should be no mandatory requirement. I know your concern is for noneligible persons that would receive relief and care for which no recovery can be available by the state, but adopt a more realistic solution to this whole problem -- and this is a serious problem which we all recognize.

The Federal requirement that in order for nursing home care provided to Medicaid beneficiaries to receive Federal financial participation the nursing home must meet the Title XIX skilled nursing home requirements by January 1, 1969, has caused many problems for California. These problems are the result of the Federal policy that by July 1, 1968, the states had to

determine that those nursing homes that had not yet met the Title XIX requirements showed reasonable expectation of meeting them by January first.

Obviously, HEW did not anticipate that California would have to defend in court what HEW meant when it said, "reasonable expectation." In California there was litigation, and the court decided that an administrative determination that requirements will not be met at some time in the future is insufficient grounds for denying a permit to a provider without going through extensive due process procedures.

The 1967 amendments created a new non-medical care concept called, "intermediate care." This level of care was to be somewhere between that provided by boarding homes and skilled nursing homes and was to be paid for through a vendor payment program handled by the same agency which paid cash categorical aid grants.

However, I believe that intermediate care is not a true solution. There is a need for a more adequate spectrum of non-medical out-of-home care, a realistic determination of individual true need for care of such nature, and an adequate formula for payment of such care. The vendor payment feature of intermediate care is a smokescreen: It benefits home operators, not the needy persons. Intermediate care may be the nucleus of an expanded industry with an insatiable appetite for public funds. The Federal interim standards for intermediate care contain so many, so many, quasi-medical elements that current difficulties and

inconsistencies will be compounded rather than remedied in this whole area, and this whole area needs clarification.

And, ten, I believe there should be an effort to provide more consistency in Federal policy directives. For example, the states were told that Medicaid programs should be closely coordinated with other health care programs, such as physical restoration programs under rehabilitation auspices and programs for crippled children under Maternal and Child Health auspices. States were encouraged to use the management systems of these older programs to assure high quality care and to use Medicaid funds to finance such care for those who meet Medicaid eligibility requirements. California did just that and instructed its fiscal intermediary to make payments accordingly -- for crippled children's diagnostic service.

A recent HEW audit report now takes tentative exception to nearly $1 million so paid out in this manner, casting unjust reflection upon the fiscal intermediary. In our opinion, these payments were properly made, as encouraged by HEW. The purported policy modification was ambiguously worded and constituted, as interpreted by the HEW auditors, a virtual reversal -- not a modification, but a virtual reversal -- of all previous directions.

This is but one example of confusion which stems from a law which is unnecessarily complex. There is an urgent need to simplify the statute, to permit the states more flexibility and to correct the inequities of coverage.

I have already mentioned the insensible requirement of category relationship. Though, equally shortsighted is the limitation on the financing of care in institutions for mental disease: Federal funds are available only for those 65 years of age or older.

If mental health is to be enhanced, and strides to be made in the solution of this problem, I hope this regressive restriction will be eliminated as soon as possible.

These are recommendations which I think will improve the operations program and improve the state's passing ability to do a better job. We are committed to the good health care of all of our citizens in this day, whether they can afford it themselves or not, we are committed to that. And we think the Federal Government can do much more to assist the states to give it the flexibility to do a better job.

I know your time is limited and your agenda is large, I'll be happy to answer any questions you have.

HEARING OFFICER LEE: Thank you, Mr. Williams.

Miss Solis.

MISS SOLIS: I would like to know, Mr. Williams, is there an Advisory Council, a State Council on --

MR. WILLIAMS: Yes, it's the State Health Planning Council.

MISS SOLIS: I see. And what is your consumer representation on that Council?

MR. WILLIAMS: I'd say, the membership is in the state of

change at the moment.

Carroll? Mr. Koyer is here, who is --

MR. KOYER: There is none, at the moment, no direct representation from the consumer; but we have on the Council a number of members who work with organizations who provide medical care and who historically have the interest of the consumer at heart. One of these, for instance, is Mr. Weisman with the Kaiser Foundation Health Plan; another one is Mr. Foyer, who is a member of the Council for Health Plan Alternatives, sponsored by labor organizations.

MISS SOLIS: Mr. Williams, in one of your recommendations, you mentioned the need of relative responsibility --

MR. WILLIAMS: Yes.

MISS SOLIS: I would like to ask you whether you do not see one of the problems resulting from this -- which you brought out earlier -- in terms of the fact that some of the medical care costs sometimes can create tremendous problems to families in terms of making really potential recipients of welfare. Would you not see this as a problem in the institution of this relative responsibility?

MR. WILLIAMS: There are two separate suggestions, of course; but the lien practice of placing it on the real property owned by a person who receives the health care which is not collected until after that person and his surviving spouse is deceased. So it is no personal denial of resources they have,

they are allowed to live in the place of residence until the recipient and his surviving spouse passes on.

My theory in recommending this is, that normally, the beneficiary of the estate of this decedent is an adult child who did not contribute to the support of their parents -- or relatives who did not contribute to the support of the decedents. I think it is appropriate, as long as you do not burden the recipients during their lifetime, to have the State share in the proceeds of that estate, so long as it did support their medical care during their lifetime. I think it is only fair that the State stand in line, as far as these proceeds are distributed. As far as relative responsibility here, there should not be any undue burden on the supporting family; but there are instances of large incomes where no contribution is requested. As far as the lien is concerned, I might say this, also: That what I was getting at, we did take a lien for services rendered in the County Hospital. And this, to my knowledge, never handicapped the persons who received the service, and the accounting was able to recoup funds that was to be used for additional service.

MISS SOLIS: I just have one more question: This program Title XIX, it's not really total yet in its implementation as a health care program, as much as it is a medical care program for which payments are made for services rendered.

And I am wondering whether a health formula -- there has been the problem of resources of care, because this is not really

guaranteed in this program, except the payment for services, and, of course, you know my interest would be in rural areas where we do have, say, such aid, poor distribution of medical resources. Is this a problem in California?

MR. WILLIAMS: I think it's a problem any place, but it's a problem approaching solution.

I am Chairman of the State Comprehensive Health Planning Council, and one of their studies is to determine resources and the needs and try to make sure the resources are distributed evenly to meet the needs.

So there is an effort being made to eliminate these gaps. Under medical, yes; it's a, basically, a system of providing care, but the theory, I believe, would be appropriate. And if you have people who need health care services and they have the ability to pay for these services, whether through government assistance or otherwise, this will attract the providers to the area -- not instantly -- but the direction will be to assure these services will be available.

HEARING OFFICER LEE: Mr. Shreve.

MR. SHREVE: No questions.

HEARING OFFICER LEE: Mr. Williams, I'd just like to ask one question about the rapidly rising costs of medical care which certainly have had a profound effect on Title XIX programs around the country. And the reimbursement incentive experience that are authorized in the legislation -- and I wondered to what extent do

you feel it's possible to implement such reimbursement incentive experience? I'm thinking, particularly, of your program with the San Joaquin Foundation and, at least, the early indications there that very significant cost's savings can accrue from effective local surveillance, both of utilization, the appropriateness of services; and the cost of those services. And, I think, the biggest impact appears to be in institutional costs, and the big cost of medications, hospital costs, and nursing home care.

And to what extent do you think those kinds of experience can be further encouraged; what further do you think can be done to improve effective utilization at the local level?

MR. WILLIAMS: The San Joaquin project will complete its year in February, and while we have some optimistic indication of the success, we're not in a position to really evaluate them fully. So, February, we will know more about that.

But we are encouraged with what we see of the results, and this concerns the deliberate health services. Insofar as institutional services are concerned, we do have an ability with the nursing homes to set individual rates, according to two factors that determine their formula: We do make specific audits, and we can put a ceiling on what we pay, so we do rule out the inefficient operator or the one who's not operating properly. As far as utilization of those facilities are concerned, we have higher authorizations for admissions, and physicians to admit a person. Even in the local health services, we have local peer

groups who are doing the reviewing as to fees, quality of care and extent of services. We see improvements consistently. This has only started in the last 18 months.

As far as hospitals are concerned, our indications are that hospitals have shown a biggest percent increase in cost -- I think 34 percent in this last year -- this is why my recommendation that the states be given flexibility to deal with those hospitals who meet certain efficiency standards where the states are not required to pay for services. I think if the Federal Government will allow the states to do so, we will reduce the rapidly increasing cost of this program.

HEARING OFFICER LEE: Thank you very much, Mr. Williams. We appreciate your coming this morning and giving us really this comprehensive review in a very short period of time of the problems that you have seen, and, of course, the opportunities for improvement which is really the most important purpose of this hearing.

Our next witness will be Mr. Louis Flores, who is the State Vice President of the Mexican-American Political Association.

Mr. Flores.

MR. FLORES: Good morning, Dr. Lee, Members of the Panel.

Last night, as I was going over the preparation for this particular representation -- I had went to a lot of trouble getting statistics, and these kinds of information -- and as I was listening to the astronauts and watching the astronauts and

listening to some of the commentators, one of the commentators made a remark and said that for many, many years we knew how to get to the moon, the only problem was to develop the priority of when we should get to the moon, and then putting the system together to get there.

And so, I took all my statistics and I threw them away. And the problem with providing medicare and, particularly, medicare for the needy of which classify probably 70 percent or 80 percent of the Mexican people southwest is one in which all the bureaucrats and the agencies develop a priority of when they are going to give this medicare and this medicaid, and then, putting the system together to do it.

It is no longer a situation which can go year from year in hearings, and none of these hearings determine what you are going to do the next year.

You must determine in advance, for five to ten years in advance, maybe twenty years in advance a plan of action which will meet not 50 percent, not 60 percent, not 70 percent, but 100 percent, and in some cases, 110 percent of the medical care of the needy.

I have a newspaper clipping with me in which the Senate Committee about ten days ago held hearings in Los Angeles and, I think, they're going through the same process, and I also have in front of me a list of your agenda, and I see for a minute, Dr. Lee, and Mr. Williams, and more persons far more applicable

to discuss medical care for people than I am. But in the clipping from Los Angeles, there is a two-letter page -- or two-sentence paragraph -- states, "It is suggested that government agencies have bilingual personnel to explain programs." It is interesting to know that the State of California should go from agency to agency, office to office, whether it be a public health, whether it be the Department of Motor Vehicles, whether it be the schools, there is only one local in which bilingual places (sic) and bilingual people and bilingual signs are used to the utmost, and this is at San Quentin State Prison. It is the only agency, the only department, completely succeeding in giving bilingual services. How uneven that a State Prison should be the only one.

There are sections of the Welfare Department that you can go into, and you can go get some of these services, and you run into a young lady or a matronly lady who has had one year of Spanish in a high school, and when the reports come out of the Welfare Department, particularly, in their justification and in the medical departments and the justification for getting many of these, you can pick out any one of these reports, and you will find a reference made to this, that adequate translation services have been given.

Even in a court of law, I recall one in which I had to help the interpreter, I was told by the district attorney that this interpreter used Spanish better than I did.

I'm not sure when the Department of Health, Education and

Welfare or all these agencies who have all these problems -- or so they say -- are going to address themselves to the fact they have to share a border with Mexico that is from immediate California to miles long.

And I'm not sure when you're going to come to the conclusion that the immigration policies which have allowed this country, particularly the State of California and Texas for their great agricultural combines to import people from Mexico for very hard labor, people whose English capabilities are very minute.

The Mexican population in the Southwest is the only immigrant who is not an immigrant population, because this is part of their country, that continuously have a problem of dipping into its own pockets to supply the kinds of services that you're talking about. The only help that has come along in recent years has been from out of the Office of Economic Opportunity, and in the County of Napa where, I believe, in which the Mexican people run the little Service Center, 30 to 35 percent of the services requested of that service is transportation to doctors and transportation to health clinics to get to those doctors.

When you talk about Title XIX, and you talk about X million of dollars, and all these kinds of things don't seem important; however, they are tremendously important to that one person who has need of a doctor, and even with money in his pocket, can't even get there, because he can't understand the system.

I don't know how to make this important to you, I could discuss it in Spanish, and Miss Solis and I could probably have a good discussion. All through your Department -- I'm not just talking about Medicaid, your educational offices -- all through it, these needs have come up, in the same article from Los Angeles, always talks about meeting with the National Advisory Committee of Mexican-American Education, and we talk about bilingual tests, and we talk about bilingual teachers' aid -- it would seem to me that is one of the things that are required -- as a matter of operation-- that will allow just minute medical services that you have now, to be able to get out to the community people so they can utilize them for the best possible things.

It's another order of things, I happen to make good $15,000 a year, and I'm able to get medical care for my family for $250 a year. I just go down there, because I work for the University of California, and join the Kaiser Plan which I pay $14 out of my salary, and the University of California pays $6 out of their salary, and such as extra things for glasses I happened to pick up, my glasses were $33, no eye examination cost, and some drugs. For $240 to $250 I have very little medical coverage for my family. It is sufficient that it relieves many of the tensions that both my wife and I feel that whenever one of our children get ill, so for $244 on this type of an operation, it would seem to me one of the things that the Department of HEW ought to look at, is the possibility of allowing community groups

to form themselves into credit unions for medical service, such as we are allowed now to form credit unions for developing an economic pace.

These credit unions put together with some sort of a State law, Federal law, to regulate them so that the treasurer doesn't run off with the monies, will then go about the business of pulling indigent people and needy people together for the purpose of developing medical plans for which they could buy from things such as Kaiser Foundation, Blue Shield, Blue Cross, all of the various insurance companies that participate in this area.

Part of these costs or even, maybe, the majority of these costs, could be reimbursed from Federal and State monies for health and welfare recipients.

Just as where credit unions with their membership take care of their obligations, their bookkeeping, the matters of taking care of their own business, I am sure that these organizations could then develop within themselves the manner in which they could take care of their business in this health venture. There is great need for this.

We have heard Mr. Williams talk about escalation and medical payments to doctors, the newspapers lately have had a controversy as to whether this is true or not, but Mr. Lynch, our Attorney General, was trying to make political hay out of this -- this could be true, I don't know.

However, the question is, it has happened. But yet, when

the University of California went on to the Kaiser Foundation Plan -- or the plans -- not only Kaiser Foundation, but Blue Shield, and all of this -- I do not recall an escalation of prices, and I do not recall an escalation of fees going up. It was just a matter of fact, that here was a group of some 3,000 odd people from one particular section of the Lawrence Radiation Laboratory who wanted medical care and were able to purchase it without any fantasies.

I would urge that throughout this next year that this be one priority, Medicare, Medi-Cal, Medicaid, whatever you want to call it, to choose somewhere in the State of California a place where this could be tried out. And that this program be given a fair chance of succeeding, and by this, I don't mean that you try it, fund it for one year, and after one year when all the problems put in this together are manifested, you terminate it -- and look at it and evaluate it in such a manner that would tend to terminate it.

I would suggest that a minimum of five years be given to trial period. And that the evaluation techniques throughout this trial period could be developed by both HEW and the various medical professions that have the interest to participate in this, and at the end of five years, perhaps, we might develop in this country the means by which the problems of the needy in medical care could be met. And, that is, through a possibility of people banding themselves together and forming themselves into groups,

that then they go out and purchase medical care for their membership, and that this medical care would be as complete as any that's now on the market; certainly, no less than what could be given by the Blue Shield or the Blue Cross type foundation.

I would put that as top priority. It has been shown, and there's no doubt if you want to take off and take a look at it, and when people get together and -- they could do a much better job than any agency, department, than anybody else can. You must make available to them -- that is the only way they will be able to get it. They do not wish a handout any more than you wish to get it, but you must help them to be able to get started so this process can take place, so they can then set up this system to set up their own needs, however they wish to raise their funds to begin with, a matter of dances or fiestas, or whatever you want, people can and do that. Credit unions have shown this to be true. I'm sure, if you look at other organizations of this type, I'm sure, you'll find this to be true.

HEARING OFFICER LEE: Thank you very much.

Miss Solis?

MISS SOLIS: Mr. Flores, I know that the Mexican-American Political Association has been a State-wide organization, I know you have a number of committees. I wonder, if you have a health committee in your Association?

MR. FLORES: We have a Welfare Committee, we don't have a health committee, as per se.

MISS SOLIS: Well, many of the problems which you pose, certainly, in terms of manpower, in terms of the development of effective services with regard to the Spanish-speaking population are real problems, and, I think, that an organization such as yours who do have a resource content, who do have some of the potential of manpower development, could very well address themselves to some of the problems of health and contact of the kinds of agencies who can assist.

You will recall the hearings of 1966, and the health recommendations that were made at that point through organizations such as yours. And there have been developing -- in fact, one of the recommendations that came out of that meeting was the collection of data on the Spanish-speaking populations which has become an implement to various tests and, I think, this is an area that does considerable work.

MR. FLORES: I would agree with you on the fact that you need manpower, you need organization. I would suggest that you don't choose the Mexican-American Political Association, for the main reason, it has "political" in its naming --

MISS SOLIS: Well, I --

MR. FLORES: -- many agencies, as soon as they hear politics, immediately cover behind their desks, and these various positions, they --

MISS SOLIS: Well, I --

MR. FLORES: -- I would suggest this, though: Within the

last two years, at least, Spanish-speaking, Mexican-speaking people, have gone into job development, man development, in which there is many people doing this kind of work who have developed many roots in the community. I would suggest, there is a good resource of manpower that would be able to help, I would suggest that you utilize it. I'm sure the Department of Labor will help you, I don't see no reason why not.

MISS SOLIS: I want you to understand, I'm not using MAPA as a specific organization, I'm using it as one of the many kinds of social and welfare organizations that have this interest and betterment of the conditions. And I'm not asking you to supply the manpower, but --

MR. FLORES: I understand.

MISS SOLIS: -- the organization to address itself to some of the problems.

MR. FLORES: That's why I'm here today.

Any other questions?

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: Just one thing. I want to thank Mr. Flores for his very thought-provoking suggestions, and I want to assure him they will have full consideration. I'm very happy to have you here.

HEARING OFFICER LEE: Mr. Flores, I would just like to ask you a favor; that is, if you would send to me in Washington -- that is one of the points you seemed to make very clearly, was a

point that Miss Solis made in her question to Mr. Williams, that is, what we have now come to call consumer participation, this is really citizen participation in decisions relating to their own affairs and programs that affect them. We have a number of advisory committees. Miss Solis happens to sit on the most important National Advisory Committee relating to the Medicaid program.

We have advisory committees in a number of other areas in the Department of Health, Education and Welfare, not only in Washington, but advising in our regional offices. There are also State Health Plan Councils increasingly important, and will be -- Mr. Williams, I think, very clearly pointed out -- increasingly important in the future in determining priorities. This is a point I think you also made that we really have to set a national priority to commit the resources to this program.

So I would appreciate, if you would just communicate directly with me and suggest people that you think would be effective members of advisory committees, because there's no question that even participation in these areas can -- it's a very important two-way source of communication.

And, of course, the other point I think you made about the establishment of credit unions, the local -- again, the local organization could do this -- any more specific suggestions you have along these lines and what we might do to enhance that, stimulate this -- what I would consider to be a private enterprise

approach to the problem -- again, with active local citizen participation, we would welcome more details on these suggestions. I realize there's not enough time here to develop these ideas fully.

MR. FLORES: Just one word about your advisory committees. In the past, advisory committees, with some exceptions, have been chosen on the merits of how they relate to the person who is in charge of any particular -- whether it be a local office or whether it be a state-wide office or whether it be a federal office -- this does not always make for the best type of people who have interest of those people whom you wish to get advice from.

HEARING OFFICER LEE: That's right.

MR. FLORES: I would suggest anyone who you have a recommendation from, whether it be from myself or whether from anybody else, you wander back to the community where the recommendation came, whether they have any back-up service or it's just a name there -- the next thing we have a Spanish surname who nobody knows and doesn't really care about what's going on.

HEARING OFFICER LEE: I guess that's a very good point, and one -- we often make that mistake, we often make that mistake, and I think it's a point very well taken.

Thank you very much for coming.

Our next speaker will be Mr. Charles W. Stewart, Vice President for Government Programs of the California Blue Shield.

Mr. Stewart.

MR. STEWART: Thank you, Mr. Chairman.

My name is Charles W. Stewart, and I represent California Blue Shield in San Francisco, California.

California Blue Shield acts as a carrier for non-institutional services in the State under Title XIX, and under Title XVIII for Part B services. I'm here today to respond to the announced purpose of this Committee of seeking ways of improving the Title XIX Program.

First, we endorse the general approach that has been taken in California under the Title XIX part of Public Law 89-97. We feel that the inclusion of the private sector by State Government in the administration of the Medicaid Program has been beneficial to the program's intent of providing medical and social services to needy persons requiring care. The cooperation of the various professional provider associations in the administration of the program has been of great assistance. Particularly, it has resulted in a dual structure of controls and discipline combining the best of the governmental system with the maximum of administrative flexibility available in the private sector.

Our dual role in the public and private sectors did not have its beginning with Title XIX and Medicare. Rather, it is a commitment which dates back to our Articles of Incorporation of 1939 which have found expression through our administration of publicly-financed programs since the end of World War II when we

became involved in the administration of the Veterans' Home Town Care Program, to be followed in 1957 by the Military Dependents' Program and Public Assistance Medical Care, and in 1962 by Medical Assistance for the Aged. It was thus possible to build the administration of the large programs of 1966 on a firm and well-tested foundation of its predecessor programs, using to good stead the expertise, techniques and relationships built over a long period of time.

I think that the dual private-public role has proved its worth. Responsibility for his private programs gives a carrier an added incentive to be prudent in the administration of a public program, and thus provides the much needed checks and balances on which the fiscal stability of a public program depends so greatly.

One area of coordination can be improved. This relates to the fact that approximately 65 percent of the Title XVIII beneficiaries filing claims with our Blue Shield Medicare Department are also covered under Title XIX. These so-called "overlap cases" are difficult to administer, due to the necessity of providing a consistent approach from the viewpoint of beneficiaries and providers, while adhering to two separate sets of procedural instructions. Although most of these instructions have not resulted in significant difficulties, the coordination of the two programs can be improved. For instance, the possibility of utilizing a single payment for both Title XVIII and

Title XIX services rather than the present system of issuing separate payments under the two programs should be further explored. This idea was considered early in the program by State Government and the Social Security Administration, but could not be accomplished due to the fiscal implications involved, as to who would assume initial responsibility for payment prior to the adjudication of eligibility and adjustment of claims between the two programs. We suggest that the subject be reopened now, when many of the difficulties experienced early in the two programs are on their way to resolution.

A related problem, although not necessarily involving joint action between the Social Security Administration and the Medical Services Administration, is that of eligibility verification for the Title XIX programs. In our view, the basic difficulty is the lack of a uniform numbering system for the Title XIX beneficiaries. This difficulty is not present in the Title XVIII program where a national system is available. This lack has created serious difficulties in the rapid identification of Title XIX eligibles and has caused the carriers and the State to deal with only the symptoms of the problem by creating a system, the "Multi-Card Identification System," in various parts of the State.

The basic eligibility verification problem is in not having a numbering system which remains constant for the individual, regardless of where he may reside in the State or, for

that matter, in the country. The lack of such a constant numbering system also will make program evaluation more difficult as time passes, since an unduplicated count of individuals seeking services, or moving on or off the program, will be a guess at best. One advantage of a uniform system would be an improvement in our ability to identify persons who may have previously been program beneficiaries and when necessary to include their medical history in their records, thereby facilitating administrative and utilization controls.

A major area of concern to Blue Shield, as a service-oriented organization, is that the requirement for categorical linkage before an individual is eligible for Medicaid in California does not lend itself to a medical care program's needs. Presently, under the Title XIX program, it's not enough to be needy and sick to get medical care, but you must also have some other family or personal problem. This is to say that persons who are equally in need of medical care -- but who are not blind, disabled, or parents of needy children -- still are not covered by Medicaid.

As we see it, the real need of the program is a system of eligibility based upon financial and medical needs, not upon the arbitrary categories previously used for the income maintenance welfare programs. Much administrative simplification could result from such a change.

For our part, California Blue Shield will continue to participate actively in the development and progress of the

Medicaid Program in California, which is in keeping with the provisions of our own By-Laws, which instruct us, "to promote social welfare, endeavor to extend services to the fullest extent consistent with prudent management..."

Thank you for your consideration.

HEARING OFFICER LEE: Miss Solis?

MISS SOLIS: No.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: No questions. I want to congratulate Blue Shield on the handling of the number of problems they have had, however.

HEARING OFFICER LEE: Mr. Stewart, I would like to ask a couple of questions.

One relates to mechanisms that you have, at the present time, and whether you think they can be improved either here or elsewhere for the review of physicians' fees and the utilization of services, whether in or out of the hospital?

And the San Joaquin experiment is one example of that -- I'm aware, of course, of the activities of many county medical societies -- and how effective do you think the programs are, and what do you think can be done to improve them?

MR. STEWART: As I see your question, there are two parts to it, Dr. Lee.

The question of the review of physicians' fees is the first question you've asked, and in that regard, I think we have,

over the period of, roughly, three years now since the inception of the Title XIX Program, and also, Medicare, established a much more sophisticated system of fee surveillance, if you will, than has existed previously. I'm referring, of course, to the availability of the physician profile system. This is not, at present, used in the Title XIX Program for reasons of the fact that it was designed to operate at a level of payment which results from the individual physician's usual and customary and reasonable charge as the law requires under the Medi-Cal program. It is used there, and it functions very well. It results in a questioning of about, oh, I'd say, roughly, 2 percent of the injury claims are adjusted downward.

Yes, sir?

HEARING OFFICER LEE: Two percent?

MR. STEWART: Two percent of the individual claims received, and these are adjusted downward by amounts ranging from very small amounts to large sums, depending on the issue developed. The system used for Medicaid in California is a predecessor system to the profile that has now been used which is based more on broad band coefficiencies establishing a range of fees used in the community and comparing the range of claims against those fees to see if it is reasonable.

It lacks the degree of specificity for the degree of profiles, and we have not yet been able to apply the profile system. Primarily, it needs to shift from the present fees which

has been the effect on physician fees on the Medicaid system since 1967, January 1967 level, so there was an attempt to shift over to this, it has not yet occurred, it has been under decision by the State Department of Finance.

We think the profile system is quite effective. We have examined the escalation of fees in California and contrasted it to what has happened elsewhere in the country. We found that in California the rise of physician fees has been less dramatic than it has in other parts of the country. And, in fact, has very closely approximated the increase of living.

So we feel the controls that exist, especially with this more sophisticated system coming on, are reasonably adequate and do pass on what the law intended the individual determination of what is the reasonable charge.

As far as the question of what, I believe, you're asking as to utilization control mechanism; I think, in this area, we are only beginning to do the job that needs to be done. We have had now the experience of examining claims over quite a period of time, we have the ability of knowing what has gone on, we have developed a considerable capacity to do searchings on the record on a monthly service basis for individual providers.

In this regard, then we are able to compare their activities as -- again, compared to what the statistical average on norms would be, and to conduct a check-back, usually, the local community resources, to determine whether or not there was a valid

reason for some determinations. This has resulted in a number of recommendations for suspension -- some have occurred.

We've also had a considerable amount of education process that goes on as a result of the activities of various professional societies, review committees, and we feel that this also serves the intent of the laws. Since we're not really set up, under Title XIX or XVIII, to put Paul Measly out of business, but only to make them come along to where their practices aren't abusing the program and their skills are still available, and much of this has also occurred through the device of prospective review.

As far as the future, I think we are looking forward to a much closer coordination between ourselves and the other fiscal intermediaries in the State under Title XIX. And in due process, and in an effort to tie together the utilization patterns, not just a single provider, but some of the institutional activities of these providers.

And when we get the whole picture, hopefully, identify these and move on ahead. This does require a system in which the information now comes in, the form of the billings can be collated and translated into some sort of a whole state, and that does not presently exist.

HEARING OFFICER LEE: Thank you very much.

Our next speaker will be Mr. Harold S. Fishbein, Executive Secretary of the American Association for Maternal and Child Health.

MR. FISHBEIN: Dr. Lee, and Members of the Panel, I am happy to be in California, because we are National with State Divisions, and we have 150 members in California, in the California Division.

I have been working in Illinois. Illinois has a law which says all children in Illinois must have a physical examination and must be immunized against six diseases: measles, diphtheria, tetanus, whooping cough, smallpox; in addition to that, polio; and in addition to that, it is mandatory that some notation be made on the exam form about the state of nutrition; in addition to that, the law provides that anyone entering the Chicago School System for the first time must have this examination. Naturally, the students may have the examinations by private physicians -- that is, for those who can afford private physicians.

But the question arose, first, to do the examination for those on an "A, B, C" -- or those requiring medical assistance. Since it is in conflict with the law, you cannot make anyone a truant who did not have a physical examination.

But through the cooperation of the HEW and the Illinois Department of Welfare, a system was arranged whereby children on welfare, that is, under ADC under Medical Assistance, would be examined.

Again, the question arose, where will they be examined, who will do it, what will the examination consist of, and how

will it be paid for?

And it was decided that a fee of $10 would be set up for the physical examination and the immunization. And my late brother, Dr. William Fishbein, who was with the Chicago Board of Health, had worked out a system for the children on Head Start. They were examined at the Board of Health stations on the weekends by doctors, by residents, with a staff consisting of doctors, nurses, technicians and clerks. I was the coordinator of that examination for Head Start, and then was brought into this physical examination of the school children in January of 1968, the program started in February of 1968.

Again, a question arose, what do you do with those children who are not on welfare who do not have the green welfare card, and who will examine them, and who will pay for them? And since the law says, when you give an examination to somebody and charge the Federal Government, you must not charge the Federal Government more than you charge anybody else. It was provided you must examine anybody who appears, send them a bill -- they would not be liable to the enforcement of the charge -- but, at least, you must tell these people they have to be paid.

Now, a complication arose. The Board of Health says, "you can't make a charge to anybody in the Board of Health Station." As a result, the program had to terminate in June. And then, the Board of Health took it over. And whether they are completing it, at this rate, I cannot say.

But we did learn many things as a result of this examination. In the first place, there were 126,000 children on welfare. Of the 126 thousand, I would figure half were below school age. I would take another half who were not in the grades provided, which would be 30,000. We examined of those 30,000: 9200.

Some, maybe, had private doctors. The question then, what happened to the rest?

We went into an examination of children who went to camp, because most states say that children who go to camp must have an examination. And the OEO provided the submission of the children--and they always gave us cooperation, because of our experience of examining the children.

So we had a physical examination. This could not be done at the Board of Health Stations. We utilized the voluntary agencies, such as the YMCA, hospitals, settlement houses, OEO lodges. What we learned from this experience is -- several things we learned -- which would be of value to this panel.

In the first place, I don't think many state executives are familiar with the statement by Mr. Cohen in his address in the District of Columbia, "By July 1969, all State Medicaid plans must provide for the thoroughly and periodic screening and treatment for eligibles under 21." It is surely no overstatement to say that this single provision in the law by discovering and preventing illnesses in young people will inevitably raise the

health standards of the nation.

I am sure that many state officials are either unaware of this problem or either unable to figure out a system whereby these examinations can be conducted.

My first recommendation would be that the whole family must be examined. That any examination of children without parents is useless, and we therefore must bring the parent into the examination.

Second, that you bring all of the members of the family, at one time that will be convenient, and that should be on the weekends. We tried examinations on weekdays, we tried it in the evenings, but we found that impossible.

The third thing is, the examination consist of an examination by the doctor, a screening on dental care -- in which case, referral is made to the dentist -- the immunization of the six or seven shots, an incidental shot could be -- and we did this before we were stopped in our project, we tested -- or we inoculated several hundred with German measles vaccine, and the project was delayed, I think, of the German measles, has been delayed, because of our discontinuance of the project and the necessity of having enough people to accomplish it as required by the Department -- by the FDA for this examination.

The new Commissioner has stated that one of the principal problems is planned parenthood. Now, how are you going to get these people in, this is the great problem of all these groups,

because here was a free service offered, and only 33 1/3 percent took advantage of it. As I say, it's a matter, first, of education. You must acquaint these people with the service which is being offered; and second, you must teach them how to take advantage of the service.

Second, you must have these examinations conducted in a place close to where they live. Any place which involves any manner of travel or distance -- because, it would take people who are on welfare -- the matter of even paying a bus fare becomes a matter of such deprivation, they will not come. We found that out when we did this examination of the children going to camp in the voluntary organizations, we had a greater, much greater response and a greater turnout.

If you can use this education for the mothers of planned parenthood, if you can even take a Pap test on the mothers, if you can take a venereal test on the family where you have brought them all together. Now, there is not one of the voluntary agencies, I am sure, that will not cooperate in this venture, and that includes YMCA, settlement houses, hospitals, lodges, any charity, recreational groups, who will provide the facilities.

You can secure the medical personnel that are required in overtime work -- or our "moonlighting" work -- not overtime. This is another proposition: That we could not use the city people on overtime, there was no provision for overtime. The only thing was, they could take time off and they wouldn't ask

time off for the weekends -- time off during the week to do week-end service. You can get people who are working -- this is a fringe benefit, also -- but the people who are working in the hospitals and these other agencies have a chance to make a little extra money.

This is to show the result of the program: We examined 14,000 children. Of the 14,000 children, 98 percent -- the Chicago record of the immunization, which is one of the best in the country -- 98 percent had complete immunization, as far as the six diseases are concerned.

Some of them had to be referred; some in an emergency state, some in a coma, some in the last stages of diabetes, were discovered on these examinations and had to be sent immediately to the hospital. The follow-up system was through the Department of Public Aid.

The examination was made in quadruplicate: One form going to the Welfare, one form to the family, one form to the school, and one form to Public Aid. And it was found that 50 percent of the children had not -- had never had a dental examination.

Now, you can see that just as a result of this test experiment or this test operation, as it worked out to be, that if this is carried out, that there's some means, first, of fulfilling the statutory provisions; second, to provide a medium for planned parenthood education and for tests of the parents in

order to avoid future medical shortages. Immunization which will immunize diseases in the future or crippling paralysis or the mental defects as the result of measles.

HEARING OFFICER LEE: Thank you very much, Mr. Fishbein.

Miss Solis?

MISS SOLIS: Mr. Fishbein, what is the composition of your membership in your Association?

MR. FISHBEIN: We have right now, I would say, 3500 members in all 50 states.

MISS SOLIS: And are these primarily pediatricians --

MR. FISHBEIN: No, they're obstetricians, pediatricians, nutritionists, pediatricians, psychologists, social workers.

MISS SOLIS: I see.

MR. FISHBEIN: Our organization comprises all of the dissidents, we are working here with the California Medical Association -- which has been very cooperative -- this organization is 50 years old and was the predecessor of the college of-- I was interested in seeing Dr. Wilbur's statement in the Medical News of the necessity of the medical profession overcoming these barriers which are standing in the way of every American receiving modern medical treatment and modern medical diagnosis, and the profession must take the lead. And, I think, the profession is taking the lead now.

And through organizations such as this which is composed of all members in our organization, a doctor must be the chairman

of the board, and the board must be -- in the majority, must be doctors.

MISS SOLIS: I would like to ask the question -- and it's a difficult one, because I have heard various opinions in other states, and you may wish to just answer from your own personal opinion: There are various children's programs, of course, operating currently over and above Medicaid or services under Medicaid. One of these programs -- not speaking necessarily for the programs under Children's Bureau -- one of the programs, let's say, Crippled Children's Service, there is a difference of opinion in various states whether the services which are provided through this program should be provided through a regular aid program.

MR. FISHBEIN: On Crippled Children's?

MISS SOLIS: Yes.

MR. FISHBEIN: Well, my own opinion about it is that any voluntary aid must be encouraged. Now, it's true that many of them are fund-raising organizations, and it's true that their activities are limited.

But as we found out in this, that if you leave it to the public factor that the Department of Health -- now, this statute upon physical examination of school children has been in effect in Illinois since 1959 and never enforced, and it was only when we worked out the system with voluntary agencies, with medical agencies, we brought it in, we found the implementation of the

program and found it possible.

Now, if you're going to say, "let the government do it, the government can do it," as one of the previous speakers said, if they want to make this the program and develop the resources of it --

I happen to be the brother of Morris Fishbein, while I don't agree with him altogether, with all of his programs -- I come from the other side of the street -- nevertheless, one thing is true, from my own experience, I've been, also, in charity work, I was Director of UNRRA in Berlin, I was with the Red Cross, so my experience is otherwise -- but it is true, unless you get the voluntary agencies working with you in the field as to the services available, you will not have the means to bring them in. You must get to them through the voluntary agency.

Now, this combination that Dr. Wilbur mentioned of the state and of the public agencies and the private agencies and private individuals and organizations like the Crippled Children's Societies, the Polio Foundation --

MISS SOLIS: I wasn't referring to the volunteer societies, I was referring to the Crippled Children's program administered in this State, in various states.

MR. FISHBEIN: I don't want to speak about something I'm not altogether familiar with -- I wouldn't want to make any statements on. But if the Crippled Children's Program -- again, if the Crippled Children's have a private doctor, that's the best place

for them to go, and their own medical aid, the provisions that Dr. Cohen mentioned in his statute of periodic examination, diagnosis and treatment is the answer.

Now, the question is, physical examinations only are not worthwhile, unless you have a follow-up. This is another one of the propositions we faced, that unless you have a definite need of following up the results of the screening and the physical examination, it becomes worthless. But then, again, you must get after the same parents who have the child brought in for examination to take the child for treatment which is, again, part of the examination that can be given the family.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: No questions.

HEARING OFFICER LEE: Mr. Fishbein, I'd like to ask you a couple of questions. Particularly, relating to mobilizing the resources of the voluntary sector, the voluntary agencies to help achieve some of these major health goals. We have been very concerned about this, and have been working with a number of voluntary organizations, many of whom are very suspicious, of course, of government, and the barriers of communication, I think, are still very great.

I'd like to ask, first of all, if you think it would be helpful in reaching many of these residents of poor neighborhoods who are recipients in these programs, if it would be helpful to have more minority group members on the boards of voluntary

agencies? This is one thing that we have been, at least in our relationships, struck by, that there are very few, very often, members of minority groups who are there. The need to reach these groups is very great. But the difference between the volunteers in the agencies, the board members, and the people who the agencies hope to serve seems to be very great.

Do you have any comments about the benefits of that; and, if so, how it might be achieved?

MR. FISHBEIN: One thing I can tell you, and which I've never seen mentioned, and this is one of the peculiarities in the Chicago ghettos, the Spanish-Americans will not go into the black neighborhoods. We had to move the examination of the Spanish-Americans. I wouldn't say all of them, I would say, 97 percent of the Spanish-Americans will not go into a black neighborhood.

HEARING OFFICER LEE: As to minority contribution, do you think my statement is an accurate one?

MR. FISHBEIN: I would say the minority groups are represented in the voluntary organizations. There has been no segregation, no discrimination in any -- at least, with the Chicago voluntary organizations with which I am familiar, they have all been represented.

The problem of helping the minority groups are the people in the ghettos. The problem of getting them to take advantage of your services, any public service that is offered, is, one, first, education; second, elimination of fear; third, proximity; fourth--

now, for instance, when the Office of Economic Opportunity offered 1600 children the opportunity of going to summer camp for a week or two, it became so difficult to raise those 1600 children, in spite of the large population in the ghettos of Chicago, that they practically had to go out and corral quite a number of them. This was accomplished by the YMCA through the Boy Scouts, the Girl Scouts, through the Jewish agencies, through the Catholic agencies.

The problem is not in the organization, it is not an organizational problem; it is part of the general education of the people in the ghettos. And part of the ghetto problem that you must get some things -- solving their fears, the necessity that they feel in their mind of remaining close to their domicile.

HEARING OFFICER LEE: I would like to ask you another question about improvements in the Medicaid Program and your comment about the message of improving the utilization of services.

In a number of, both, OEO House Centers, Neighborhood House Centers, where there is a good deal of neighborhood participation, of people employed in the Centers, we've seen more effective utilization of those neighborhood resources than through the ordinary Medicaid payment for services. And we've also seen this in maternal-infant care projects where the servies are placed conveniently in the neighborhood, we find the utilization of service the same as -- this includes family planning, as well as other health services -- the utilization in upper or

middle-income neighborhoods. You might say, this out-reach approach with citizen participation is quite different than the payment approach under Medicaid.

How do you see these two being more effectively brought together?

MR. FISHBEIN: I think, and as I say, and the point that you make, as long as the service is close to where the people live, as long as transportation does not enter into a cost factor, as long as you can stress the importance in it, if you can make some degree of compulsion. I've seen it in the statute as Mr. Cohen mentioned about being compulsory to have a system --

HEARING OFFICER LEE: That's in the law.

MR. FISHBEIN: It is in the law. As I venture to say, very few state officials know this is in the law, and now, by '69 July, they must have started up activities to have a system. I saw no reference here of it, I saw no reference in Illinois, although, I had correspondence with Dr. Weber in the State of Illinois, something like this to fulfill this position. You must have it close, you must educate the people both as to the service and how to utilize the service.

There is fear in these people. There is fear of facing a government official, there is the fear of inquiry, there is the fear of going into private lives, there's a fear that something is involved in it that's going to cause a discontinuance of their aid.

The ignorance is not only with them, but there's an ignorance with many on the part of the population. For instance, I picked up the paper yesterday, and one of the columnists had a remark about ADC parents who were having children and how aid should be cut off if any mother who has an illegitimate child, somebody who should have known better, because of her contact with doctors, and the rest of them. Any provision, naturally, doesn't mean you are going to punish the child for the mother's sins -- if you call it a sin on the part of the mother -- and putting the mother in the position -- the ignorance is not one way, the ignorance is also on the part of the people on the outside who really don't understand that by giving the people this kind of service, it is going to benefit the children, because every defective puts a load on the population which somebody is going to pay for, any distributor of disease is a distributor of disease to your children or your grandchildren.

HEARING OFFICER LEE: Would you also like to comment on the point Mr. Flores made, we need to have programs of information and education for the people who participate in the programs who are recipients. He made a very important point, very often the providers, whether it's a physician, social worker, public health nurse, volunteer in the agency, cannot speak the language of the recipient, so they can't communicate.

Do you think we need to have educational programs for the other professionals and the non-professionals involved in the

provision of services so this better understanding can be achieved?

MR. FISHBEIN: We had this problem, we had Spanish neighborhoods we put Spanish doctors in. In this, we had Spanish neighborhoods, we put Spanish-speaking clerks, and Spanish nurses in there.

Naturally, as I say, this is part of the fear to come in and speak a language which no one understands, to come in and see 15 or 20 people about -- record-keeping is a job, you've got to be asked a lot of questions -- and the fear of even answering those questions is something that is going to happen to you. You must get every public agency -- not only those interested in Medicare -- but as I say, the YMCA, the lodges, the recreation groups, the settlement houses, the churches, they must all be made a part of this, so that they can -- now, the parish priest has a great influence on many of these people, he can tell them what to do and to come for the examination. Now, we didn't have much trouble with the Catholic children.

I made a mistake of not understanding -- the law says that private parochial schools had to have this examination. I didn't realize the children in parochial schools had to pay tuition. I opened the station to pay for the parochial -- I had the provision of 400, I had 100 who were on welfare. These are the things you learn.

HEARING OFFICER LEE: Thank you very much, Mr. Fishbein.

We appreciate your coming and giving us this important focus on child health, as it relates to the Medicaid Program.

I would like, now, to ask if there is anyone in the audience who did not have the opportunity to communicate with Mr. Shreve and ask for an opportunity to testify in advance. And if anyone is present, we would like, at this time, to give them the opportunity to come forward to state their name and to give us a very brief statement -- both, submit a statement in writing and to make a verbal statement of about two minutes -- if they would care to do so, at this time.

(No response.)

HEARING OFFICER LEE: If there is no one here who wishes to make a statement, what I would like to do at the moment is then have a 10-minute break, let you stretch your legs, and we will return at 10:45 for our next witness, that would be Jacquie Carey, who is the Assistant Administrator of the California Coordinated Health Care Service.

(Recess.)

HEARING OFFICER LEE: We will call the meeting to order.

I would like to ask Jacquie Carey, Assistant Administrator of the California Coordinated Health Care Service, if she would step forward, please.

Is Jacquie Carey here or is there a representative of the California Coordinated Health Care Service present?

(No response.)

HEARING OFFICER LEE: If not, we will go on to Mr. John Bigelow, Executive Director of the Washington State Hospital Association.

Mr. Bigelow.

MR. BIGELOW: Miss Solis, Dr. Lee and Mr. Shreve: My name is John Bigelow, and I am the Executive Director of the Washington State Hospital Association with offices in Seattle. This is a voluntary organization of all the general and special hospitals in the state of Washington, including several federally-operated Veterans that are Public Health Service and military hospitals. I am also a member of the Medical Care Advisory Committee to the State Department of Public Assistance for the Title XIX or Medicaid program.

I appreciate this opportunity to appear briefly before you to present the views of Washington hospitals on this important subject. And, I am doubly appreciative that you are hearing from a few of us Westerners who are not from the State of California.

In the time that is available to me I would like to cover just two points: first, the essential need for federal Medicaid matching funds to the states to be maintained at not less than the current matching ratio; second, the benefits to be derived from greater coordination of Medicare and Medicaid programs.

The State of Washington has had a fairly comprehensive program for the medically indigent for many years. Because it has been a state-wide program administered by a state agency, rather

than by the counties, the state hospital association has been closely involved with it. Through good times and bad, through policy changes of the state administration, through cutbacks and budget pinches, the community hospitals have been concerned and involved.

In our state there has been a steady decline in the number of hospitals owned and operated by the counties. Another one closed a week ago today, leaving just two in the State. One of the two probably will close in June when free choice will be extended to all those receiving public assistance and to the medically indigent only, the non-categorical.

This means that the community hospitals are serving the hospital needs of all the people in their communities. Any action that affects Medicaid patients affects the operation and the planning of the entire hospital.

Prior to the Medicaid program, community hospitals were subsidizing substantially the State's welfare medical care program. It was not the hospitals themselves doing the subsidizing, of course, but the other patients who were charged more than their fair share of costs in order to cover the underpayment for welfare patients.

This situation continues, to some extent, under Medicaid; but, I hasten to add that the situation is vastly improved. Compared to the past, the Medicaid method of reimbursement on a current-cost basis is a great improvement and is within acceptable

limits for the present.

This does not mean, however, that our long-standing problems of financing care for the medically indigent have been solved entirely and permanently.

For example, the Washington State Department of Public Assistance last week announced medical care program limitations effective January 1st, due to budget problems. The announced cutbacks are regrettable. They are not consistent with our national aims of appropriate and necessary medical care for all, regardless of economic status. But these cutbacks are minor compared with what would happen to our Medicaid program if federal matching funds were reduced as some in Congress have proposed. History has shown that states place a low priority on health care programs for the poor when state funds are limited.

Community hospitals no longer have the financial capability to underwrite medical care programs for low-income and indigent persons. Government has established these programs with the intention of supporting them financially. This burden cannot be shifted to community hospitals without disastrous consequences to the entire hospital system.

We are going through a period of cost adjustment in hospitals. Wages are catching up with the rest of the economy. We implore those in leadership positions to resist the temptation to use increased costs as an excuse to delay further the attainment of national health goals that all responsible leaders, in

government and in the private sector, agree are necessary and just.

These goals cannot be attained without federal support and federal direction. Community hospitals will continue to help all who come to their doors, but there is growing awareness that this is not enough if we are to achieve our national health goals.

This leads to my second point: We strongly urge that new efforts be made to coordinate the Medicare and Medicaid programs. There needs to be greater uniformity of benefits. Time and money saved through simpler procedures such as a single annual audit could be expended toward broader program coverage.

The State Department of Public Assistance and the Federal Department of Health, Education and Welfare; the State Legislature and the Federal Congress all have mutual interests. They want to know whether hospitals are operated efficiently; whether funds provided hospitals for patient care are spent for that purpose; whether the persons receiving care need the care.

It should be possible for HEW, the State Agency, the Congress and the Legislature to get together and do what is necessary to achieve coordination of these programs.

When this happens I am certain all will benefit, including those persons needing health care and who are likely not to receive care under our present system.

There needs to be greater uniformity of benefits. Health care needs do not respect categorical financing programs. When it would be so much more beneficial to keep a person in good

health at 40 or 55 or 60, why do we, under our Medicaid philosophy, allow his well-being to deteriorate until he reaches the magic age of 65?

The sad fact is, that despite numerous excellent reports on the health of the nation and the general agreement that health care is a right not a privilege, we are now in danger of losing ground in the Medicaid program, rather than making additional progress.

Speaking specifically for hospitals, we are making progress in inter-hospital and in hospital-community relationships. We will learn much from our Model City projects. Our planning efforts, understandably slow in getting started, are finally moving.

We are just beginning to understand what the area of the consumer means, and it will take some time to adjust and adopt to it and make of it what is intended. One reason for lack of satisfaction on the part of consumers with their representatives is that we are forcing a new idea into an old system. I favor more short-term appointments or more ad hoc committees in order to obtain the best possible of variety of ideas from consumers.

All of these things that I have mentioned will not proceed if the Medicaid program suffers a serious setback. All of these things will make significant progress if the Medicaid program is supported by Congress and if there is greater coordination of the Medicare and Medicaid programs in terms of benefits and operating procedures.

Thank you.

HEARING OFFICER LEE: Thank you very much.

Miss Solis?

MISS SOLIS: Did I understand, Mr. Bigelow, that you will be discontinuing your county hospitals?

MR. BIGELOW: We have two county hospitals remaining in the State. They are under the control of county commissioners. In one of the two remaining, the commissioners have indicated that in view of the free choice to all the medically indigent, as well as the Medicaid recipients, that possibly the utilization of that hospital will decline to the point where it will no longer be able to be self-supporting. The other county hospital has close association with the University of Washington Medical School, and probably will continue in one way or another within the institution.

MISS SOLIS: But those patients who are served by Medicaid are not necessarily referred to the county hospital?

MR. BIGELOW: They are, at present, in the counties where there is a county hospital.

MISS SOLIS: They are, in other words, not really allowed a free choice?

MR. BIGELOW: No. They are captives of the old anti-quated county hospital system. We have urged that this be over-turned for many years, with Congress requiring the states to do this.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: I just want to congratulate you for bringing forth a point about the need for a single annual audit. That's a problem that has bothered our controller. The audit by our audit agency, the state agencies, and so on, does keep not only the hospitals but the other providers under a constant state of invasion. We are hopeful to cut the cost and have these representative audits. It is not a simple problem, I am happy you gave attention to it.

MR. BIGELOW: I'm happy too.

HEARING OFFICER LEE: I would like to ask, Mr. Bigelow: A problem that is of great concern to the Congress, and that is, the cost of rising medical care. The point that Mr. Williams made regarding participation of hospitals in the Medicaid program, that they would have to meet certain cost effective necessary criteria, that they would have to operate efficiently, and that they -- as I understood the implications of his statement, at least -- would have to participate in effective comprehensive cost planning. Now, these are things that have been growing; particularly, the planning mechanisms.

What is your feeling about this question of certifying the hospital for participation that meets, at least, part criteria; and the second, that they participate in area-wide planning.

MR. BIGELOW: I think these things are all desirable in

concept; but unfortunately, we have not had sufficient time, probably, nor have we had examples of what might be accomplished.

We have -- as I say, we've been in this program of providing hospital service to the indigent for many, many years, and we have seen time after time, that when state finances get a little bit tight, immediately there's a cutback. Well, the cutback is not going in services per se; it's simply the state says to the hospital, "this is all we will pay you. Maybe that will result in cutting back services; maybe, it won't. This is your problem; but, this is all we will pay."

I think, if it be demonstrated that these objectives have measurement of efficiency, participation and planning are meaningful, that you will find hospitals are readily and willing to participate.

As you know, we do not know yet what planning in the health field is. We see frayed possibilities in this.

I think that the emphasis on cost has been unfortunate, in a sense, in obscuring what is being done by hospitals, what has been done by hospitals for many years. There seems to be an idea abroad that hospitals have been totally unmindful of public concern over costs, that they have just operated in a helter-skelter sort of way. And that when you go into a hospital -- the individual hospital you will find, generally, this is not true, they are pretty well operated and pretty efficiently managed, they have a well-trained staff.

What is true, that our critics are saying, that the entire focus on the hospital in the past has been on the individual institution. The patient came in the front door, the attention was focused on his problem and the best was done for him that could be done, and he left the front door, and that's when the hospital interest in him ended.

Now, there is this entirely community-wide conflict with health care. And, the changing rule for the hospital is not being simply as a place for short-term acute treatment, but also a place that could be the focal point of home health services, rehabilitation health services, a broadly expanded range of services for outpatients, rather than focus completely on inpatients.

This adapting to these new concepts does take time. And, I think, until -- I think, it's a little dangerous to experiment broadly -- I mean, it's all right to have demonstration projects, but a little bit dangerous to impose certain things on the entire hospital field. We have the present delivery system of hospitals, as we have known it, and it continues to work very well.

And the cost thing is so simple in concept that I seldom spend any time on it anymore. Two-thirds of the hospital cost is in payroll -- and wages have gone up, they could not do otherwise; therefore, your costs have gone up. There are much more important aspects of the hospital problem than cost.

HEARING OFFICER LEE: Thank you very much, Mr. Bigelow.

Our next witness was to have been Dr. Powell, Director of

the Watts Neighborhood Health Center. I believe, however, Dr. Powell could not be with us, and Mr. Green is here from the Watts Neighborhood Health Center.

Mr. Green, thank you.

MR. GREEN: Dr. Powell asked me if I would come here today and testify the need for the Title XIX.

Mr. Spencer Williams and Mr. Flores and, I think, Mr. Fishbein, mentioned some areas which would relate to the situation in Watts.

But, first, I would like to relate a story about one family that's living in the Watts area. The head of this household, he's a man of 41 years old, he's a head of household of ten. And he works in one of the newly created programs that the minimum pay level of $4,000 a year. His job did not provide as much as White Cross, Blue Cross, Kaiser, or none of the like.

A few months ago when the wife needed an amount of surgery, she went to one of the local hospitals in the area. And, in short, the hospital bill was $260, the doctor bill was $165; and two days later they had a bill from the Los Angeles Anesthetic Association for $65.

This is one example of a family that did not fit in Medicaid, did not have any insurance of a type. And, Mr. Williams mentioned that, perhaps, when the extension is made that the State would make a lien on the house, that the husband and wife would not be required to pay, after death, the children that

would get the home, you know, the payments and the like.

Mr. Fishbein mentioned that some of the problems in Chicago--that they haven't had without fear -- some people fear that if they would volunteer or do certain things that they might lose welfare rights and the likes of this.

We have some families in the Watts area that have worked for 40 and 50 years to pay for a home that is now substandard, and some of these people, even though they may be sick, they won't go to the hospital in fear of a lien on their home. And for those that want to know the family mentioned, is me.

Mr. Flores mentioned that within the State of California that most of the agencies that teaches bilingual is our penal institutions. And I recall back when Reagan was campaigning for governorship, one statement that he made, he said that if he's elected governor, he will attack crime. Most of the people in Watts felt that Mr. Reagan was saying that he would attack poor people; because most of us are aware of the fact that the Negro population of this State is five percent, the Negro population of the State's penal institutions are 35 percent. And where you have five percent of the people, supposedly, committing 35 percent of the crimes, some of the reasons could boomerang back to the health situation within certain areas.

In Watts, we have the multi-purpose health services center, which have been in operation now for 14 months. Before that, we had one county health center that only did preventive

medicine; therefore, the people there at Watts needed hospital -- or even outpatient clinic -- had to travel a distance of 14 miles and ride, I think, three buses -- three there and three back -- which was six buses.

Now, that the center is open and operating and is offering, supposedly, a comprehensive medical service of the small boundaries of Watts that are in a survey that are, supposedly, 42 or 43 thousand people living within that boundary, and there is a lot of those people that Title XIX, as it is now, will not reach those families.

And Mr. Fishbein, I believe, he mentioned that one of the ways to relate to the people within the ghettos is to have volunteers working at the registration offices, or whatnot, you know, but most of the people feel that all of their life they have did work on a volunteer basis, and when agencies come into the area creating jobs, the people that are there to be the recipients have the jobs there bypassed.

This is another thing that could cause a lot of fears. In 1972, I believe, the Martin Luther King Hospital in Watts is supposed to open, and the people that, I believe, that it would serve, is something up to a quarter of a million people. And this would cover the entire southeast, and portions of southwest Los Angeles which is a neighboring suburb.

Mr. Fishbein also mentioned about the kids in Chicago that went to summer camp. We had the same situation in Watts

last summer. I don't recall the number of kids, but I do know that they had a little difficulties recruiting doctors to give immunization shots, and the examination, and so forth; because within the area it's only about five doctors live there, and the doctors that live outside of Watts that works in Watts, they feel as though from eight o'clock to four o'clock they work, and after four they have no association with the people, they don't want to relate with them.

So, in short, as a resident of the Watts area or as a consumer of neighborhood health services, we at the Multi-Purpose Health Center, and those of the residents of Watts, we do feel that Title XIX should be extended where it would reach more citizens that it is not reaching.

HEARING OFFICER LEE: Thank you very much.

Miss Solis?

MISS SOLIS: I want to thank Mr. Green for a very descriptive statement on some of the problems that are not only problems of Watts, I'm sure, but other very large urban areas.

Mr. Green, do you understand, from the people in the area -- now, I had heard you say that you want multi-purpose -- your community health center is just really for people that live within a specified area --

MR. GREEN: Yes, that's right.

MISS SOLIS: -- so that people who do not come within the line of that specified area may not have that kind of care.

What is the experience of people who are not on welfare, but who do need medical care in terms of applying to the Welfare Department for that service; will they do that?

MR. GREEN: Mr. Bigelow mentioned the fact that some of them need more knowledge as to what's available and how to get the services. There is a large number of people that live inside the boundaries that we serve, and also on the borderline outside of boundaries that we serve. About the most comprehensive way I can get to it, is that we do have a large number of people in search of medical services, and that could be inside of Watts and outside of the Watts area.

And, additional to that, immediately outside of the area we have a large population that we do not serve, the population is larger than that we do serve. In the last year and two months that we have been in operation -- I believe, that as of to date -- we have served about 5,000 more patients than had been expected within one year's time.

So the feeling of the people outside is about the same as it is inside.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: No questions.

HEARING OFFICER LEE: Mr. Green, I would like to ask you if your experience at the Neighborhood Health Center in Watts -- and you may or may not have data on this -- seems to be similar as that of other areas, where providing good medical care in

decent surroundings and under circumstances that are suitable to the people who are being served by the Center, and geographically close to people, if it's been your experience that you've been able to reduce the need for hospitals?

For example, at the Columbia Points Center in Boston, they found that the cost of the center has actually been met through reducing hospitalization. People can be treated at the home, treated in the neighborhood, treated in the clinic, and don't have to go to the hospital, are not admitted, and the cost savings have been very great.

And I wondered if it's been your experience or if it's too early to tell from the data you have available, whether this seems to be also true of your Center in Watts?

MR. GREEN: The only answer to that that I will give, and the only answer that I am prepared to give, is that I know for a fact that we have made a heck of a lot of referrals; that is, people that needed services that we just did not have the technical skills to render. Now, the number of referrals, I don't recall, offhand.

HEARING OFFICER LEE: Another aspect of the Neighborhood Health Center has been one -- I think, a very important contribution -- has been the participation of the citizens in the area in the policies of the Center. And in a sense, determining, really, the scope of services and the nature of the Center.

And has this been working, do you think, pretty well in

Watts? Is there a lot of activity, consumer or citizen participation in the program in Watts, and do you think it's been effective? How do you think it could be improved?

MR. GREEN: Oh, according to the number of people that we have encountered with over the past 14 months balanced against the total population, I would say that we have had very good participation. I don't recall the exact import of the question you asked.

HEARING OFFICER LEE: I asked how effective it has been. It has been effective, there has been good participation? Do you think it has been effective in terms of the operation of the Center itself?

MR. GREEN: The operation of the Center and the participation: Yes, it's been good, very good.

HEARING OFFICER LEE: You mentioned one thing about Medicaid that you felt it should be extended so that more people could be covered. The Medicaid does pay for services in the Neighborhood Health Center in Watts.

Have there been any special problems in this regard -- except there are a number of people who are ineligible -- or has that worked reasonably smoothly or are there improvements that you think might be made in that?

MR. GREEN: The ones that live within the area that is eligible, it's been smooth operation. But, again, there is a few families that they have no coverage at all.

For instance, the men that, say, work at the car wash, there's no Union; the men that work at small fountains, no Union; they work at minimum salary of 65 and 70 dollars a week, they have families of five and six children, these are the people that are suffering.

HEARING OFFICER LEE: Yes, this is certainly -- it seems to me you have identified this group as a major group that isn't being served, really, by any program, at the present time.

MR. GREEN: Right.

HEARING OFFICER LEE: Thank you very much, Mr. Green.

MR. GREEN: You're welcome.

HEARING OFFICER LEE: Our next witness is the Very Reverend Monsignor Timothy E. O'Brien, Director of the Catholic Charities, Archdiocese of San Francisco.

MONSIGNOR O'BRIEN: Dr. Lee and Members of the Panel, first of all, you elevated me. I'm not quite Director of Catholic Charities for the Archdiocese of San Francisco.

HEARING OFFICER LEE: I stand corrected.

MONSIGNOR O'BRIEN: I am Director of Health and Hospitals, and Assistant Director of Catholic Charities for the Archdiocese of San Francisco.

HEARING OFFICER LEE: We're happy to have you here, at the present time.

MONSIGNOR O'BRIEN: I'm also President of the Catholic Hospital Association of the United States with a membership of

over 800 health facilities.

I might offer to you the observations of a professional social worker turned professional hospital director. Like Title XIX, I too had to integrate my welfare experience with my new health responsibilities. Keeping a harmonious balance between my two professions is not easy, but it's necessary to avoid schizophrenia. So, you see, I think I have some little insight in the administrative problems that you face in the Title XIX.

It also seems to me that two days after Christmas is a most fitting time to discuss Title XIX. In the spirit of this clerical collar which I am pround to wear, may I suggest that there is a similarity between Christmas and Medicaid. For Christmas is the message of salvation offering joy and peace to all men; Medicaid is the message of mainstream medical care offering quality and non-discriminatory care to all men, especially the poor. The challenge of Christmas is to bring this message to all men and to make it meaningful in their life. The challenge of Medicaid is to bring the message to the poor and make it meaningful in their life. The weakness in Christmas, if you will, is not the message but our delivery of it. I submit the Medicaid weakness is not the message, but our delivery of it.

With your permission, I would like to make a few points regarding the why of Medicaid, some ideas on the what, and finally, a thought on the how -- how all of us can be better missionaries of this good message.

In the years past, and to this date, the Church which I represent with many other religiously and socially minded people served the sick poor to the best of our ability. We are proud of our record of charity. In this State of California, we can be proud in most areas of the care given through our County Hospital System. In the past, medical care was a privilege and so we needed this charity care. Thank God, many responded voluntarily to his sick needy neighbor.

But today, today, medical care is a right. And really there is no need for this charity care. Charity's purpose is not to subvert human rights, charity covers a multitude of sins, but not injustices. Today, there exists the responsibility to give every man his right with no distinction between rich and poor, black and white. In the past, there were two ways of delivering health care: One for the haves and the other for the have nots. Today, there can be only one delivery system of health care. I submit to you that Title XIX hold an important key to the development of this system.

Title XIX, and health care in general, must understand its place and relationship in the beautiful mosaic of human life. Dr. Paul Corneley, President-elect of the American Public Health Association has stated -- and I quote -- "It has been recommended before -- and must be repeated -- that the only certain way of improving the general level of a people's health is through improving the entire social economic and political climate in

which they live" -- the end of the quote. In the December newsletter published by the Task Force on Urban Problems of the United States Catholic Church this idea was expressed in these words -- and I quote:

"Social equality is a prerequisite to economic independence and mobility, and political equality and effectiveness are necessary to maintaining social and economic equality. One must not only be equal but feel equal in order to live an independent life; that is, a life in which the inevitable choices which one must make are there to be made and are not, in fact, determined by circumstances.

"It may not seem immediately apparent in a discussion of health care that independence is so important a consideration. But it is, for history has left in its wake a grotesque trail of ruined bodies and wrecked souls who were dependent on the good will and intentions of others..." -- the end of that quote.

Today, we speak of the community hospital. All hospitals, we say, should be the expression of the local community. Community concern, community involvement and community commitment--these are the foundation of the community hospital. Consider the role played by most suburban hospitals in their communities. Here, the local people contribute substantially, dollars in the fund raising, volunteers in the pink ladies and candy striper, leadership in its board of trustees and advisory boards, medical participation in the doctors living in that community.

Social engagement of the community in the hospital is necessary for the hospital to be successful. Medicaid offers to the needy an opportunity for social engagement in developing community health and welfare programs. Social engagement may be a painful course, but meaningful medical service to those in need is largely dependent upon social engagement. A Catholic hospital was never built -- or can it be successfully operated -- without a meaningful engagement of the local community. Medicaid offers to the poor the opportunity to be involved. We must help them to exercise their new won opportunity. The success of Medicaid will depend on the response of the poor to participate in the development of the communities voluntary health programs -- and note, I said, "to participate."

Clearly, this more subtle aspect of the Medicaid program which I have chosen to describe does not constitute the whole program, but it does provide the necessary philosophic foundation. From this foundation flows a medical program designed to help the poor overcome their greatest disease--poverty itself. For this is the disease which separates the poor from the community. Medicaid can, and I believe must help the community eradicate all discrimination, all separate but equal, all so-called "charity cases, ward cases, welfare cases, county cases." Medicaid will help the community hospital recognize in all patients only one factor: His God given dignity as a human being needing medical care.

Permit me to offer a few brief thoughts on the what, what can be done to improve the program in the future.

Number one, keep the fiscal intermediary as a voluntary agent. The desire for greater efficiency of operation and tighter control should not prompt the destruction of the fiscal intermediary concept. Take away the voluntary agency as fiscal intermediary and you help reconstruct a two-class health system.

Number two, abolish the existing eligibility requirements. Do not tie eligibility to welfare and categorically linked. The present system is inefficient and does not face reality. As others have indicated, study the possibility of an eligibility factor relating to one's income tax report. Consider means for offering eligibility to the marginal income family being driven to despair by a catastrophic illness with extensive hospital and medical bills.

Third, develop -- what I like to call -- a Medicaid Head Start Program. Many of our poor are not capable of accepting and enjoying mainstream medical care. A crowded clinic waiting room is comfortable, a doctor's office may be cold and frightening. Head Start prepares the child of the ghetto to find mainstream education, a meaningful and liberating experience. Medicaid, to be successful, must, in my opinion, develop its own Head Start Program. An effective Head Start Program may help eliminate some of your administrative headaches.

Number four, establish realistic controls on the

providers of health care services. These controls should reward the provider who seeks to cure poverty itself. The financial controls must pay actual cost. They must not be an incentive to the provider to establish two types of health care services. They should offer to the recipient of health services the feeling that his rights are being protected. These controls must make the provider realize that he is accountable to the poor for the privilege of serving them. And, whatever these controls, they must help preserve the American Voluntary Health System.

In conclusion, my thoughts on the how: How we can be better missionaries of the good message which I believe Title XIX is. I guess, I'll have to use my rights as a clergyman and say, believe in the program; believe that Medicaid can destroy discriminatory health care for the poor; believe that you, the leadership of this program can develop the nuts and bolts to make the program achieve its goal; believe that by this program we are finally giving to the poor what is their right; believe that the joy in our life is to serve and be accountable to all men, and specially to the poor. Believe in this program, and it will be successful.

Thank you.

HEARING OFFICER LEE: Thank you very much, Father.

Miss Solis?

MISS SOLIS: Father, have you developed some thinking, some components of your idea of the fourth recommendation on the

Head Start?

MONSIGNOR O'BRIEN: Head Start Program?

MISS SOLIS: Yes.

MONSIGNOR O'BRIEN: I submit, the only -- I have not gone too far in it. I would submit, at this point, I think that the Head Start Program in the health field will have to take some of the same pattern as education. Namely, that we move the educational Head Start Programs away from the school, we operate many of them in little corners, in little rooms -- we didn't build big structures, for they are really communication and participation of people.

What I would say here is what was referred to earlier, this educational, mainly to help these people to understand how this can be a meaningful experience in their lives. It's probably going to open up other social problems, but I think that -- I do not see this as basically operating out of the existent hospitals, this is what I'm saying. And it would have to be programs not of medical care, because Head Start programs are not school programs, as such, realistically. They are to prepare them.

And so, I would see this as the community effort to bring this to the public, to the poor, to help them to realize so they can enjoy it, and find it a rewarding, meaningful experience.

I think one of the things -- that is, problems with our large hospitals, with large clinics -- is that a clinic waiting

room, in my estimation, is a pretty poor place for a social event or a social gathering, but probably more meaningful dialogue and more friendship goes on between the people in that clinic.

I sat one day with a group of doctors, and they said, "I think the people running large clinics could teach doctors something about how you could make your waiting rooms far more warm and meaningful an experience, and not be filled."

Hospital clinic waiting rooms, interestingly enough, do not have large stacks of magazines. The experience there is the people sharing, they know they got three hours to wait, but this is what -- this has become a part of social entity in their life, and, I think, we have to look at this, and this is something we have to face as we try to help these people realize that the world outside of poverty can be a warm, accepting, meaningful world, that it doesn't have to be a frightening fearful catastrophic situation for them.

And, I think, you have done a marvelous job in the program for providing the mainstream. I feel the more important challenge is helping them to see it, to see the beauty in it, to see that something positive in their life, to see it as something that's going to help them to be the person they want to be; not something that's going to frighten them, to scare them, to cause them to leave a world that they know, and come back scared.

This, to me, is the challenge.

MISS SOLIS: Father, don't you think, too, that part of

that also is helping those of us who are deliverers of the source understand that there are resources of strength in the poor? I think we spend a lot of time talking about the deficiencies and deficits in poverty and not enough about the resourcefulness of people and the strength within themselves to make use of the health service.

MONSIGNOR O'BRIEN: I agree with you wholeheartedly.

MISS SOLIS: I think this is an area where we gear ourselves so much to change, so much about that particular patient; and there is so much still to learn that will make the job of delivering care so much easier. I think they could be good teachers, too.

MONSIGNOR O'BRIEN: Oh, I will tell you one little story. I sat on the Phil Burton hearings here, when we had the Watts hearings, I'd like to refer to. I learned a tremendous lesson there in that period of a year and a half, two years we went through it. I came in from a background that says, "let's build a general community hospital down there." Like we usually do -- Catholic hospital, Lutheran hospital, Episcopalian hospital, it doesn't matter -- I realized, "unh-uh, no" -- we didn't know -- we didn't hear what they were saying to us.

And we do have to listen loud and hard, we had tremendous listening to do.

We're expecting -- if I may use my social work background -- we're expecting the patient, the poor to be like any

other patient, we're not accepting the client wherever he is at, in his given situation, and his particular hang-ups, if you will, and his relationships.

If we really accept the patient and the client, we can learn a tremendous amount; but we're not going to be able to meaningfully help them, unless we learn to accept him where he's at, to love him where he's at. Maybe, he has something to teach us, as you said.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: Yes.

One question, Monsignor -- I think I know the answer, but I'd like to have you comment.

MONSIGNOR O'BRIEN: Oh, oh!

MR. SHREVE: I presume, in your description of which you loosely called a head start, you would also include what we normally call preventive medicine training and sanitation, and all of these other fields which have, to some extent, been neglected?

MONSIGNOR O'BRIEN: Absolutely, absolutely.

HEARING OFFICER LEE: I have no questions, Father. Thank you very much.

MONSIGNOR O'BRIEN: Thank you very much.

HEARING OFFICER LEE: Our next witness is Dr. Arthur Howard of Fresno representing the California Medical Association. Dr. Howard, we welcome you.

DR. HOWARD: Mr. Chairman, Members of the Hearings Committee:

I am Doctor Arthur F. Howard, Chairman of the Committee on Federal Medical Care Programs of the California Medical Association. I am a physician engaged in the private practice of medicine in Fresno. Parenthetically, I might say, I'm also a member of the Health Review and Program Council, the Advisory Council to the Medicare Program in the State of California, and also, President of the Fresno Foundation of Medical Care, whose activities in the past year and a half have somewhat restricted that private practice.

I wish to thank this Committee for the opportunity and the privilege of addressing it today on the vital subject of national and state health care. I shall, in the course of this presentation, refer to those areas of health care in which this Committee has indicated special interest. These areas of interest are: The Medicare and Medi-Cal Programs in California. It is my sincere belief that we should be concerned here with physicians' fees and their relationship to Medicare and Medi-Cal; manpower shortage in health care; delivery of health care services; payment for physicians' services; prepayment for health services; proper utilization of health facilities and manpower; quality of health care in relation to health costs and special problems in health care for the aged.

The first question -- "Have Medicare and Medi-Cal

contributed to rising health care costs?" -- has been the subject of broad inquiries conducted in the past by state and federal government agencies and by congressional committees. Regional conferences planned by the Social Security Administration -- one to be held in San Francisco on January 15 and 16 -- will continue to probe this subject.

The medical profession has participated in all such inquiries and hearings to demonstrate its vital interest in the matter of health care costs and expenditures and to underscore the steps it is taking to provide the highest quality of medical care to the public at a reasonable cost. The medical profession, through the efforts of the California Medical Association, its component medical societies and allied health organizations, has not only made vigorous efforts to institute systems of surveillance affecting costs and quality of medical care, but also has made a number of suggestions, referred to later in this report, to state agencies and to the California Legislature in an attempt to resolve many of the problems that face not only California, but the nation as well. We are vitally concerned with, and for some time have been involved in, all aspects of the health care areas to which this Federal Committee is presently addressing itself. It is to these specific health care areas that I now wish to draw the Committee's attention.

My presentation will touch on the highlights of reports which contain authorities and statistics and other vital supporting

data.

Physicians' fees: In California, the California Medical Association developed and has, since 1962, maintained a Physician Fee Index to keep itself informed of the rate of change in physicians' fees. This continuing study was begun to compare data on rates of change in our State with U.S. Bureau of Labor Statistics' data on selected cities and the nation as a whole.

Our Index shows that physicians' fees in California rose four percent in 1967, well below the six percent increase reported nationally. And that physicians' fees in California increased slightly over two percent during the first half of this year in contrast to the almost three percent nationally.

The CMA's Physician Fee Index data supports the findings of the 1967 Gorham Report to the President that Medicare has not had a significant effect on the acceleration of physicians' fees. Furthermore, the fact that physicians' fees in California have increased during recent years at rates lower than those in the United States as a whole, can only lead to the conclusion that Medi-Cal has had no effect whatsoever on the percentage of increase of physicians' fees in our State.

The November issue of Monthly Labor Review contains an article titled "A Closer Look at Rising Medical Costs," which provides some illuminating information on this subject. Among its various findings is the observation that "The rise in physicians' fees during 1946-67 period is partially due to the general rise

in price levels and to the physicians' need for increased income to cover his personal and business costs. Some charges clearly reflect the shortage of doctors. The postwar emphasis on medical specialists has also helped boost physicians' fees since general practitioners have become scarce, and specialists, with their extra training, are able to command higher fees..."

The impact of wage increases for nurses, estimated at 20 percent across the country in 1966 by one eminent authority cited in the Monthly Labor Review article, has been felt by physicians as employers, and is reflected in the upward movement of their fees.

The Monthly Labor Review cited that out of the cities studied in 1967, the increase in physicians' fees was smallest in San Francisco and the Los Angeles areas. The percentage of increase in Los Angeles ranged only 64 percent, and San Francisco was in last place.

Health Manpower: There are serious manpower problems, although no critical shortage in any occupation, according to preliminary findings in the first State-wide manpower survey of California health personnel.

The survey was conducted by the California Health Manpower Council and entailed visits to 200 hospitals, more than 50 nursing homes and 75 clinics, commercial laboratories, medical and dental offices.

Other areas in health care in which the CMA is actively

engaged are: Peer Review, Prepayment Program for Medi-Cal Recipients, Proper Utilization of Health Facilities and Manpower, Quality of Medical Care and the Special Problems of the Aged. Each of these areas are dealt with in detail in the written report before you and are too involved for a lengthy discussion, at this time.

However, CMA's efforts in all of these efforts is a positive statement that we feel that it is an effective and a dignified way of providing health care services for needy citizens. And we believe that the Medi-Cal Program is the most successful Title XIX Program in the nation.

The CMA further believes that the use of non-governmental fiscal intermediaries and the continuing review of claims and services by thousands of physicians at no cost to the taxpayer or to the government, are factors largely responsible for the outstanding success of the program.

The CMA again pledges its full cooperation in legislative efforts to improve the Medi-Cal Program in the interest of providing quality health care for our indigent citizens.

Thank you.

HEARING OFFICER LEE: Thank you very much, Dr. Howard.

Miss Solis?

MISS SOLIS: No.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: No questions.

HEARING OFFICER LEE: Dr. Howard, I would like to ask you a question about the cost problems, which has been one of the major problems plaguing the program, and one of the major concerns I think, of the Congress.

Would you have some specific suggestions, in light of the California experience indicating a much lower increase in physicians' fees -- of course, the physicians' fees don't really account for a large percentage of the cost for these programs --

DR. HOWARD: I think 19 percent.

HEARING OFFICER LEE: -- rather, it's the institution cost, in the utilization of institutions.

You touched, very briefly, on the efforts of the CMA, and your own efforts clearly indicated your involvement in this, in terms of the CMA, in terms of Title XIX Advisory Committee, in terms of the Fresno Foundation on Medical Care. Would you care to comment on the California experience in this area; what steps may be taken, either by the profession or in cooperation with the Blue Shield or insurance companies and government, to provide more appropriate utilization or -- not just cost controls, because I think one of the problems is having the right service for the person at the right time, and I think one of the things is the nursing home area, and is one of the most complex sides of this issue.

DR. HOWARD: I think -- and I've made this statement since I first went on the Council -- in the nursing homes, people are

incapacitated, in the sense they cannot move about; but the regulation of fire marshals, and so forth, must go into nursing homes. They're really not getting nursing home care in the sense they need it, nurse's aide or R.N. to take care of it, and this is where the intermediate type facilities could be developed. I think the Federal law now provides for such.

This is not really a medical care, this is a social problem. The cost of paying a nursing home for true nursing care is being charged to the program, but they're really not getting it. We have no other place to put these people, they can't go to a boarding care home, they have an amputation of one or two legs, they have some other disability, the wheelchair confines them.

The basic thing is, there is a large nursing home for people that are not getting nursing care, in the sense we understand it.

HEARING OFFICER LEE: So many people have commented on the need to expand the program, particularly in the area of the medically needy, and there have been a number of examples cited.

Would you care to comment on that? As a practicing physician, and also, as a representative of CMA, you certainly have seen the problems faced by people in this category.

DR. HOWARD: Of course, the biggest problem we have is people that, under true need, would be the requirement of categorical aid. I could give you example after example of people who are truly medically indigent, and the husband is with his wife

and is making $500 a month; and therefore, is not eligible. If he were to leave her the next day, then that child who is in the hospital could be covered.

These are the things that are disturbing to doctors. Many true medical needs are not met because of the lack of categorically, being categorically linked.

HEARING OFFICER LEE: Thank you very much, Dr. Howard.

Our next witness is Gordon R. Cumming, who is the Hospital Administrator of the Sacramento Medical Center, and an old friend. Gordon, thank you for coming to the hearings.

MR. CUMMING: Thank you, Dr. Lee, Miss Solis, Mr. Shreve.

My name is Gordon R. Cumming. I appreciate the opportunity of appearing at this hearing and hope the following comments will be of interest and value. These are my personal opinions and not necessarily those of any group or association.

As you know, in California our Title XIX program is called Medi-Cal. It became effective March 1, 1966, with the full support of both major political parties and with support of all sectors of political and professional interests in California including doctors, hospitals, labor and consumer groups.

In California we have developed a big program which serves approximately one and a quarter million people and provides a wide range of benefits. Inevitably a program of this magnitude has had growth and development problems. Most of these have been financial. Inflation has taken a much higher toll than most

people expected. Now we sometimes hear lament and reference to the good old days when care for the medically needy was cheaper and less complicated.

I think it's very important to recognize that Medi-Cal has achieved much of its objective which was to end segregated medical care for the poor in California. Eligible medically needy patients now have reasonable access to all providers of health services which serve the general population instead of being served in a separate county hospital system. This is good. If government, hospitals and doctors have acquired some problems, this is much less important than the fact that the people are now so well served.

It is important to recognize that our revolution in health care is only one part of a larger social revolution which creates stress in many sectors of our society. The old ways are under attack. Since health care is now a social service and a civil right, our ingenuity in providing equal health services to the disadvantaged is a big challenge and responsibility. It is and should be generating pressures on government, medicine, hospitals and all other components of the health care system to assume leadership to organize the delivery of health services in the most effective possible ways.

The public, providers of health care services and government have a mutual interest in making available good health services to our people in an economical and efficient manner.

This mutual interest involves reliance on mutual competence, responsibility and cooperation. Society cannot expect high quality without being willing to provide adequate financial and other support. Health providers cannot supply high quality without obtaining this adequate support.

To deserve and receive public and governmental support providers of health services must be able to satisfy the public that funds are being expended prudently for services of high quality which are provided in an economical manner. For example, government should have no obligation to reimburse hospitals without reasonable evidence that these tests of effective public service are met. I believe we must acknowledge that hospitals have a public nature regardless of their ownership. If hospitals are to be reimbursed adequately for effective service the public should insist in restraint on costs and full public cost disclosure.

Our national objective for 1975 is to provide comprehensiv high quality services to all the medically needy people of our country. Some reorganization of the Medicaid program through Federal action is necessary if this desirable objective is to be attained. Using California as an example, limitation of Medi-Cal to welfare recipients and to linked medically needy has made it impossible to achieve one state-wide standard of service for medically needy people and has worked against the logical system of Federal-State-County financing for the Medi-Cal program. I

imagine a similar situation exists in other states.

In California Medi-Cal established one state-wide system of service for the recipients of public welfare, with essentially equal benefits and equal financial responsibility on the part of patients and their responsible relatives. This is true also of those categorically linked to welfare eligibility. For all the other needy poor, no Medi-Cal eligibility exists. Our 58 California counties establish eligibility and service standards for these patients. This not only is unfair to the patient from a service and individual financial liability standpoint but results in a complex and confusing organizational and financial state-county partnership in producing the money to match Federal funds in the Title XIX program.

In summary, I believe, the political decision to establish Medi-Cal and similar Title XIX programs is sound and popular. It is unlikely to be reversed. The program has had growing pains because of its magnitude and complexity but has functioned very well under the circumstances. The objective of comprehensive, high quality medical care for all medically needy people by 1975 is desirable and should be pursued strenuously.

To achieve this objective, in my judgment requires: First, aggressive Federal leadership in exercising control on program scope quality and cost. This leadership should include encouraging experimentation and innovation particularly in systems of delivery and paying for services. This will lead logically to

greater emphasis on preventive services, which will improve levels of health and give us more for our money.

Second, present Federal law which includes the requirement of categorical linkage for eligibility under Title XIX should be changed to make all medically needy eligible for Title XIX benefits. This is necessary to attain the program objectives for 1975. It also is necessary to make the program and its financing more effectively serve the public interest.

We cannot afford to practice false economy through failure to support the provision of good health services for the medically needy.

In recent months much has been written and spoken about team effort in advancing the objectives of the Medicaid program. I believe very firmly that much public benefit has come and will continue to come from this commitment to public-private cooperation involving knowledgeable providers and self-regulation. I hope in this process the fullest possible use will continue to be made of the fiscal intermediary as a buffer between government and the voluntary health system.

I shall be glad to attempt to answer any questions you may have.

HEARING OFFICER LEE: Miss Solis?

MISS SOLIS: Mr. Cumming, I'm afraid that I don't really know what many people mean by "quality."

Quality as a physician sees it? Quality as a hospital

administrator sees it? Quality as the consumer sees it? I know we have very many variations of the definition -- if we have a definition -- however, your concept, and in your observation -- and this has to be a personal opinion, of course -- has quality of service provided through the hospitals that have become community hospitals who were that of formerly county hospitals, has that shown improvement in terms of quality of service?

MR. CUMMING: I believe there has been marked improvement of quality of care for people, both in the private hospital setting and in the county hospital setting in California during the last two years.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: No questions.

HEARING OFFICER LEE: I have no questions, Mr. Cumming. Thank you very much.

We will now stand adjourned. We are running a little behind schedule, but pretty close, so we'll reconvene, instead of one o'clock, 1:15 for the afternoon session.

Thank you.

(Luncheon Recess.)

HEARING OFFICER LEE: We will open this afternoon session and welcome some of you back, and welcome those of you who have come in for this afternoon's session.

Mr. Shreve will be joining us a little bit later, but I think we will proceed with just the two of us.

Now, our first witness this afternoon is Duane Higer, Executive Secretary of the Nursing Home Association in Idaho.

Mr. Higer.

MR. HIGER: Thank you very much.

In the words of Wilbur Cohen, "We have almost three years of Medicaid behind us. This is a good time to review this experience to examine the program closely with a view toward making it more efficient, economical and responsive."

And my plea today is a simple one, probably, I hope, a simple one to you; or maybe, some ideas might be forthcoming.

Mr. Jenkin Palmer, who is the State Representative, had planned to attend this hearing, but he has a cattle snow bound in Southern Idaho and couldn't make it, but sends his greetings.

In addition to being a part-time executive secretary for the Nursing Home Association in Idaho, I am also Administrator of a 52-bed county nursing home, a $500,000 project which we're very proud of.

Some of the words I have, to begin with, is irrelevant, but I want to leave this up to this Advisory Committee.

As a Council, we have worked very closely with the County Commissioners, representing our nursing home in Pocatello, and in the past through experience, have established a closer liaison with the State County Commissioners Association which represent our 44 counties in Idaho.

There are 52 nursing homes with some 3500 beds of which,

approximately, 2700 are welfare recipients. Since the ratio there is about 70 percent are on welfare or indigent roles, the Idaho Association of Licensed Nursing Homes is presently attempting to assemble data from all members of the Association concerning average costs of patient care and revenues derived therefrom.

This information, when compiled, will be used for two purposes: One, for assisting the Association in its task of representing the nursing homes of Idaho in the field of legislation, both on the county and State level, and, two, to provide the participating nursing homes with summary information which can be utilized by them in assessing their own operation by comparing it with State-wide averages and percentages.

This information will also be given to county commissioners, because they certainly represent the grass roots level of people. It will also be given to members of the Fiscal Budget Committee, because we attempt to work very closely with them.

The fiscal management of Title XIX benefits is truly a complex administrative responsibility, and we realize that this takes extensive team work on the part of many to represent the people, to not overpay some providers of service, and yet not underpay them.

The 1967-1969 Biennium Budget Report of the Department of Public Assistance is, approximately, $8 million, and some $3.5 million will be given to nursing home care.

So we need the cooperation of the Fiscal Budget Committee of the State Legislature and the Department of Health, since they write the laws that providers of service must conform to; that is, if they plan to stay in business.

We also cooperate as closely as possible with the county commissioners and other officials in the State.

What we need, and what I'm talking about is, we need an advisory committee that actually does something. Two years ago, we asked the Governor to appoint an advisory committee, he did. And in the two years, after nominating an accountant that sits on this Advisory Committee, the Chairman of this Committee, of course, is the Department of Public Assistance Commissioner, this meeting has never been called. The President or the Director of Blue Cross in Idaho who is also a member of this committee, and he's never been notified of any meetings.

The problem with having a committee like this is one man tends to rule the whole program. And in the words of State Representative Jenkin Palmer, this man has a 43-year old dynasty he rules and controls completely as he sees fit.

Now, he's extremely thrifty and he's run a good program, and he's hard working, I'm sure.

But we feel, for providers of service, especially proprietary homes are competing to pay the wage scale and give proper service as specified under the State plan of rules and regulations for nursing homes by the Department of Health. I run

a county nursing home. I have a problem financially, I look to the county commissioners for funds. I'm not amortizing a mortgage, I'm not paying taxes, these people need to be heard from, and a grievance advisory committee could hear their problems.

I talked to State officials that were to serve on this advisory committee two years ago. One, Laurie Larson told me that she had never been advised of a meeting, and never knew of any meeting held.

And that was a period of three years. So we have five years that we've passed through, no advisory committee meetings.

I've talked to the Governor about this, and we're hopeful this will come about, but we've never been notified.

We feel that if the Title XIX program is to fulfill the requirements and demands of all the participants and the people that receive monies from the Department of Public Assistance, that should mean we have an advisory committee in which we can be represented.

The method right now, and the method that's been utilized in the past 10 or 20 years has been one of frustration. Each year we go in and complain, we take cost statements in, we've had two raises, $30 in the last three years, that's $30 per patient per month.

Like most states, we're faced with minimum wage laws, and we feel if we have someone on this advisory committee, then the proposals could be made with costs so that these costs could be

taken to the Legislature.

In 1967, there was a special session called because of communication. The communication between the Department of Public Assistance and the Legislature.

I'd like to take just a moment to read through part of the State Plan for Medical Assistance for the State of Idaho. It's very precise, it's quite definite. But as far as any allotment is concerned for nursing home administrators, I'm speaking definitely now to the proprietary interests, they have a real problem because they face, at times, bankruptcy, because we are required to compete, we are required to staff, as the Department of Health writes up specifications.

I'm sure you are familiar with this, I'm also certain part of it is irrelevant. Let me read from the first page of the State Plan for Medical Assistance for Idaho: "As a condition to the receipt of Federal funds under Title XIX of the Social Security Act, the Department of Public Assistance submits herewith the State Plan for Medical Assistance, and hereby agrees to administer the medical assistance program in accordance with the provisions of this State Plan, Title XIX of the Social Security Act, and the policies and interpretations of the Commissioner of Welfare of the Department of Health, Education and Welfare as contained in Handbook Supplement D, Medical Assistance Programs, and in related regulations and policies..."

Paragraph A, "Single State Agency: The Department of

Public Assistance is the single State agency with authority to administer or supervise the administration of the plan..."

Paragraph B, "State-wide Operation: The State plan will be in operation, through a system of local offices, on a State-wide basis in accordance with equitable standards for assistance and administration that are mandatory throughout the State..."

I'm sure, this is the same in most states. Let me skip over a few pages, please.

Turn to Page 9, Part IV, Paragraph B, "Staffing for Administration of Medical Assistance Programs," Part 2, "The Department of Public Assistance will provide for the establishment of an advisory committee to the Commissioner on health and medical care services. This committee will be appointed by the Commissioner" -- two-thirds -- excuse me -- "The Department of Public Assistance will provide for meeting the following education and experience qualifications for skilled professional personnel..."

This deals with personnel. The former paragraph is the only one in here that relates to this advisory committee.

Now, we've worked as closely as we could with the Denver Regional Office, and the cooperation has been excellent. In fact, we feel if we had the cooperation on the State level as we have from Dr. Van Orman's staff, namely, Sterling Peterson from the Denver Office, our problems would be minimal.

One thing I bring to you today is that we need an effective advisory committee in Idaho. Now, we've gone -- I know of

five years -- without this help. At the last minute, we make a desperate plea for money, and when some of the homes are nearly bankrupt, then the Commissioner listens to them. And we have received an increase of $15 a month in October, we had hoped to receive this increase the first part of 1968.

And this is all I have, at this time, to testify to, but we are open to ideas. We want help from the Denver Office, and we've come here. We're now working on a plan to have a fiscal intermediary, such as Blue Cross or Blue Shield. The legislative committee working on the fiscal budget is also interested in a type of fiscal intermediary, because they, too, are frustrated with the same problem we are.

HEARING OFFICER LEE: Thank you very much, Mr. Higer.

Miss Solis?

MISS SOLIS: Mr. Higer, who is the department responsible for the licensing of nursing homes in your State?

MR. HIGER: The Adult House Division.

MISS SOLIS: Does your Association include both publicly operated and proprietary nursing homes?

MR. HIGER: Pardon?

MISS SOLIS: This Nursing Home Association --

MR. HIGER: Pardon me, does it have both?

MISS SOLIS: Yes --

MR. HIGER: Yes.

MISS SOLIS: -- in its membership?

MR. HIGER: Yes.

MISS SOLIS: The Medical, the advisory committee to which you refer, is this on the general State Medical State Assistance Advisory Committee or is this for nursing homes?

MR. HIGER: It's for the total program.

MISS SOLIS: It's for the total program?

MR. HIGER: Yes. And we hoped for a representative from the Nursing Home Association to be on this. Governor Samuelson, in 1967, appointed one of our members to this committee which has never been called.

HEARING OFFICER LEE: I have no questions. Thank you very much, Mr. Higer.

MR. HIGER: Thank you, sir.

HEARING OFFICER LEE: Our next witness is Dr. Stanley Skillicorn who is the Medical Director of the Santa Clara County Migrant Clinic, and he's Past President of the County Medical Society, which has been one of our most progressive, and he has certainly played a key role as a medical leader in Santa Clara County in a number of areas, not only improved the care of medical care available, but to make it available to all the citizens in the county.

And Dr. Skillicorn is accompanied by two other citizens of the County. Stan, we welcome you to the hearings and your people who are with you.

DR. SKILLICORN: Thank you very much. It's very nice to

see you. And it's an unexpected pleasant surprise to see you, Miss Solis.

My primary concern for appearing today was not to represent myself as the Medical Director of the Santa Clara County Migrant Clinic or my other activities, but as a practicing physician.

And the request was made, primarily, that I might be given the opportunity to, with your permission, have testimony made by consumers. I wasn't sure this would be part of your hearing process, but I took the liberty of bringing in somebody with me in that regard. In a moment or so, I would like to kind of informally interview a patient of mine who is on Medi-Cal, hopefully, that we might get a viewpoint of the program from her perspective, rather than our own.

But before doing that, I would like to express a couple of concerns in regard to Title XIX or Medi-Cal. And my greatest concern has to do with those citizens that are not included in the program, and one area I'm particularly close to, of course, are the migrants who come to California each year or move around California, taking, servicing our agricultural areas, work that nobody else seems to be able to do, and most of whom are not covered in any medical care program.

I hope the day will soon be coming that, particularly, this segment of our population will be covered in some form or another for adequate health care.

And secondly, I would like to express, at least, a moment of concern regarding a number of practical problems of implementing the program. The practical problems that I have become aware of as a physician seeing patients on Medi-Cal, I'm not concerned with my problems as much as it becomes immediately a problem for the patient.

There are very few physicians that I know of that aren't having troubles with Medi-Cal, whether it be billing or appointments or whatever, who assume the responsibility entirely on their own, and then they, very quickly, because of busy schedules and otherwise, delegate the responsibility. The patient will lose his outfall, too often.

In Santa Clara County, about 16 percent of our population is Mexican, and we have about 40, 45 thousand Mexican people who do not read or write English, we have 5,000 who do not even speak English. And to move in a world of "Buck Rosy" with the tropical acquiring of Medi-Cal for this group of people, I think you can understand it can be very difficult, and it is very difficult.

I want to have this young lady come up and point out the problems with "her people," as she calls them. They won't speak out, they won't communicate when they know they have needs, when they know they even have rights they're reluctant to speak out, for a variety of reasons, we'll show in a moment.

I'll give just a couple of brief examples. I do not hunt for these; the examples being on the top of the pile in my office,

as I left -- to show you the problems.

I'm not sure this is appropriate for a hearing in this degree of formality, but it is very important for the patients using Medi-Cal.

One of them has to do -- I'll leave the name out, I have them here -- one is a patient who is 67 years old. This is a relatively minor thing, but it's been going on since June of 1967. I've seen her intermittently for a rather severe problem. She came from Mexico, she is a citizen, she has a Medi-Cal card, we began billing Medi-Cal. And started getting notices, "First, you'd have to bill Medicare, they pay first, and bill us the remainder."

We got several notices back, and finally got the classical one back, she could not prove her birth date, she is not eligible for Medi-Cal. From Medi-Cal, "We don't pay until Medicare pays."

How long is this going to go on for a patient who believes she built up a bill of $9 in one and a half years. I don't have the nerve to bill her, because I know she doesn't have it.

It frustrates patients, most offices would then bill the patient who is then thrown into a dilemma -- she doesn't understand the technicalities of bureaucracy.

More tragic is the fact that some doctors being confronted with this kind of difficulty is discouraged about taking the hard-core patient, because of the letter writing, and so

forth, that has to be gone through.

And another one, very briefly, just came in the other day, is a young boy that I've been seeing for many years for convulsive disorder, has been on Medi-Cal, very poor family, and I received a notice that they have a notice form code 12, "This patient cannot be found on the State's master eligibility file on the number shown on the claim. Please submit correct number, or otherwise bill the patient."

We have a procedure in our office, we photocopy the card just to be sure we don't run into this kind of thing. So, somehow, the number doesn't show on the master file. I doubt if he's kept the September card, because they get a new card each month, but I doubt that he has it.

There would be no alternative, I suppose, unless we took it upon ourselves to try to substantiate he indeed did have a card that month, and write other letters back. This kind of a disturbing mechanism can be overwhelming. We haven't fatigued in our office, but we are getting close to it. This is just the mechanics.

This kind of a thing, as I said before, is reverted back to the patient, sometimes in hostility, we're capable of this, I'm quite sure.

Now, I would like to get on to my primary reason for being here and requesting to be here which is to hear from a consumer at firsthand. I want to clarify this, because I am a bit

embarrassed, because I am taking advantage of this gentleman and his wife. They are patients of mine, have been for some time, their name came to mind when I thought of this, and -- "of course, they'll be here."

I've been a secret admirer of Mrs. Benavides for some time, because of her humility and humbleness, but mainly because of her perseverance and stamina to be able to get through much of the bureaucracy that it takes to get through for proper care. She has a burden, which I won't go into at length, because of her family for health reasons, which most of us, I doubt, could hold up under. She has a 10-year old child who has been mentally retarded since childhood, has epilepsy, does not speak, though communication does carry on between the mother and child. And has a husband who is unable to work for health reasons, and has several small children, and she has been keeping this family going for a number of years.

I would like to ask for your permission -- none of this is prepared, I tried avoiding directing her into which I thought she would say, I'm not sure whether it will be good or bad, though, I'm sure she will be very gracious about it.

HEARING OFFICER LEE: We're delighted to have her, and appreciate her coming, and also, to have this opportunity to have this kind of presentation. This is the essence of these hearings, it's to reach the people who are involved in the programs, and to learn from their experiences how the program can be improved, to

eliminate some of these kinds of problems that you've mentioned, and some others that Mrs. Benavides may identify for us.

DR. SKILLICORN: Thank you very much. Mr. Benavides would be happy to participate, but he does not speak English clearly, he did want to come with us.

I discovered on the way up, they've never been in San Francisco before. They've lived in Morgan Hill for seven years, I've also discovered they've never been in an airplane or even a train. So people live in different worlds than that in which we live.

Mrs. Benavides, I wonder if you can explain to us what your reaction -- you do have a Medi-Cal card?

MRS. BENAVIDES: Yes.

DR. SKILLICORN: Can you tell us, very briefly, what this has meant to you? What does Medi-Cal mean to you, as a patient?

MRS. BENAVIDES: Well, I don't talk very good English, but I hope you understand it. This is the first time I'm going to be in a place like this where I'm talking in the front of everybody, but I hope you understand what I want to say. I don't know too much English, but I don't understand very good, either. I'm doing my best, I'm just going to say what I know what I feel. That's all I know, I hope you understand what I'm going to say.

What Dr. Skillicorn said about Medi-Cal, I think it's a great help to me, because I don't know what I'd do without the Medi-Cal, the way I got my child and my husband.

But I know it's very good, and I hope everybody has it, because I know a lot of people that they have a big problems, too, and they don't have it.

And the way a big problem -- I understand other people's problem, because I went through a lot, and I understand other people.

But a year ago, I received a bill from the drugstore about $92, and they was for the medicines that Medicare didn't cover -- and didn't they make me pay all that money? I don't know why, because I went to the Welfare, and I say, how come they send me the Medi-card, and they didn't tell me I was going to pay later. And they say that they don't know, either. So I have to pay the bill myself, so this is what I don't understand, because they sent me the Medi-card every month, and then, later, two, three months later, they sent me the bills. I don't know, they tell me, you know, sooner and not, when I don't have money, because, you know, the drugstores, they want all the money, they don't want to wait. The only thing I don't understand.

I'm very grateful for the Medi-card. Like I say, I don't know what I'd do without it.

I got this arm over here, it's all burned (indicating), it's all burned, because I don't have any money, I don't have any insurance, I don't have nothing, if not for the Medi-card. At this time, I do not have this arm like this (indicating).

Like two years ago, I was losing this arm (indicating).

I didn't pay no attention before, I had no money, no insurance. When I received the Medi-card, I was losing the arm, it cost $1,200. So you see, I didn't lose my arm, so I'm proud of the Medi-card there.

I hope everybody has it, like I say. I've been going through so much. I understand other people. If you don't have this problem, I still say, everybody need it.

I know some family over in Morgan Hill, their husband is working on parts, they make trailers for the big camps and campers, like that. This family, it's a big family, about nine or ten in the family, and the man earn 104 a week, and she got an 11-year old, he got epileptic spells. And her husband -- he already has a heart attack, he's very weak, he's still working over there, because it's people they are afraid to talk. And he's been going to Dr. King in Morgan Hill for a number of years, I know, and she's been paying, and she's been paying that little boy medicines, and only because he earned $104 a week, and he's working with the Birch Company.

I wish you'd see that family, he sure need it. He's got a lot of kids, and most are -- two are big, they're going to school, and they need a lot of money for their things at the school. And that people sometimes, they don't buy something for the kids or, you know, they would lose the money to pay the bills and to buy the medicines.

So, I say, everybody needs it. So I don't know if you

want me to say something else.

DR. SKILLICORN: No, this is fine. One other thing I'd like to ask, Mrs. Benavides, do you have any problem in your local area now that you have the card of getting medical care; do you have problems getting doctors to see?

MRS. BENAVIDES: Oh, yeah, yes, like I say, about these bills, no doctors want to see you no more.

About three months ago, my boy -- my boy, the one he's ten years old, he cannot make -- he got trouble with the bladder, and he cannot make water. And we were so afraid, and we took him to the -- morning, about 9:30, we took him to five doctors in Morgan Hill, and nobody wanted to take him. He was all night and all those hours not making water, and he was all swollen. He would just holler and holler.

And we went to these five doctors, and they don't want to see him. I say, "I've" -- "the Medi-card"; they say, "no." They, you know why, because they're having trouble receiving the money with the Medi-card.

They sent me to Wheeler Hospital, they didn't do nothing. They took me to Morgan Hill's hospital.

Yesterday, I took a lady, she's from Mexico, she doesn't know English. She told me to take her to the doctor, her little boy was very sick and vomiting, nobody wanted to see him. He said, "you got Medi-card?" She says, "yes." He said, "no, go somewhere else, the Medi-card doesn't want to pay. We got a lot

of bills behind, and we don't take nobody with a Medi-card no more."

DR. SKILLICORN: Thank you very much. Well, I think we can go on and on, I think it's the personal experience -- I think, it's the personal experiences that one has in regard to the consumer level. So many things, I'm discovering daily, merely by trying to explore a little, the many, many problems that exist, that we know exist, that I think are rather striking.

We mention the difficulty of getting a card, and then being so pleased to have a card, and then not being able to find a doctor to go with it. For a variety of understandable reasons, with an extreme shortage of doctors, who are frustrated with the delay of payments, and expenses on their own. This doesn't help the patient.

With her observation, I hope to explore further on my own of the rather large, of the large, significant number of people who are not eligible for a specific number of reasons -- I'm sure, legitimate reasons -- a family of 11 with $104 a week with sick people in the family, and I don't know how many of us could stand any kind of a medical bill with $104 a week with 11 children. I hope we can look at it honestly and do something with this.

She mentioned, "why these hearings? Is there a question there is a need?" I said, perhaps, "there is." I never cease to be amazed that society kind of recognizes there is a need there, but really doesn't believe it until you touch it and feel it.

I apologize to her for putting her on exhibit. I hope you appreciate, not from my viewpoint, but from Mrs. Benavides's viewpoint. This is not their everyday activity.

HEARING OFFICER LEE: Thank you very much.

Miss Solis?

(Statement made by Miss Solis in Spanish.)

HEARING OFFICER LEE: Thank you very much. I have no questions, Stan. But I certainly appreciate this statement, and this, really, as I said before, is the essence of what these hearings are about.

Our next witness is Vernon Bier, a consumer of medical services.

MR. BIER: My wife and I are both totally disabled. She is drawing Social Security and a VA Pension, and I am drawing the same. We are not 65, so we're not eligible for Medicare. She draws a check of 66 and $87 Social Security. I draw one $105 and 82.30; but some time ago, the Veterans Administration switched me from 50 percent service connected from World War II, and they switched me over to non-service connected.

Well, I applied for Medi-Cal, because -- I have heart trouble, and I have kidney trouble. I go to UC. The doctor ordered me, because my wife is disabled -- and the Welfare said, "we'll give you one for two and a half, two and a half an hour," that's 300 a month. We receive on our total combined incomes a little over $300 a month. Well, they give you a Medi-Cal card.

Your liability is going to be $86 apiece a quarter, but it's a Group 2 card, it does not pay for medicine. But you still got to pay the $86 apiece, before you can see a doctor.

And by adding that to two and a half to pay off our housekeeper, we had $40 left, and our rent is $61. There wouldn't be any money left for medicine.

I have the Medi-Cal cards right here, and they're Group 2 cards, I have them right here. And I don't understand it. Some people, they can go to work and still receive Medi-Cal, and that's a funny situation.

It wouldn't harm me any way on Social Security, you're allowed to make $125 a week. The first thing you go and apply for work, "Why is the reason you've been out of work for five or six years or more?" If you mention heart trouble -- "our insurance carrier would not allow you to go to work" -- and you're right back where you started from.

The reasons the Veterans Administration is cutting down on all these service-connected stuff, if they have to write down to the UC Hospital -- it was a carry-over from when I was in the Marine Corps, instead the VA made a mistake, I appealed it and appealed it, it doesn't do any good. They had to pay me $300 a month, plus my own patient care.

HEARING OFFICER LEE: Do you feel,Mr. Bier, that the limitations on the scope of service is -- in other words, the fact that you can't get drugs covered --

MR. BIER: Why should I pay out $86 and my wife pay out $86 a quarter, you're not even covered for medicine when you go to a drugstore. This is not a Group 1 card, this is a Group 2 card.

HEARING OFFICER LEE: There are, of course, proposals that will be considered by Congress to extend Medicare to Social Security beneficiaries who are permanently and totally disabled.

This, of course, was proposed and will, I'm sure, be further considered. This is one approach you feel there are improvements that can be made, however, in simplifying the program now under Medi-Cal and providing more services, providing drugs and meeting some of these other necessities --

MR. BIER: Especially on Medicare. We received our total disabilities on Social Security under the old law, but you still got to be 65 --

HEARING OFFICER LEE: Yes, right.

MR. BIER: -- in order to receive Medicare.

HEARING OFFICER LEE: Right. Miss Solis, did you have some questions for Mr. Bier?

MISS SOLIS: No questions.

HEARING OFFICER LEE: No questions. Thank you very much, Mr. Bier.

Our next witness will be Mrs. Espanola Jackson who is President of the San Francisco and California Welfare Rights Council.

Mrs. Jackson, I should like to add, at this time, if you'll

excuse me -- that we will have a little bit later an open period when those witnesses who have not been afforded an opportunity to testify or were not able to get into the program, you will have an opportunity a little later on in the open period, just as we did this morning, which will be open for people here.

Mrs. Jackson.

MRS. JACKSON: Yes, I want to take three minutes.

One, Medi-Cal is in the same bag as the Public Assistance Programs. Because of restrictive eligibility requirements many needy people and families are not eligible for Medi-Cal.

For example, a family with employed father, even if he has 8 children and makes only $300 a month is not eligible because of the categorical linkage requirement.

Disabled person who does not meet ATD requirements are not eligible.

G.A. recipients do not have Medi-Cal coverage.

With the increasing cost of medical care a much more comprehensive medical plan is needed for all people. This country has a poor medical record compared to many other countries who are not as rich as we are. See Page 1 Question 2, the goal of the program.

The State Drug Formulary should be eliminated and all prescriptions should be allowed.

Welfare recipients and Group II Medi-Cal recipients should be represented on the State Medical Care Advisory Committee. See

Page 4, Questions 9 and 10.

Four, the Federal Government should take more responsibility for the Medicard program and not leave it up to the States to set up their own eligibility requirements. Many States exploit and abuse low-income people. Governors and State Legislators and administrators often try to deprive poor people of basic necessities. This happened in California when Governor Reagan tried to cut-back on the Medi-Cal Program. The Federal Government should provide for equal standards of medical care in all States.

HEARING OFFICER LEE: Miss Solis, do you have a question or two?

MISS SOLIS: Mrs. Jackson, aside from the eligibility factors which we have enumerated, what are some of these specific other problems that people on Medi-Cal are experiencing at the present time?

MRS. JACKSON: Well, we have cases where a woman might need one tooth in the front of her mouth in order to apply for work. The dentist will not give her that one or even two teeth, they have to have all teeth extracted, and this is unnecessary.

We fellows know we've been exploited, because the Medi-Cal is set up to help poor people that need it and needy people, we're not being helped, period, because we feel as though under psychiatric doctors, if there needs to be group therapy, this should be allowed or pain killers, any type of medicine that a doctor states that a person needs should be given to that person.

But, at the present time, if you don't have the money to go to a drugstore to get the other medicine that the doctor has prescribed, you can't even get it, because they don't allow it. I don't see why recipients, poor people, have to be left up to have second or third-grade medicines. If I want penicillin for my child, and my daughter, I have to pay like $8 for penicillin, because if they use the type that is prescribed with the Medi-Cal program, they break out in sores, and they can't take this medicine. I don't know why we have to put up with this abuse. The program set up for the poor are being abused.

MISS SOLIS: Did you hear the previous witness, Mrs. Benavides --

MRS. JACKSON: Yes.

MISS SOLIS: -- with regard to physicians not seeing patients with Medi-Cal cards.

Is this precedent to your area?

MRS. JACKSON: Yes, it is, because we have complaints all the time.

HEARING OFFICER LEE: I would like to ask another question along that line, Mrs. Jackson: Is the reason given by the physicians that they aren't getting paid or that there's too much paper work; or are there other reasons that you feel the physicians, private physicians, are unwilling to see people who are eligible for private care and the care is paid for?

MRS. JACKSON: I received a call the other day, and the

doctor asked me what were the Medi-Cal requirements, who was eligible. And we feel as though the same information the Welfare organization gets should be given to all doctors.

They're the one that needs this information, the information as much as we, the recipients, need ourselves.

There are doctors who refuse to see a recipient -- "we don't get our money on time." Just like the whole Welfare Department, you know, they're late on everything, nothing is ever done on time.

HEARING OFFICER LEE: I would like to ask another question. We had a good number of statements this morning and a number of discussions about ways in which there might be better representation of recipients or consumers of the poor citizens --

MRS. JACKSON: Right.

HEARING OFFICER LEE: -- on various advisory committees and various roles as they relate, not only to Medicare and other health programs --

MRS. JACKSON: That's right.

HEARING OFFICER: Would you like to comment on it? I certainly would like to hear your views about it.

MRS. JACKSON: I feel that any HEW programs that deal with poor people, recipients, that they should have a recipient, a poor person on any advisory board. If you have people you are supposed to be concerned about sitting on those committees, I don't think you would have to have these hearings so often.

HEARING OFFICER LEE: One of the problems, we just recently had a meeting in Washington with a number of the representatives of the Board, a number of poor people came in. Said one lady from California, one of the problems has to do with how do you get a person nominated, how is the person selected or children.

Mr. Flores, this morning, made an interesting statement. I asked him if he would send me some names of Mexican-Americans who might sit on advisory committees --

MRS. JACKSON: I can give you names if he can't, we have two Spanish groups here in San Francisco, we have an English and a Spanish group. We have representatives. If people don't know about it, we can give you the names. The chairman of those groups, I can mention it -- the Council will get you someone that will be representing the people, that's not the problem with welfare rights.

HEARING OFFICER LEE: He said, not only could he do this, he said, in addition, we ought to check out his recommendations to make sure he is representing the people who are recipients. I think this is a point you're making --

MRS. JACKSON: I feel, as though, if you're involved with this Medi-Cal program, you just don't have recipients, you have, maybe, non-recipients, like the young man that was talking a few moments ago, he was drawing Social Security, he can represent himself, he is in that bag all the rest of us is in. It's not the idea of who you select, as long as the person is there representing

the poor people.

HEARING OFFICER LEE: Yes. The selection process, I mean, it is important, I think --

MRS. JACKSON: We, for one -- when I say this -- in the welfare rights movement, we are not in that bag, because we know anyone we would send that we would elect of the welfare rights movement would represent us, and not be brainwashed by the rest of the group.

HEARING OFFICER LEE: Of course, we've had very close contact with the welfare organization in Washington, and I think very effective communications. I think this has been very important.

MRS. JACKSON: Yes. We're together, aren't we?

HEARING OFFICER LEE: I hope so. Thank you very much, Mrs. Jackson.

Mr. James Treece, who is here, Chairman of the Board of Social Services in Colorado, I believe, is not going to make a statement. Is that right, Mr. Treece?

MR. TREECE: I have a brief statement.

HEARING OFFICER LEE: Step forward, please. Thank you.

MR. TREECE: I'm here today, Dr. Lee, Miss Solis, because the State of Colorado will commence a Title XIX Program on January 1st.

We have been planning for this day for several years, and have been and still are seeking better ways to operate the program.

We want, of course, to avoid the problems encountered by other states.

Until arriving today, I didn't understand I was to testify, and have, therefore, hurriedly put together these brief remarks.

First, a quick survey of where Colorado is today in its medical program, and what the effect will be of implementing Title XIX.

Colorado pioneered in 1956 with a constitutional amendment which provided the aged with pensions of $100 per month, with a cost of living escalator and a $10 million guaranteed medical fund for the 50,000 pensioners. The escalator provision on pension grants has taken them to $126 and a further $2 increase is due in February.

The assumption that health care for the aged couldn't cost over $200 per year per pensioner has proved wrong by over 50 percent already. Colorado has, since 1956, a good medical program for its elderly.

Colorado has only had a stock Blue Cross, Blue Shield program, plus drugs for its ADC recipients, and has no program on a State level, but only a county program for its disabled.

Colorado's Title XIX Program will just serve, unfortunately, the recipients and the categorically linked conditionally, however, it will double the amount now spent on medical care for the needy. It will raise from $30 million to $50 million, and is an

indication of the improvement which will occur in care for ADC and disabled recipients.

A few thoughts now for how HEW can better serve the states: First, I would suggest we need a newsletter to be distributed to each member of policy-making boards to tell of the achievements and difficulties experienced by other states in the administration of the various welfare programs. For example, we would like to know in Colorado that California has experienced the problem of controlling physicians' fees, we want to know what the problem was, why it occurred, how it was corrected, so we can avoid the abuse in the first place. If another state has a good method of saving on drug costs, we would like to know that, so we can find a way, perhaps, to copy that.

In the same vein, we would like the freedom in our State -- and I assume the other states would like this freedom, also -- to innovate. I am not welfare oriented. I would suspect that most welfare workers are not welfare oriented, I was not chosen, I'm sure, for my interest in welfare, we were probably chosen, as were most Welfare Board members, to represent the taxpayers of the State on these Boards.

To the extent, though, that good business practices can prevent abuses by suppliers of goods and services, this saving can provide more services to the recipients, plus, I feel, a well-run welfare operation can make welfare more acceptable to the public, generally.

So my point is, give us who have a very real say in welfare, the community, so to speak, the chance to do our very best by the programs.

We who are not welfare oriented have interesting experiments. For example, a couple of examples from my own experience: Denver needed traffic guards for its elementary schools. I conceived the idea that under Title V, welfare mothers could provide this service. Happily, they worked out fine, and they enjoyed this work, and the children and the community are now well served by the welfare recipients.

At the first meeting of Denver's War on Poverty, I proposed the Neighborhood Health Center. As I conceived it, it would be an analogue of the charitable groups then serving the poor with the governmental service, a program like Mr. Fishbein's program. Instead, the private continued alongside the public and did not combine their services, but a new concept of health care began in Denver which is being emulated throughout the country.

Don't bind us by rules so the good ideas are lost. In 1963, nursing home operators would come to me and say our payments were so low -- "that you're driving us out of business." Well, I don't know whether that was true or not. So we instituted our own audits of their cost, not recognizing those that we felt were unreasonable or were faulty, and since that time, Colorado has undertaken to pay those costs, plus a fixed profit. Because costs are reimbursable -- based on prior audits, so that, typically,

those are six months old.

The homes must prevent their costs from rising too fast. Because of ceilings on costs, the homes must prevent their costs from rising too high. And thus, we believe we have in Colorado a very reasonable system for compensating nursing homes. Perhaps, it can be improved, and perhaps it should be copied.

But my point is, don't stifle the opportunity for the states to develop new programs and new approaches.

Dr. Howard, I believe, this morning spoke of custodial care homes, and he said these are not medical care facilities by a physician's definition. All right, that may be true. But shouldn't Title XIX, in all reasonableness, recognize such a home and reimburse recipients in it for care. It makes financial sense, because as Dr. Howard pointed out, in these homes you have persons who do not need this high quality care in the nursing homes; on the other hand, it recognizes that various infirmities of old age can render a person dependent. So therefore, it can be justified on the basis of a medical need.

Dr. Lee, Miss Solis, I would say, in summary, that let your Departments be flexible in its policies and regulations, because in that way the public will be best served.

HEARING OFFICER LEE: I want to thank you for your presentation.

Miss Solis.

MISS SOLIS: I don't have a question, so much as a comment, sir.

And that, I have heard during the course of the day today some comments made about the fact that if there were X number of things done to the program, that hearings of this type would not be necessary. However, I do feel that on the state level, there is ample opportunity to conduct an ongoing evaluation of a program which has much more meaning to the local people and the state people, and this cannot just be done by top administrators, it has to be done with the collaboration of the rank and file workers who are really seeing what is happening on the implementation, and in terms of the consumer and what the program means to him in his utilization of it.

I don't know which states have really developed this; or whether evaluation is merely just filling out forms and coming into different hierarchies, and sometimes, the hierarchical forms have little to say about what has happened. Like, in a program, when I ask for reports, I'm not sure all the data I get is really what's happening on the local level.

I think this is very difficult; it is very time-consuming. But, if we're really looking at a program in an evaluating way, it has to start at the local.

HEARING OFFICER LEE: No questions, Mr. Treece.

We now have, at least, three witnesses who did not have the opportunity to make their request known in advance of the hearings.

So I would first like to ask Mrs. Little, who is with the

Bay Area Welfare Rights Organization, if she would come forward.

Mrs. Little, we are delighted to have you here, and we are sorry you didn't receive the invitation adequately in advance.

MRS. HELEN C. LITTLE: Thank you, Mr. Chairman. I was very disturbed because I didn't get one. I was accidentally informed through Medi-Cal Division, someone that knew me and knew I was very concerned with this type of thing.

As you can see, I'm handicapped myself. I do know the problems of not being able to receive the proper drug that your doctor prescribed. I know we have a "substitute drug," as it's called. When a doctor prescribed a certain drug, it means that the drug he feels his patient needs most, not a substitute.

I didn't write out a briefing of any kind, I never do, I can't work that way. I have to work from what I feel within myself, and this is the only way I can present to you the problem that lie before people that are on aid, and is not on aid.

As a chairman of an organization which is the Bay Area Welfare Rights Organization, I'm fully aware of recipients and non-recipients that should be receiving the proper medical care, that does not have the opportunity. There are numbers of people, that because of the work category, they are not eligible for Medi-Cal, and there are children that are deprived.

There are the aged -- and when I say "the aged," I don't mean the age of 65, because they do have Medicare which is attached to Medi-Cal now -- and it gives them a poor relief.

But, those that are not, gets the bad end. They don't get the care, they don't get the medicine, they don't get the Medi-Cal services, because before they can receive anything, if they are drawing Social Security -- there are a number of them who don't draw Social Security, some have plain VA who are not eligible for Medi-Cal. Those people are just as important as the one that is completely and totally disabled receiving recoverment disability from a state.

These are the things I think should be considered, and how to go about it is one of the problems -- I'm sorry, I had to get it down, I wouldn't be in such a strain, my throat won't be in pain tomorrow morning, and I'd be in severe back pains again (referring to microphone).

I feel it's high time the Federal, as much as we all pay taxes, regardless of what type of aid or what you pay the taxes -- I pay the same taxes, even if you are renting, you're paying the same kind of taxes, you're paying the landlord's taxes for him, you're still paying tax. I think the Federal Government should come in.

Every time you look up, they're threatening to cut people completely off. You have to go through Sacramento, you have to go through the Chairman of the Finance Committee, you have to find out if the money is appropriated, if it's available. But for some reason or other, it's not available. This is one of the things we contend with at the State -- I'm sure you are aware of

it, one way or the other.

I feel, for example, a person who has sugar diabetes cannot wear a shoe, the doctor says the next thing is the sandal slipper. That means your toes are not forced, combined in such a way that the perspiration and the blister form, and the crack of your skin. I have what is known as diabetic allergic skin, you can't get the type of shoe that is required, because it is not called an orthopedic slipper. It means that your doctor has to write out this orthopedic -- it's between you and the doctor and the department store that ydu might be able to get that particular type shoe in. I can't wear a low household slipper and walk, because it tears the muscles in my legs now. I'm not the only one, there are a number of people who have the same problem. These are the things that are concerning me and the organization.

I think a number of other people in organizations, in groups, that is being forced, because Medi-Cal says, "well, you can't have that, because it didn't have a certain name attached to it."

A doctor says, "this is what you need," this is what a person need. A doctor is not going to jeopardize his reputation, because that's something that is sacred to him. And I'm quite sure that none of them does.

I can say one thing, though, that we have a few rest homes that we do. I was in them, my doctor had to pull me out before the three weeks was up. In fact, I was out for five days, I was

to be in there three weeks, I had to be in the hospital for one and a half, because of the type of care that the nursing home -- so-called nursing home -- render is ridiculous.

If you'd like some information, and you want some questions, you ask the questions, and I'll answer them. I'm not taking them secondhand. I've also had members of my organization that have gone through the same problems. More have died than come out, though.

HEARING OFFICER LEE: Miss Solis, would you like to ask some questions?

MISS SOLIS: No questions. She's answered my questions.

HEARING OFFICER LEE: Mrs. Little, I would like to ask you to comment on Mrs. Jackson's statements which were made by several other people; two things, really.

One is, whether you or members of the Welfare Rights Organization in San Francisco have encountered the same problems that have been described by people with Medi-Cal, having difficulty obtaining the services of a physician? And, if so, whether the problem seems to be their statement about payments or red tape, or if there are other problems that you are aware of that we might improve?

MRS. LITTLE: Yes.

HEARING OFFICER LEE: Ways to improve the program so that isn't a problem.

MRS. LITTLE: Yes, there is. I have run into a bag where

the dentist has discriminated against many of the recipients who have the Medi-Cal card, because of the length of time he has to try to get his money back. I know a specialist I'm constantly in contact with him, as far as the recipients attended. This is one of the problems they have had, they attend people and then they wait.

I have one doctor, at the present time, where Medi-Cal owes him somewhere close to $50,000. He hasn't received his money for over a year on Medi-Cal.

HEARING OFFICER LEE: I would like to also ask you for your views on the need for more consumer participation in the advisory committees, and not only in Medi-Cal, but in the various health advisory committees that we have, not only in the State, but also the Regional office in HEW, and also in Washington?

MRS. LITTLE: I feel strongly that it should be represented across the board. Doctors, a few people sitting up there dictating or deciding what I might need. I couldn't say what you need, because I do not know you nor do I live in your category; therefore, you couldn't say what I need, because you don't know me or my category.

It is very important that people, that they have across the board representation. I realize that sometimes a 35-man board would be ridiculous; but nevertheless, I feel it needs more of the people that are receiving -- there is a need to receive, be the one -- not the one that gets his paid on the easy track.

Because when you apply, because when you go before a pharmacist and say, "I need Metaphedrin," is one of the drugs, nerve sedatives, that doctors are recommending very strongly now for recipients, as long as he goes through a long preliminary of writing letters to this one and that one, you might be able to get that particular drug on your Medi-Cal card. If there are people on that board that have to go through with this, have to go through this type of thing, then they are better able to help form and set up a regulation where you could go step by step, and each individual will receive, as according to their need.

HEARING OFFICER LEE: Thank you very much, Mrs. Little. Thank you for coming.

MRS. LITTLE: Thank you for permitting me. I didn't get here this morning, I didn't get a notice. If I had, I would have sat in properly.

HEARING OFFICER LEE: This is absolutely proper, and this is one of the reasons we had a break period, for people who didn't receive this invitation sufficiently in advance would be able to come forward and present their views on the program.

MRS. LITTLE: One of the big problems -- I'm sorry, may I?

HEARING OFFICER LEE: Absolutely, go ahead.

MRS. LITTLE: One of the other things, as far as dentist is concerned and psychiatric care, is often allowed to get a private psychiatrist to take a Medi-Cal recipient, because he

wants -- he's taking his time, unless they go through a clinic. The clinics will accept -- a few of them, I know, I know Mount Zion does, I don't know what other clinics, I know Mount Zion does, I think Presbyterian has a psych clinic -- unless you go through there, it's hard to get a private psychiatrist to take you in.

The reason of it is because of delay in payments. The dentistry, if a person has got to have a majority of his teeth out before he can get a partial plate -- his teeth are missing, for example, say, that he's got four jaw teeth out, two on each side. That is part of the digestion, you don't chew from the front, you bite from the front, who wants the front tooth open like an open parlor? It's important, too, but it's just as important to the digestion track to have the back teeth. Unless you got four out of one section and three out of the other, you can't get a partial plate. They say, "that's impossible." I think this is one of the worst -- if people don't wind up with ulcers, because people don't digest their food properly, they don't have the teeth to chew it.

HEARING OFFICER LEE: Thank you, Mrs. Little.

MRS. LITTLE: Thank you.

HEARING OFFICER LEE: The next person I would like to ask to testify is Mr. Samuel Klein. If he would step forward. Thank you, Mr. Klein.

MR. KLEIN: Mr. Chairman, ladies and gentlemen, you can

solve the problems. We should solve the problems a year ago, two years ago.

We elect representatives to spend thousands of dollars to be elected, doing nothing. We must help these mothers.

HEARING OFFICER LEE: Mr. Klein, if you would step back just a little (indicating microphone) --

MR. KLEIN: We must have a heart to help these mothers. Many thousands of them don't get Social Security, they live under Old Age Pension, how much is the Old Age Pension? $85 a month.

You work for a government with thousands of dollars paid, you got different persons, they can't go to the hospital. Medicare is all right, but the hospital wants the money in advance before. They can't get any help, they got small incomes. The space for families, the families and children, the children fighting for our country helping our government, don't you think you should help them? Shouldn't we have a heart?

People, I go to them, something must be done today, not tomorrow. I suggest we should have a thousand social workers, a thousand nurses, and help every home, check every home to find out who needs it, who needs it.

Some people don't, that's all.

But the people who needs it, we must help them. We are government, and if you need money, we can get money from the Federal Government. The Federal Government, we have money, the State has money, special funds, the city has money, they are not

poor. These mothers are there today, not tomorrow.

It's a sin for San Francisco, several hundred thousand people, 750,000 people, 750,000. Race or color doesn't make any difference, they all need it.

I belong to the Senior Citizens groups, I go places, I go back from one of the blind places, the mothers, they need help. I'll leave with you, my friends, are we going to do something today, not tomorrow? It's very nice of you to have a public hearing, but what's the matter with our representatives, the Legislature, the Assemblymen, what do they do? What have they done for our people?

They spent $450,000 to be elected for themselves, for business, not for the people. We must have help for the people. Men needs help, he needs help.

Yes, we have two State Senators for the job, Marks and Moscone, and they are helping. We should have people checking every home and find out who needs it, and not to have them starved, and have nurses' aides in the homes, and have social workers more to check and find out.

Are you going to let them starve? I'll leave it with you.

I'd like to have an answer from you: All the money we have, money I know we have, it's a shame for San Francisco. We must help these mothers, good mothers. I'll leave it to you.

Ask me any question, I'll answer you. As far as you've

got plenty of money, not to let them starve or suffer. They can't go to the hospital, they need money before they go to the hospital. They have no money. They have no money for medical, it's better to go away from the hospital, maybe they can help them, certain nurses, maybe they can help them. We have a government, you must help them.

Thank you.

HEARING OFFICER LEE: Thank you.

MR. KLEIN: You want any question, I'll answer them.

HEARING OFFICER LEE: Do you have a question?

MISS SOLIS: Mr. Klein -- is it?

HEARING OFFICER LEE: Yes, Mr. Klein.

MISS SOLIS: Mr. Klein, are you from this area, San Francisco area?

MR. KLEIN: I've lived here for many years. I belong in a lot of places, if you want to know my representation, I'll tell you where I belong, if you want. I live in this area San Francisco for a good many years.

MISS SOLIS: Thank you. Are you saying that you feel we don't even really know the amount of need that there is among the families in this State with regard to medical care?

MR. KLEIN: That's right, whoever needs it must -- and do it today, not tomorrow.

It's not nice to come here and beg, they're not beggars. They're rich people, this government, right here, State of

California, the representatives to come and see what we can do for 15 and 20 people, and check, maybe they can answer to the Mayor -- I know the Mayor has worked with us, he's doing a good job. Two Senators, Marks and Moscone approach what can be done, at least, two Senators, Marks and Moscone.

Now, they haven't got too many, the Supervisors. Now, they come up -- unless, you're paying -- I held office once before in another time, nine years, before I never wanted anything, I'm not looking for business. But these mothers must be helped, and they shouldn't be starved. They're independent people fighting for our country, fighting -- to get killed in the thousands, think about these things, think about these while I talk to you.

HEARING OFFICER LEE: Thank you. Do you have any other questions?

MISS SOLIS: No.

HEARING OFFICER LEE: Fine.

Our next speaker is Mr. Bronstein, who is here to speak on behalf of a group of disabled persons.

MR. BRONSTEIN: I think, over three people that speak here -- I've been waiting since I was released from the hospital to speak on this.

I feel issued to help with disabled -- already, that a person worked in this life, it is his duty to his community while working, while any person, that regardless of education. I would

like to underline the problem for assistance of medical aid to the disabled persons by telling you my personal experience. I do not want to appeal for personal sympathy in my choice. I want to underline my personal experience which are the cruel effects of life.

The necessity to help disabled persons, the persons that can be anywhere, it would be a research director with a research program, it could be a fireman who does his duty who is fighting fires to risk his life, it could be anybody who is tracked down by the fate of life suddenly becomes disabled.

My personal experience, I'm sure -- I mention as follows: I'm a mechanical engineer, educated, I cannot speak for the underprivileged, because I had the privilege to receive the highest education, I took advantage of it. I worked my life very hard, and I finally graduated from the University. I am a mechanical engineer, and I worked various in this capacity, 1953 till 1966, I was working in one of the bigger companies here in San Francisco as a project engineer. The tension of my profession was crawling up on me, forced me to quit my job. I had to work as an assistant engineer in San Jose.

One morning when I went to my office, I suddenly felt very badly; I was paralyzed, and I didn't realize that. I was collapsing, and I went to the doctor's office. The unfortunate condition that I had an attack similar before was not recognized, probably, by my private physician, who couldn't warn me. I was

tracked down by a bad, bad, bad mental breakdown, collapsing of my brain.

I ended up in Memorial Hospital before I realize. The doctors believed I had a brain tumor, the doctors told me -- at my release -- "you are permanently disabled, you will never be able to go back to your profession, you have a brain tumor." They told me, "if you try too hard" -- I had former contact with my former company -- "if you try too hard to come back to the normal life to go to work back, your brain tumor will increase, you will die or you will go completely insane."

A few days later, I was home in my room in San Mateo, I was paralyzed from both sides, I couldn't move. Then the next -- it was an unbelievable cruelty -- when I submitted my medical bills, I had submitted my medicals to my immediate group insurance in the Buster Baker's Life (sic) for claim, and the company wrote me they will not honor my insurance, they left me alone. I had always paid my highest taxes since I worked here in this country, very good positions and paid the highest premium, naturally, to Social Security. And practically, doctors, the hospitals, didn't wait, they gave those bills to a collecting agency who threatened us with court action.

I was disabled, there was no help to help me. All my lifetime savings went down the drain, with the result that I am today, my wife, my family could save a small portion of my lifetime savings which are slackened, because I cannot afford to go

to any hospital. I had occasion, a doctor in general hospital recommended an immediate operation, my family said, "no," because of the financial burden connected with hospitalization.

After my experiences, I went for help to assistants of the social worker of the Welfare Department. I asked the social worker to call in my family to discuss it with her, it was impossible due to my illness, that I could discuss that serious a matter with my family. The social worker disclosed to us that any savings that was left for the Old Age Security of my wife, not to make her a burden of the Welfare Department in case of my death, that the operation, the hospital operation, was prohibited to me. I canceled immediately my operation. I prefer to go through a certain type of pain before I rob my family into financial ruin.

My family -- I am dear to my family all the time -- I mention this, not to plead for personal sympathy, I mention this, perhaps, there is a similar situation, perhaps, in which thousands of hard-working people here, they might be politicians, they might be engineers, they might be teachers, or any other high responsible level threatened by mental breakdown. The tension was high, a lot of scientists, a very high life pressure competition -- a breakdown, a person doesn't realize it, either. A doctor, any profession, a lawyer, anybody, is threatened by the same tragedy I was struck.

I am pleading, I am bringing this to your attention with

the hope that we will take some action to grant the disabled person, the totally disabled person Medicare. I think there was something initiated by the Secretary of the Department of Health in Washington, Mr. Wilbur Cohen, I see it in the San Francisco papers that Medicare should be granted to disabled persons. I know, by stipulation, I promised my family, if I am getting sick, I am not going to the hospital, I will die on the street. I will not leave my family financially -- no head of family financially responsible to the family will do things like this. We got legal advice from the Welfare Society that any penny that my wife earns has to be -- could be taken and paid for my wife in case of my illness, in my hospitalization. There is the situation.

HEARING OFFICER LEE: Thank you very much, Mr. Bronstein.

Miss Solis, do you have any questions?

MISS SOLIS: No.

HEARING OFFICER LEE: I have no questions.

I would just comment, Mr. Bronstein, the extension of Medicare to the permanently and totally disabled who have received Social Security benefits was considered by Congress. They asked the Department to do a special study of this and to have an advisory committee advise upon it, and that advisory committee's heads reported to Secretary Cohen, and he will very shortly make his own recommendations to Congress on the advisability and costs of extending this coverage.

MR. BRONSTEIN: Good.

HEARING OFFICER LEE: Because, as you so clearly point out, your experience has been duplicated indeed by thousands. And, as a matter of fact, there are well over a million people who are permanently and totally disabled who, in many cases, have been unable to get adequate coverage.

MR. BRONSTEIN: I know of -- interrupting you -- the cases I heard, one became a deserter, I could not substantiate -- heard it on television, my family heard it on television.

One fireman was badly injured, he suffered the same thing I had suffered. This man had to pay all his medical bills with the help of his family. The man was so desperate, he shot himself. His son became a deserter.

It was a case of moral decay. This is a case, is a problem of the disabled.

HEARING OFFICER LEE: There are many problems, and we appreciate your coming and making this statement.

MR. BRONSTEIN: You're welcome. Thank you very much for the opportunity of speaking.

HEARING OFFICER LEE: The next witness is Mr. Tom Jenkins, who is Past President of the American Association of Homes for the Aging.

Mr. Jenkins.

MR. JENKINS: Mr. Chairman, Members of the Committee: I am Tom Jenkins, an attorney in San Francisco, and I have just completed two terms of the Presidency of the American Association

of Homes for the Aging, which is a voluntary association of homes throughout the United States, consisting of approximately 1,000 members of voluntary nonprofit and governmental homes who are concerned with long-term care facilities.

In view of the time, I have a statement to simply put in the record, and I will only highlight, very briefly, for the Committee, with the hope then that Mr. Halversen of the California Association and Mr. Friedman might take the rest of my time for comments to you.

I would say, to summarize first, that we are concerned throughout the country with one major area of activity; and that is, a philosophy of care which today seems more and more to be determined and dictated by the source of funds, rather than the needs of the people involved. And, I would repeat that we are concerned with the philosophy of care as dictated by the source of funds.

Secondly, we feel that standards of care should be, to the extent possible, the same under Title XVIII and Title XIX.

And thirdly, we are concerned that fragmentation of care for the elderly in long-term care facilities which is being caused by this philosophy of determining care by source of funds, by various levels of care -- and I'll detail that slightly -- is, in fact, more costly, not less costly.

The American Association has, since its inception, been concerned about the best possible care for our elderly, and the

facilities throughout the country. And we have expressed this concern by speaking of, "Continuity of Care and Comprehensiveness of Care." And by "continuity" we mean that we feel that people should receive continuous care from the time of entry until death. And by "comprehensiveness," that their care should not be simply that that relates to one of their needs, a medical need or a social need, but that the individuals in these facilities are human beings as well as patients, and they need, at all times, to receive the complete comprehensiveness of care that involves the social, emotional, as well as psychological care.

Out of that philosophy and experience we have two cardinal principles that evolve: One, from the time that a person enters a facility, they should receive an identification with a portion of the facility, a room which becomes their home, and to that extent this identification should result in as little movement as possible; and secondly, that the other principle is, that the care they receive should be received in that one portion or part of the facility, and should not be fragmented.

At the present time, as a result of a number of legislative actions, there are four different kinds of care given: A section providing intensive care or ECF care, a section providing skilled nursing care, a section providing intermediate care, and a section providing residential care. It is our firm belief that this fragmentation of care results in a traumatic experience for the individuals we are to serve. And secondly, that, in fact, it

is more costly.

There has been some considerable discussion about the more recent intermediate care, and I know others have made remarks about it this morning, and you will undoubtedly hear more as these hearings continue. I will say to you that it is the firm belief of those who are administrators and board presidents throughout the country in the long-term care facilities, that far from being a savings to the taxpayer, that the intermediate care will result in a vast administrational burden. We say that for a number of reasons, but one of them is because the necessity for administrational capital required, if you are to do the kind of work that you do in these facilities giving comprehensive care, will require that you always have vacant beds in one part of your facility or another, if you are to move them from one bed to another in order to get reimbursing.

And this goes back to my earlier statement about philosophy of care. We're not talking about moving them for the kind of care they need, but you move them from one wing to another, one floor to another, because you're getting your money from this source or that source, depending on the level of care. We feel that the operational cost and the capital cost will be greatly increased by this fragmentation and by the additional of intermediate care.

We would also say to you, we understand it is the intent of Congress in setting up these levels to cut costs. It's our firm belief that, in fact, much can be done and much will be done,

but those who are concerned with this area urge you to find another means by which you reimburse the people who have needs, not based upon cost accounting centers, as we presently do, but upon the basis of need.

And I would conclude here on -- this is ten pages I'm compressing and putting into the record -- but, in conclusion, it's the fear of the Association and its members that the present system and proposed systems, dominated as they are by reimbursement mechanisms, will not only erode a way of life for the aging which has stood the test of history for its humanity, but will immeasurably increase the costs of health care in this country.

HEARING OFFICER LEE: Mr. Halvorson or Mr. Friedman, would you like --

MR. HALVORSON: Dr. Lee, I'm Lloyd Halvorson, Executive Director of the California Association of Homes for the Aging. And we propose to use our allotted time to go over my very brief paper which I will send to you, if you wish it, and then, Mr. Sidney Friedman will respond to any questions concerning this presentation.

We certainly appreciate the privilege and the opportunity to testify here, and we are very much pleased HEW wants to hear from those who are involved with the Medicaid Program on a day-to-day basis. We wish we had a little more time to present what we had to you, but we are going to give you the salient points with regard to improving Medicaid for the residents of the nonprofit

homes for the aging in California.

The California Association of Homes for the Aging is an organization of over a hundred nonprofit facilities serving the aging. Many provide nursing and convalescent care in facilities licensed by the State Department of Public Health. In addition, a number of them are certified as Extended Care Facilities. A large number of residents of the nonprofit Homes are eligible under Title XIX for Medicaid, known in California as Medi-Cal.

It is encumbent upon the nonprofit Homes for the aging, based upon their basic purpose and because of the demand of the community and the requirements of their boards of directors, to give high quality care. In this context, the Homes provide comprehensive services and a complex of professional and supportive personnel to achieve these goals. To serve the best interests of older persons, Homes for the aging are multiple-function, socio-medical agencies providing comprehensive sheltered care; the institutional character of these Homes becomes a positive factor in making those under care feel secure and comfortable.

Older persons in Homes for the aging, or other types of congregate living facilities have the same rights and requirements as other citizens; namely, the right to self-determination, the right to privacy of person and thought, the right to personal dignity, the right to have social needs met and social roles fulfilled, and the right to good medical and personal care. These are inalienable rights and their infringement or failure to provide facilities for exercising them violates the older persons'

prerogatives as a human being.

Accordingly, Homes for the aging are not disease treatment or patient centered but person centered. Attention is given to all the life concerns of the resident. Because movement and flux are traumatic for the elderly, fragmentation of care and services are avoided in a Home for the aging; rather, continuity of care is provided, from near self-sufficiency to total dependency, in one facility.

With this philosophy of care as the objective of Homes for the aging, the California Association of Homes for the Aging is concerned that the qualifying requirements for participation under Title XIX and Title XVIII as well, be applied flexibly so that they will do the most good for the residents in our Homes.

Continuity of care is important in each of our Homes, just as it is important philosophically under Medicare. We are concerned that the high standards in the requirements under both Title XVIII and Title XIX not become too arbitrary in their application, to the point where they stand in the way of service. For example, there are instances where the well-being of a resident would be jeopardized if that individual is moved from a room which he has occupied merely in order to satisfy technical space allocations required by the law. A compartmentalization of categories of care tends to undermine this philosophy of the non-profit Homes and the humane treatment of the aging. Reasonable reimbursement for care should be provided under Title XVIII or

XIX, based upon the services that the individual requires rather than where he lives within the Home, providing, of course, that the Home meets the licensing requirements of the State. Approximately the same formula for determining reasonable reimbursements, as used in Title XVIII should be used also under Title XIX.

It also is our belief that the standards of Title XIX should be similar to the standards of Title XVIII. The experience of Homes for the aging indicates that many of those who require long-term care need as much professional services and attendant care as those under various stages of convalescence or extended care. Under Title XIX, the professional requirements should be as theraputic as required at any given stage related to the degree and extent of nursing care which the aging person needs. We are against any warehousing or the custodial care concept, whether for those under Title XVIII or Title XIX.

The reasonable reimbursement for care is a fair reflection of what is involved, and, if necessary, additional federal funding should be made available to the States to ensure that nursing care for a person eligible for Medicaid is properly and fully reimbursed. Maximums applied by States have prevented or deterred some nonprofit Homes who have high standards of care from expanding in order to serve many more members of their communities who need nursing care.

Mr. Chairman, we hope at a later date an opportunity will be available to us in which a more comprehensive response can be

made. Also, as has been made clear by Mr. Jenkins and his Association, we are a part of that, it is expected there will be an accumulative presentation which will be made to the various subcommittees or parts of the committees of your Committee holding the several hearings throughout the country.

And we appreciate the opportunity to be heard here today.

And now, Mr. Friedman will speak, and be available to you for questions.

HEARING OFFICER LEE: Mr. Friedman.

MR. FRIEDMAN: Mr. Chairman, excuse me, I'm supposed to be the answer man, so I will not speak.

HEARING OFFICER LEE: Miss Solis, do you have a question?

MISS SOLIS: No. I did want to make a comment to both Mr. Jenkins and Mr. Halvorson on their presentation, and their highlighting specifically about problems which certainly lift out some of the fragmentation that has been created into the program, and also, the insecurity in terms of the continuity of care principle; that is, not only relative to nursing homes, but certainly, relevant to people receiving care in other classifications, too.

HEARING OFFICER LEE: Somebody described this as hardening of the categories.

Yes, Mr. Halvorson.

MR. HALVORSON: May I respond to Miss Solis by saying, our Homes are involved, also, in the assisting of community

services for allover purposes, not just those who happen to be living in our Homes. And we feel this same application of giving them a continuity of care and a sense of security, in that there is this available service to them, regardless of what or when it happens. We think this is very important.

HEARING OFFICER LEE: I would like to ask Mr. Friedman how he sees this integration of XVIII and XIX, what mechanism should be used to pay for the comprehensive care outside the hospital institutional care, whether it's normal residential living or whether it's all the way to the skilled nursing home level of care, whether you see this as a single category or how you would approach that financing problem.

Some people -- or many people -- have expressed concerns about the potential costs, and, I think, this is one of the reasons we have seen these categories. They have been an effort to contain costs, in one way or another. As Mr. Jenkins has pointed out, this may be increasing the cost, rather than obtaining the cost saving objective.

MR. FRIEDMAN: Well, speaking for myself, to answer the question, and some of the people sitting in the audience have heard me say so since before, I think it should be based upon the kind of care the person needs which is also based upon the medical diagnosis and social diagnosis, and that that's how it should be made, on the basis of what care they are receiving.

Now, who can determine or check -- and, I said before,

this is where I think the utilization of new teams can come in, and I think it would cost far less if you have a good setup in all the communities of utilization of teams, people who can independently come in and determine, if necessary, on a month-to-month basis, the kind of care the patient is getting and the kind of payment that should be made.

HEARING OFFICER LEE: But makes that, rather, you might say, retroactive or after the fact? The kind of approach that has been taken in San Mateo County where an effort is made to really say, make the social and rehabilitation diagnosis in advance of the discharge from the hospital, whether the person needs to go into a rehabilitation facility, whether they can go home with home house services provided; do you feel that it's a realistic approach, do you feel it's feasiable on a very broad scale?

MR. FRIEDMAN: I think it's feasible; whether it's before or after, I don't know where the feasibility is best. But I would project that, perhaps, you can do it before -- when they're ready to come out of the hospital, is what you're referring to?

HEARING OFFICER LEE: Yes, right.

MR. FRIEDMAN: I don't think it's as important as doing it later, after the person has the opportunity to be, let's say, in an extended care facility for a period of time.

I don't think you can win that battle, Mr. Chairman. When the patient's doctor feels they require extended care, I think,

for reasons other than medical reasons, sometimes for social reasons, I think you have to go through that bit, if you will; and then, on the extended care level get into reviewing that person after a period of time, you know, the normal period of time.

HEARING OFFICER LEE: Yes, right.

MR. FRIEDMAN: And then, doing something about it.

But I think the utilization review team consisting of a doctor, social worker, and so on, is very important in this process, and independent of the facility. In our Home for the Aged, we have the San Francisco Medical Society whose utilization review, et cetera, we don't even get into it at all with our doctors, even though the law permits us to.

HEARING OFFICER LEE: You would emphasize independent of the facility, it should be a community-wide --

MR. FRIEDMAN: Yes. I think in the long run, that would cost less money.

HEARING OFFICER LEE: Thank you very much, Mr. Jenkins, Mr. Halvorson and Mr. Friedman.

I think, now --

MR. FRIEDMAN: May I make one comment, sir?

HEARING OFFICER LEE: You certainly may.

MR. FRIEDMAN: I appreciate the opportunity for Mr. Halvorson and I to be heard --

HEARING OFFICER LEE: You're both worth listening to.

We'll take a 10-minute break. The turn of my watch says 3:05; at 3:15 we'll return to the hearings.

(Recess.)

HEARING OFFICER LEE: We will proceed with the hearing.

Our next witness will be Mr. Martin Paley, who is Executive Director for the Bay Area Health Facilities Planning Association.

Mr. Paley, right up there (indicating), thank you, nice to see you.

MR. PALEY: Nice to see you, Dr. Lee.

As the executive of the Bay Area Health Facilities Planning Association, I am pleased to respond to the invitation to comment on Medicaid, its effect, and desirable changes for the future administration.

The Association I represent is a voluntary nonprofit organization made up of 175 volunteers throughout the nine county Bay Area concerned with the orderly development of a wide range of health resources.

Those responsible for providing professional services directly to people, and those involved in managing the fiscal aspects of Medicaid, know better than we the current strengths and weaknesses associated with Title XIX in this area. My purpose in appearing today is to describe some of the experiences in our Bay Area communities growing out of the implementation of the 1965 and 1967 Social Security Amendments.

As a planning agency concerned with health facilities and services, we have been particularly interested in the shift in patient load from the county operated health institutions to other hospital resources in the community. In the year '64-65, there was an average daily census of 1,383 patients in our county hospitals, in those services associated with medicine, surgery, obstetrics and pediatrics. This represented a 73 percent occupancy figure for approximately 1,890 beds.

In the most recent fiscal year, '67-68, the average census for the same three services in our county hospitals was 1,152, with a reduced bed complement of 1,826, or an average occupancy of 63 percent. This overall decline has occurred in the face of generally rising occupancy levels in community hospitals and a constantly rising population in this area.

For example, there has been an increase in several San Francisco community hospital census figures during recent years. The total utilization of days for the City of San Francisco has remained constant, and even declined in such categories as obstetrics. I cite these figures to show a very specific effect on community resources brought about by Medicaid or Medi-Cal in this area.

Each county government has invested time and energy in investigating the future role of its medical institutions. Some hospitals, notably Sonoma and Santa Clara, have made specific changes in policy, as well as their names, to create a hospital

available to all, and not one which specializes in care for the poor. The future of Medicaid reimbursement, its scope and amount, must be known in advance if local governments are to plan effectively, and other community resources are to gage the demand for their services accurately.

During the past year, our Association has completed studies on the subject of post-acute care, and particularly those patients in Extended Care Facilities and nursing homes. We learned that a shortage of dollars for reimbursement for patients whose Medicare, Title XIX, benefits had expired created severe problems.

For example, on a given day, there were approximately 1,300 patients eligible for Title XIX nursing home benefits who had to be placed outside of the San Francisco community; some as far away as 50 miles. This tragic situation, brought about by high development and operational costs in the city, separated the older patient from family, friends and attending physician. A ceiling which was maintained for some period of $13.73 because of limited funds, created a cruel and unfortunate displacement of patients in their declining years who were less able to respond to the trauma of movement than the majority of the population.

In many instances, the patients whose Medicare benefits expire at the conclusion of 100 days, require the same concentration of specialized personnel, equipment and medication to meet his physical needs. In other words, his changing eligibility,

as far as his Title XVIII Medicare benefits are concerned, is the determining factor in the constellation of services which he can receive at the conclusion of his initial period of eligibility.

It seems that Title XVIII and Title XIX should be so coordinated, and funds made available, as to satisfy the health needs of patients whose conditions require continuation of specialized services beyond that period of time covered under Title XVIII.

This Association has been acutely aware of the various factors which affect the cost of health services, and the ability of those responsible for providing health service programs, to modernize, innovate and respond to changing demands. We have identified several factors which we believe are significantly important in terms of establishing costs in the health care field.

One, the behavior of physicians, how they practice, the differential use patterns in relation to hospitals, the number and types of specialists available in a given community.

Two, the quantity of resources for providing health care such as number of beds, number of artificial kidneys, number of radiation therapists.

Three, the number and cost of important health care personnel: nurses, technicians and therapists.

Fourth, the cost of capital for expansion and modernization.

Five, the degree to which common standarized services can

be shared amongst health facilities.

Six, the nature of health care reimbursement systems and their effect on what resources are developed, and how these resources are utilized.

Time allows for attention to but one aspect of these six points, to note the role that borrowed capital plays in determining charges to patients and/or third party payors. For example, a 400-bed hospital with a construction cost of $14 million which borrows $5 million at 7% for a twenty year time period can expect to add $3.98 per day per patient if the hospital maintains 80% occupancy. If that occupancy drops to 70%, the cost of servicing the debt rises to $4.55 per patient per day. We offer this bit of fiscal information in order to demonstrate that the use of commercial or governmental dollars to expand or modernize physical structures designed to provide health care services has a direct and lasting effect on the cost of such services to all who must use them.

It becomes important, then, for such major purchasers of health care as the federal and state government to recognize capital costs of facility development and to provide funds to those responsible for administering these vital community services.

It seems desirable that any reimbursement schedule to hospitals, nursing homes, or other health services include a portion to cover modernization and/or expansion, but that modernization or expansion activity should be justified in terms

of: (a) Program objectives of the institution; (b) the community need; (c) the comprehensiveness of the planning effort of the facility; (d) the commitment of the facility to efficiency and effectiveness; and (e) demonstrated cooperation between the facility and other resources in the community.

Because of our special vantage point and our bias in favor of long-range planning for all participants in health care services, be they facilities, fiscal intermediaries, third party payors, we believe it highly essential for the state and federal government to engage in a long-range planning process for itself.

In a sense, we think it is necessary for those responsible for administering governmental purchasing programs to provide lead time in announcing new programs, additions to the benefit schedule, or any cut-backs that might be contemplated, with advance notice to those responsible for providing services, so that appropriate adjustments can be made, and a tooling-up period can provide the least amount of disruption.

Furthermore, it seems desirable to require that state and federal governments integrate their planning for Medicare and Medicaid with the planning currently being directed by Comprehensive Health Planning to assure that effective decision-making will proceed and that the necessary services required to fulfill the promise of Medicare will be available. The integration should occur in Washington and in each state capital.

Our federal and state governments sponsor a wide range of

health programs. In some cases, direct service is provided; in other instances, licensing and other standards are set; and finally, the role played in terms of government purchase of service. All these activities should be coordinated so that significant policy decisions are implemented through all of the activities of government. In some cases, there appears to be competing, and often, conflicting, activities.

Observing the development of these new and important programs for health care in our communities, it becomes apparent that a major public health education effort is required. In the first instance, the people who have new purchase power at their command must be assisted in the proper use of both health personnel and health facilities for preventive as well as therapeutic ends. Adjusting life-long habits cannot be done overnight. There are means, and there are resources that should be brought to bear to assist whole new population groups to understand what can and should be done about illness and the value of preventive health action.

In a similar fashion, it is essential for established programs to develop a responsive service keyed to the special characteristics of different classes and different cultures.

A percentage of the Title XVIII-XIX budget should be designed to promote research and development in the organization and administration of programs to aid in achieving the promise of quality care rendered with dignity and respect for all.

Thank you very much.

HEARING OFFICER LEE: Thank you very much, Mr. Paley.

Miss Solis?

MISS SOLIS: No questions.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: No.

HEARING OFFICER LEE: Mart, I would like to ask you, you indicated there should be an integration of comprehensive health planning with Medicaid and Medicare at Washington and at the State Capital.

How do you see the integration of these in the area, and what source of controls do you see and the reimbursement, particularly, the afferent of depreciation as it relates to Medicare and Medicaid, and the institution complying with the area-wide health planning council decisions? Should the area-wide health planning council have this authority or should they recommend to someone else that an institution receive or not receive these funds for modernization?

I mean, this is the major component in addition to funds that might be used for expansion.

MR. PALEY: Yes, I think, if I can try to separate -- what I think I heard were two questions, at least, from my point of view. One had to do with the integration of various planning activities. It seems to me that comprehensive planning certainly, at the governmental level, at the Federal and State level, and

probably, at the county level, too, is established to establish general views about what is good, what's desirable. These take the form of policies. These policies then should find their way into the direct programs that government operates, whether these are programs for special support, for special disease problems, these should be related and be based upon policies that are arrived on at groups looking at the whole question of health.

It seems to me there have been suggestions in many places in the nation in the last few years about a national policy body concerned with health. Something similar to Ann Sommers's suggestion about a council of economic advisors. I think the same general design is appropriate at the state level. At the area-wide planning level, community level, they have a little bit of a different situation, in the sense we don't have many services, many direct activities that are sponsored by a planning agency.

Now, the planning organizations that are being set up now across the country are designed to stimulate effective planning at the institutional level, at the Health Department level, they are designed to coordinate the work of a number of agencies, and they are designed to harangue the problems that have been unsolved and poorly dealt with in the past.

My view -- or that of my organization -- is that these groups, whether they concern themselves with comprehensive planning, as we organized in the Bay Area a comprehensive planning agency and a relationship with our group that specializes in the

planning of certain types of services or facilities or a contract between the two. As a voluntary organization, we decided it is inappropriate for us to be delegated powers of control and authority. It may be necessary, and, I think, desirable, for anyone who is paying the bill to establish certain prerequisites in terms of what they will pay for and won't pay for, and have some control over the market.

The role of organizations, such as ours, should be to come in as a third party government, if you will, and make our recommendations based upon our best judgment. It would not seem desirable, from the standpoint of good political science or effective planning, I think, to vest in a voluntary organization -- it doesn't go to the checks and balances, legal powers and sanctions. This is a point of controversy, but it is something we come to in the form of a judgment based upon some six years of experience.

HEARING OFFICER LEE: I think you stated it very, very clearly, and separated the two questions, you separated those very well.

I would like to ask you one other question, and that has to do with the problem of categories. It has been repeatedly mentioned, both this morning and this afternoon, both categories, in terms of recipients, categories in terms of facilities in which care can be rendered.

For example, intensive care, skilled nursing care,

intermediate care, and residential care is one other example. What do you think can be done about the present categorical nature of the Medicaid Program, and also, its relationship with Medicare?

MR. PALEY: Well, traditionally, the whole business of categories and health funding, as you know far better than I, has been a two-edge sword. It has created acquisition and moved us ahead in certain fields; and at the same time, has locked us into focus which has prevented us from dealing with other related problems.

I'm thinking about the National Institution of Health, is probably a good example of a categorical approach in the field of public health. The focus of trying to separate out for any given patient specific periods when he requires one licensed program in contrast to another licensed program is most unfortunate. It seems to me that both the licensing and the reimbursement activities, programs, have to look at the patient who, from time to time, requires, more or less, concentration of resources.

And if we can begin to develop in our communities a comprehensive facility that will allow a patient to live there when he's well and to realize certain benefits, and care when he becomes ill, then I think that reimbursement mechanism pretty much has to adjust to what is, I think, both human and medically sound, from what I understand, that the disruption of an older person particularly presents all kinds of problems. Even if we weren't

concerned about the morality, certainly, the complications that arise out of disruption are immense.

I would think that we should adjust our payment mechanisms to allow for continuity within a single environment, rather than requiring that a patient move from this facility to another facility to a third facility, in order to satisfy the strict and rather arbitrary categories established in our Social Security lines.

HEARING OFFICER LEE: Thank you very, very much.

Our next witness is Dr. Robert Hall, Assistant Director for Medical Care of the Department of Public Assistance. And, I believe, he will be accompanied by Mr. Ludwig Lobe.

Dr. Hall.

DR. HALL: Dr. Lee, Miss Solis, Mr. Shreve: I'm so sorry, Mr. Lobe was the Chairman of our Medical Care Advisory Committee in the State of Washington, he is ill and is not able to come down. However, he will present a written statement at a later date.

I couldn't help thinking as I got on the plane this morning in Seattle, I was watching the splashdown in the United club taking on elevation, and the thought has kept occurring, and I don't know whether, at this late hour, to take the time, but I think, in view of what we heard this afternoon, it's almost beyond belief that this society can send three men around the moon and splash down, as I understand, 4500 feet of within the

carrier, and yet, we somehow can't provide comprehensive health care for our people. Now, is somebody watching the store?

HEARING OFFICER LEE: Very good point.

DR. HALL: It's not that I'm against going to the moon, you understand. After nine years of wrestling with welfare medical programs, I think, perhaps, as much as anyone in this country, I welcomed Title XVIII and XIX when it came down the pike.

I wasn't sure that I understood the legislation when I first saw it, I'm not sure I understand it now. Because, at the present time, I am going to concentrate on the things that are wrong. I want to make it clear that there is an awful lot that is right with XVIII and XIX.

The three general areas I want to touch on briefly are, first, the legislative -- I think I speak for those in the Executive Branch, at least, in the State of Washington, if not the Legislative Branch, are somewhat concerned about whether Congress really does mean that we are going to have comprehensive health care by 1975.

And I just mention to you -- as I understand was mentioned briefly this morning -- the Long amendment has raised some very serious concerns. This was the financial disaster in the State of Washington. This would have literally gutted our health care program. So I just want to share, take this opportunity -- and I welcome it -- to share this problem with you. It's a very, very great one.

Another thing that bothers me, and it has from the very beginning, is this business of co-insurance of deductibles under XVIII. I think this is sheer nonsense. I think it's something that should be addressed to the very early day, because it doesn't do anybody any good. As a matter of fact, I think, if someone -- surely, these machines can figure it out -- would figure out the cost of administering the co-insurance, I think it's costing us money, not saving us money.

There are also problems of coordination between XVIII and XIX. I do hope, as I mentioned to one of the Social Security people once, a little while ago, I'll be happy when they get their white hats instead of their black hats, and we really begin to administer a health care program under XVIII and XIX.

Mr. Lobe will address himself in his paper to the method of reimbursing the hospitals.

We have some very serious questions about the reasonableness of the cost, the charges that are being presented to us under the NRC.

We also have some serious question about the interpretation of home health care -- visiting nurse service shall be provided, too, when at home, when they are, in fact, confined to the home. We are also somewhat disappointed in the effectivness of the utilization of HEW. You'll notice, in being in a XIX program, I'm careful to criticize the XVIII program.

I might say, in passing, that many of the criticisms, as

Miss Solis knows, that California enjoyed from the consumers of the service: many of the same things could be said about Washington's program.

Another question we have is the matter of whether or not Part B does, in fact, cost $8 now instead of 6. We question we're getting $8 worth of service in our State.

As far as the intermediary care facilities, we have some concern about this as well. We're also concerned about moving people from one place to another. If there must be a separate facility, we see it as a social service, rather than a nursing health care facility.

My third point is outside of the Title XVIII and XIX, and yet, very clearly interrelated, and that is with the health care industry itself.

It's amazing that you have a 50, 60 billion dollar a year industry, with the lack, almost total absence of organization that you have in this country. And, I think, that it's unwise and probably foolhardy to continue to tinker with the payment system without taking a look at how the industry itself provides the services.

I won't go into detail here, but such things as duplication of services. We have a situation in our State, for instance, where we have Cobalt machines in a city of a population, if you counted everybody, you won't get 250,000 people. As I understand, the Cobalt X-ray Machine would supply service to half

a million. Yet, we have three in one small community. We have other areas where there are two hospitals, different denominations, different categories, you could say, equally supplied, duplicating the services and the cost. And there doesn't seem to be any mechanism by where there can be contained supervision and regulating. Granted, 749 is a very timid area in this beginning.

And, I would like to second Mr. Paley's remarks about organization and planning.

I thank you very much for this opportunity to speak. Thank you.

HEARING OFFICER LEE: Thank you, Dr. Hall.

Miss Solis?

MISS SOLIS: Dr. Hall, when I was listening in Washington and you read an arranged -- a very good arrangement for me months ago, I was impressed that the migratory populations in Washington are recipients, in many instances.

Do you include them in your medically needy category, migratory workers --

DR. HALL: Yes.

MISS SOLIS: -- on a selective basis?

DR. HALL: No. If they are categorically related, there is no great problem. If it's a single individual between the age of 21 and 65, there could be some problems about office calls or drugs. If they have a family, they're fairly well covered, I think.

Would you say that was true, Dean?

FROM THE AUDIENCE: (Nods head.)

DR. HALL: I can't think of any areas where there isn't some service available.

Did you find any while you were there? Did you go out over to Eastern Washington?

MISS SOLIS: Yes, I did. I was able to look at some of their coverage.

DR. HALL: I'm sure they have the same problems that these ladies were talking about here. In fact, we consider one of our problems underutilization, rather than overutilization.

Particularly, in this migrant population, they are very reluctant, they are not welcome in many of the physicians' offices, and so while we have a program, you question whether or not in fact they're getting the service. I don't know if they're getting it; it is available.

MISS SOLIS: Thank you.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: Doctor, just one question. I think we all deplore the duplication of the expense of equipment, I'm glad you made that point.

I wonder whether you feel that government should step in in a regulatory manner and control the matter there; or the National Hospital Association and others should work it out by themselves?

DR. HALL: I think it is going to have to be a combination of both. What happens, in hospitals, particularly, they're ready to plan like crazy when they get their hospital bill. I think this is human nature.

MR. SHREVE: I think we can say we've seen that in the Bay Area.

DR. HALL: And doctors are not reluctant to take advice from others, as you know.

MR. SHREVE: Thank you.

HEARING OFFICER LEE: Thank you very much, Dr. Hall.

Our next witness is Mrs. Wilma Harding, health aide for The Hoopa Valley Indian Business Council; and with her, Mrs. Beverly Chenot, who is a licensed vocational nurse in the Lake County Indian Health Project.

MRS. CHENOT: My name is Beverly Chenot, and I'm from Lake County, the project nurse for the Indian Health Project, one of nine projects in California.

I will list the following projects in California: Mendocino County, Modoc County, San Diego County, Riverside, Tuolumne, Tulare, Humboldt, Inyo and Lake County.

We're funded by the State Department of Public Health who has received a federal grant for $24,500 which supports the nine projects. The project staff includes one nurse and two health technicians. The purpose of the project is to provide health, education, transportation and a referral.

The Lake County Indian Health Project provides service to six Indian communities. Most people are under the impression the Federal Government takes care of health needs for all Indian people in California. This is not true. The Division of Indian Health provides no direct health care to California Indians, except water and sanitation programs in a few areas. Complete medical care is provided for Indians in other states, and partial dental care.

I will state a few details of our project. The majority of Indian people in Lake County received help from Medi-Cal of this State, aid to the dependents, aid to the blind and aid to the needy children, and other programs.

There are a few cases in Lake County where possible medical improvement should be met. The cases were: orthopedic shoes were obtained from private agencies; medication obtained for one Indian, a young man who was able-bodied but was unemployed, this medication was an example, the doctor suggested he apply for welfare just for the medication, and the Indian man was a little unhappy, because he was embarrassed, and he didn't want to go to the Welfare Department.

We feel if there is a policy change to eliminate this problem in the future, that orthopedic shoes can be obtained or appliances for orthopedic needs, and also, for medication.

Those are a few of the points I have brought today.

HEARING OFFICER LEE: Thank you very much.

Miss Solis?

MISS SOLIS: Mrs. Chenot, I know something, a little bit about the problems of distances in area.

What does this -- to get to a physician, what are your resources and what kinds of problems does this create in terms of the patients receiving continuity of services?

MRS. CHENOT: Several of our Indian communities are in the radius of 70 some odd miles, and in order to receive treatment, one area would have to travel about a half hour, and they don't have the funds for gas, and to continue their services is just something that does not carry through.

MISS SOLIS: Do you have any suggestions to make with regard to the problem of transportation?

MRS. CHENOT: Possibly, if Medi-Cal can provide gas mileage. Now, there is in Lake County a provision for transportation, but it's included in the grant.

Now, if a person had to go to the doctor immediately or travel, like, to San Francisco -- which has occurred before -- they would have to pay for this or, possibly, borrow the funds, in some instances.

MISS SOLIS: Thank you.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: Just one question: I know that the Indians who are not on reservations, who live in cities, also, are not helped at all by the Bureau of Indian Affairs. Don't they get

some help, those who are on the California reservations?

MRS. CHENOT: Would you repeat that, please?

MR. SHREVE: The Indians who live on the few reservations we have in California -- they are small ones, I know -- don't they get some help from the Bureau of Indian Affairs for their health matters, the ones that are on the reservation?

MRS. CHENOT: I think I will refer this question to Mr. Brown.

MR. SHREVE: Thank you.

HEARING OFFICER LEE: Thank you very much, Mrs. Chenot.

MR. BROWN: My name is Ed Brown, I work as a coordinator of this Health Project.

The Bureau of Indian Affairs doesn't have anything to do with the Indian health. The Bureau of Indian Health is HEW; other states do provide health care from the cradle to the grave, usually, there's no stipulation to income. In California, this is not true. They receive no help whatsoever, except for sanitation projects, in a few reservations.

HEARING OFFICER LEE: Mrs. Harding.

MRS. HARDING: I know I'll be very inaudible, I have a strep throat.

But first, I'd like to start off with a few recipients that I have been working with. We have a recipient who is a patient, I have been working close with for 33 years. And he has TB, he needs a lot of medication. So it takes a lot of work, and

whatever we can find to get these people, on Medi-Cal. He's unable to support himself.

And we've been having problems with dental. We had a man who was left without his teeth, because we received a per capita, and this exceeds his needs, the money that he's prorated for three months. So therefore, he was without, we had to -- had to go to the offices in Sacramento to get him his teeth.

And, I have several more here. But, I believe that all the Indians, rural, should be automatically on Medi-Cal.

The per capita that we received is just our own welfare. So we're supplying ourselves, and I just -- I just finished a health survey, and income on the reservation in the locality, their income is twenty-two sixty, and that's far below the poverty level established.

My feelings on this, I would like the local government to be changed to meet our needs. We're in a remote area. The valley is situated at 62 miles from the nearest town that's closest to the county hospital.

And, also, we have people who don't fit into pigeonholes, like alcoholics. Their medical bills are paid by the Welfare. But, I think, we should have some help for these people, to put them back into society and help them to find themselves.

And, I have one that doesn't even have a home right now and isn't allowed any grant from the Welfare, because of his appearance. So that's kind of -- that's very wrong they should

deny him any grant, because of what he looks like.

We have several blind people in our area without any bathroom facilities; but they always receive the per capita money, so they're denied anything that the Welfare has for these people.

Thank you.

HEARING OFFICER LEE: Thank you, Mrs. Harding.

Miss Solis?

MISS SOLIS: I'm sorry you're not feeling so well today, Mrs. Harding.

I just wanted you to clarify one point. One of your initial statements was that you believe that Medi-Cal should be available to all Indians. Now, could you clarify that in terms of per capita and certification problems in that?

MRS. HARDING: It is because of the income. Some of them with the per capita which averages only $764 a year, and the work in our area is seasonal, so they work six months; or if they are unable to work, well, that's all they exist on, the $764.00 a year, which is far, far below the 1500 that is -- you all consider to be the lowest. So I feel like that they should have Medicare automatically.

MISS SOLIS: Now, if they receive their per capita --

MRS. HARDING: Yes.

MISS SOLIS: -- then they are not eligible, right?

MRS. HARDING: That's right. It's proration over three months' period. And other welfare agencies accept you after you

receive this money, and you can reapply a month later. But, this just doesn't happen in our area.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: No questions.

HEARING OFFICER LEE: Thank you very much, Mrs. Harding. We hope you make a speedy recovery.

MRS. HARDING: Thank you.

HEARING OFFICER LEE: Our next witness is Mr. William Barrett, who is Chairman of the Health Committee of the National Association of Social Workers.

Mr. Barrett, welcome.

MR. BARRETT: Thank you. I am Chairman of the Health Committee of the California State Council of NASW, so I'm speaking for the members in California of this organization.

We welcome this opportunity to present our views on ways to improve the national Medicaid program.

The California State Council of Chapters, National Association of Social Workers, represents 6000 professional social workers who work daily with sick and helpless people most affected by the program under consideration. Some of these, we learned today, can speak quite effectively on their own.

The National Association of Social Workers, in its "Goals of Public Social Policy," states strong support for "governmental health policy and programs that assure to every individual, whatever his age and circumstances, full access to the benefits of

existing medical knowledge..."

As part of its social policy, the organization recommends "a coordinated, comprehensive national health program which will assure full health care to all persons in the population through provision of all the facilities and medical services necessary to provide full and comprehensive health care. A program applying the principles of contributory social insurance, tax support, and of group payments is endorsed and recommended..."

Medicaid has been a stride forward towards providing the kind of program that we truly need, but it has many gaps and deficiencies. A really comprehensive and equitable program, we believe, will ultimately need to be based on some kind of contributory, prepayment or insurance plan for all, extending the principles of the Medicare program that apply now only to the elderly. Thus the Medicaid program can probably best be improved by modifying one of the major premises on which it is based, namely, a dramatic but urgent shift from patient selection by means test or need to a universal insurance basis. The insurance principle affords an objective measure of determining eligibility and does away with the degrading and deterrent means test which denotes charity status no matter how well administered. There can be no reordering of priorities or significant progress towards equitable and adequate distribution of health services, including preventive services, without extension of the principle of national health insurance.

Pending this, and based on our observation of the California program, we recommend that the Medicaid program be changed in the three primary areas of eligibility determination, coverage and payments, and provision of social services in order to deal with deficits and inequities in the current system.

With regard to eligibility determination, we feel that the present system of investigatory eligibility determination is wasteful and needlessly demeaning, and that it can be replaced by a simple declaration process. An income tax return or some similar device can be used as a simple way to check need. States should be assisted to implement the recent directive allowing for this and should be provided data to demonstrate that this can be instituted without program costs becoming unbearable to the national economy through a wild orgy of indulgence in needless utilization of health services by the poor.

In the meantime, eligibility through categorical linkage should be abandoned. This feature means too many people among the marginally employed and underemployed are left out of the medical care coverage. As long as eligibility must be determined through a means test, this must have as a base a decent standard of living rather than being linked to inadequate public assistance categorical program maintenance standards. At the very least, the ratio of 150 percent of the AFDC standard should be maintained.

Determining of liability is difficult and complex to

administer and should be streamlined. Patient resources that are not readily available should not be counted in determining liability.

On coverage and payment: Coverage of the program should be broadened so that the present focus of the program, which is on remedial care delivered chiefly in institutions, is extended to emphasize more opportunity for preventive services, outpatient and home and family-centered care. Too many babies are now delivered without mothers having had any prenatal attention; immunization levels are far short of complete in poverty populations. Group plans that have made complete preventive medical attention available have demonstrated the economy of this.

Funding of the program from the Federal level should be available so that state fund deficiencies do not bring about abrupt changes in scope and nature of coverage, such as arbitrary number of days hospital care allowed. The present maze and welter of conflicting and obscure regulations, which change from week to week, mean neither the patients, the administrators of the program, nor the providers of care can be current and clear on what services are provided, and many simply turn away in disgust and frustration.

Rates of payment to providers under the Medicaid program must be made fair, equitable and equivalent to those under Medicare. An example of the adverse effect of the current system is the rate differential for extended care facilities and nursing

homes, which has resulted in many nursing homes either not accepting Medicaid patients or discharging and transferring patients whose Medicare benefits are exhausted, with damaging results to the patients.

Federal funds should be made available to subsidize states not able to meet costs of such equitable provider payments so that more providers are brought into the system and the ideal of "mainstream care" is more nearly actualized.

Procedures for payments to providers should be improved to prevent time delays and undue lags in payment after services are rendered.

Many groups are now arbitrarily excluded that should be included. For example, there is no logical reason to exclude persons in mental and TB institutions, children in non-medical institutions such as juvenile detention facilities, and persons jailed but not yet convicted of crimes.

Title XIX mandates that groups classified as medically needy must receive the identical scope of services. This hinders states in obtaining Federal payments for groups that are more needy than other groups. For instance, children under 21 should have the full scope of services available to them, but states are precluded from this unless all medically needy persons receive full scope. This prevents the states from zeroing in on high risk groups such as children and expectant mothers.

With regard to the provision of social services: Greater