and more explicit provision for available social services must be made in the program. Too many institutional and home care facilities do not provide such services, and the Medicaid program should require that these be a part of services such as hospitals, extended care facilities, and home care programs, and provide payment.

In California, the essential contribution of social workers as main links in assisting to provide continutiy and family-centered health care has been documented by our Select Committee on Medical Social Services, which is an advisor to the California State Department of Public Health.

Individual social workers should be recognized and paid as providers under the program. At present, social workers are practically the only health profession not so recognized. An increasing number of social workers are now practicing privately, some 14 percent of NASW members in California, and if these can be recognized among Medicaid providers, patients and families needing their services can obtain them. At present, patients cannot choose to use privately practicing social workers because the program does not cover these, and many who have begun service from private funds or under Medicare must discontinue when their funds or Medicare benefits are exhausted, but before the need for service is ended. Benefit coverage of social services from individual professional providers can mean the extension of these to many small health facilities and other health services, and

enable referrals when indicated from private physicians.

In conclusion, we would like to restate that we believe the soundest national approach to the improvement of health care services to all needful people, and particularly to the poor, will be a radical revision of the philosophy and funding approach so that comprehensive medical and health care, with emphasis on prevention, is made available to all.

Dr. Hall had stole my punch line, but I'll repeat it: We do not believe that this is "reaching for the moon," but if it is, we all know that such reaching is now practical and feasible.

HEARING OFFICER LEE: Thank you, Mr. Barratt.

Miss Solis?

MISS SOLIS: No.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: I would just like to say one thing, Mr. Barratt. I know that Secretary Cohen is going to be particularly interested in reading your testimony, because he was telling me just a few days ago how surprised he has been he hasn't had any comments in favor of the simple declaration. He's heard from a number of states who are concerned about the additional cost to them, but very few people have been heard from in favor of the simple declaration being established to establish eligibility.

I know he's going to be very interested in that, and other features of your presentation.

HEARING OFFICER LEE: Thank you, Mr. Barratt.

Our next witness is Mr. Herbert Davis, the Deputy Attorney General of California.

Mr. Davis.

MR. DAVIS: Thank you, Mr. Chairman. Thank you for the invitation to appear today.

As you know, our Office, last month, issued a report on the Medi-Cal Program as a result of an 8-month investigation, a copy of which has previously been provided to HEW, and I have additional copies here today for the Panel Members.

This report was aimed primarily at determining the extent of abuses going on in the program, and reasons of why they were existing. The report will inform you of our basic concerns over present operations of the program.

Since the issuance of the report, we have continued to receive substantial information concerning abuses in the program. This information has come from members of the various medical professions, from persons receiving care through the program, and from persons in government who have been connected with the program.

This new information has not caused us to reconsider any of the statements in our report -- except in one aspect: We may have understated our criticism.

Prosecutions will be initiated in California against the most flagrant violators, but we recognize that this is certainly not a complete answer to the problem. As we emphasize in our

report, substantial changes in the administration of the program are required.

Since we issued our report, a medical official in another state informed us that we could remove the cover from our report, replace it with the name of his state, and reissue it with no other changes. He told us that every problem and every abuse which we discussed are present in his state's program.

From the outset, we have attempted to make it clear that our only goal is to improve -- not to impede -- this program. We consider it an essential program in meeting the medical needs of Californians. We have also emphasized that our discussion of fraud in the program related to only a small percentage of professionals involved in the program.

We estimated that minimally six to eight million dollars annually are being drained from the program by illegal and unethical activities. While, admittedly, this involved only a fraction of the annual budget and a fraction of the Medi-Cal practititoners, we found that investigation of this problem pointed to very serious problems in the general administration of the program. The consideration of program changes to eliminate cheating led us to consider changes which would improve the entire program. For example, improvement in computer programming to ferret out cheaters leads inevitably to the consideration of new computer procedures to improve overall administration of the program.

I will not attempt today to discuss with you all the findings of our report or the fourteen recommendations which we made for improvement of the program.

I would like to mention one general finding: One major problem, the administration of the Medi-Cal program in California resulted from the pressure for California to take immediate advantage of the funds available under Title XIX. More allowance for cooperative preparation and analysis would certainly have resulted in a better program. In the formulation of future programs, greater efforts certainly should be made to provide for adequate preparation.

Rather than dwell on any particular aspects of our report, I would rather devote the remainder of my time here to answering any questions which you may have concerning our report.

Thank you.

HEARING OFFICER LEE: Miss Solis?

MISS SOLIS: No.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: I just wonder, Mr. Davis, whether it has come to your attention that many of the abuses on which you reported -- quite well -- had previously been discovered by our own HEW audit agency, and had been discussed with the State and the providers, and many steps have already been taken to correct some of those abuses. That's not to berate the report, in any way.

I do think the record which hasn't shown that up to now should include that statement, because the State and the providers have been making valuable efforts to correct those abuses, even before your report came out.

HEARING OFFICER LEE: I have no questions of Mr. Davis. As you know, we are studying the report in the Department, and certainly, I won't make any comments on it at this time. We certainly appreciate your coming and submitting the report in addition to your statement.

Our next witness is Mrs. Verneice Thompson representing the State Conference of Clinical Social Workers.

Mrs. Thompson.

MRS. THOMPSON: I'm sorry, we're all ill in California, I have a cold, too.

Dr. Lee and Members of the Panel, I thought I would read only part of my statement, since I have copies to give the Members of the Panel. I also would like to have some time at the end of the brief reading to discuss any questions you might have about coverage for people in the State.

I work in two places, part time as a Chief Clinical Social Worker in the Family Guidance Clinic and the Pediatric Hospital, and a large number of our patients are from the public welfare programs. And I was told, before I came, that you probably thought a good deal of social work services were built in to the programs for children on aid, for example. And I happen to know,

from my experience, about some of the gaps in that program, and I'd be very glad to answer questions, if you have some to ask.

Representing the California Association of Clinical Social Workers, as of this year, California has recognized the practice of Clinical Social work. The licensure law sets standards at a minimum of two years of practice following the Master's Degree and within the year applicants for licensure will have to pass an examination in addition to the two years of experience.

There are presently about 300 licensed social workers in the State, and it is expected that this number will double within the year. These licensed social workers are employed in public and private hospitals and clinics, family service agencies, and in private practice.

It is hereby requested that licensed social workers in California be included as medical vendors under Medicaid, which will permit recipients to have a choice of requesting the services of clinical social workers.

It is generally known that illness has a much greater impact on ward and clinic patients and their families than is the case for other patients. It is also accepted that a patient's emotional reaction to illness and the family's reaction are important factors in his convalescence and recovery. While the great attribute of the Medicaid program is the assurance to the patient that he can have the best medical care from the physician of his choice, it is not enough, for example, to simply issue a

card to a recipient and assume that he will get the same personalized, quality services as those patients who either pay themselves or have their medical needs covered by private insurance companies.

If clinical social workers were medical vendors with provider numbers, it would be possible for recipients or physicians to request the services of a clinical social worker with those problems which accrue to the patient because of his illness. Coverage should include services to spouses or children when their emotional reaction to the patient is a factor in the patient's illness and recovery.

The clinical social worker would counsel the patient and family to handle the emotional impact of the illness; to work with community agencies, for example, the schools, juvenile courts, or whatever, where there would be a need for some consultation and coordination regarding the patient or family member. Even more importantly, the physician and social worker could work as a team to meet effectively the physical, emotional and social needs of the patient.

The current control which applies to psychiatrists and clinical psychologists involving referral from a physician and reauthorization after several visits would appear adequate in the use of clinical social workers.

I've listed -- and I won't read them -- I've listed the areas and settings where clinical social workers are currently

employed, and the way they're paid in the agency -- or the agency is reimbursed for their services.

Now, I think, in California we face an opportunity and challenge to test public usage of the licensed social worker in California. The California Association of Clinical Social Workers is committed to regulation of practice, both to protect the public and to facilitate and encourage the highest possible standards of professional performance. If we were vendors we could make known the wide range of services available to physicians and recipients. We would also establish a State Committee to check the quality of service given as well as to check on charges made by social work practitioners.

I think that is as much of the report that I need to read.

I would be happy to answer questions you would have about the report or the patients who are served where I work part time.

HEARING OFFICER LEE: Thank you.

Miss Solis?

MISS SOLIS: Mrs. Thompson, I don't have a question as much as I do have a comment. And that is, there has been a great deal of concern expressed by various people, and also, by the staff at HEW with regard to the lack of social services as related to Title XIX.

I think, in fact, I have heard such comments as, "Under the old medical assistance, at least, the patient was followed through in terms of his social needs" --

MRS. THOMPSON: Yes.

MISS SOLIS: -- "and this is not assured under this current program."

However, I do believe that there is much concern with regard -- you were not here earlier when I made the comment that this is a medical program and we need to look at it in its further broadening as a health care program in which we encompass the social needs of the family, and so on. We are quite interested in this aspect.

HEARING OFFICER LEE: Mr. Shreve?

MR. SHREVE: I was quite interested, Mrs. Thompson, in Mr. Barratt's footnote that a number of other states are expected to license clinical social workers soon.

I should have asked him: Do you happen to know whether, if in any of our Western States, such action is anticipated in the near future?

MRS. THOMPSON: I'm not sure of the ones Bill had in mind.

Bill, do you know?

MR. BARRATT: I think, they're mostly in the East.

MRS. THOMPSON: Yes, I think, they're in the East.

MR. SHREVE: Thank you.

MRS. THOMPSON: We're probably the only ones out, in this part of the country --

MR. SHREVE: California is often ahead of the other states, that is well and good; but I would like to see some of the others

come along, too.

HEARING OFFICER LEE: Mrs. Thompson, I would like to have a comment about a problem that has come up a number of times, and it may relate to your statement about the gaps in social services; that is, the categorical nature of the program, and whether you feel there are improvements that would result from removal of some of these categorical restrictions and the necessary linkage, at the present time, at least, a federal financial participation to those categories and making the program as categorically related --

MRS. THOMPSON: Yes, I only underscored Mr. Barratt's report in that regard.

HEARING OFFICER LEE: Would you, also, in terms of the -- there's another, it seems to me, another theme, a point, that was expressed more this morning, and this has to do with effective consumer participation.

MRS. THOMPSON: Yes.

HEARING OFFICER LEE: In advisory councils and in various ways in relation to the program in terms of our own experience in provision of social services, do you feel that we're -- in terms of local institutions, state and at the national level -- making an adequate effort in this regard to achieve effective recipient or consumer participation in these programs? And do you see improvements that can be made?

MRS. THOMPSON: Well, I'm very sorry that I wasn't -- didn't feel well enough to come for all of the hearings today, and

so I have to guess about that.

I would think there would be great room for improvement. Many of the parents of children receive an aid, for example, and the parents themselves simply are not aware, they're not sophisticated, they're not aware of how involved they can be, they're not aware of what it means to discontinue services with somebody who's not cordial, who's not -- who doesn't receive them properly, you know.

It really -- it, I think, is one of the most tragic experiences that I have -- all of the time in the clinic -- is to talk to parents and hear them recount some of the services -- recount the personal attitudes of physicians who serve them or who feel they have to serve them because they have a Medi-Cal card.

Now, this, by no means, is a derogatory remark about the medical profession; but there are many medical practitioners who simply aren't accustomed by practice to taking care of poor people, and they are self-conscious about having them in their offices. Many offices are located in quite middle-class neighborhoods, and the recipient feels the slight and simply feels this is -- that they can't do anything about it. And I spend a major of my time with them, as I see them in the clinic, to help them find the right kind of service or to speak up if they feel they've been slighted or to consider going to two or three physicians and in picking a doctor who serves them according to their own wishes.

I get many calls from workers in the Department of Public

Welfare Guidance Clinic to see their patients, to see the children, because they feel the children will get a greater reception, they will get a skilled service from a team of practitioners, that they will get that service in the Guidance Clinic; and they will not get it if they refer them to a private practitioner who has to work in certain ways with them.

So there are gaps that are subtle -- I think, there is a lot of work to do in making the consumer aware in these gaps. But, I think, including social workers, will provide to aid this. Many doctors are accustomed to taking care of patients like this with the aid of social workers. When they serve them the way they do now, they are not permitted to use social workers in the traditional ways they do in the hospital.

HEARING OFFICER LEE: Thank you very much.

We have one additional witness who has asked to testify, from Contra Costa Medical Services.

MISS THOMPSON: I am Eleanor Thompson, Contra Costa Medical Services, and a Supervising Social Worker, so I speak from this experience with patients.

We've talked about the Group II people today, but we haven't mentioned the problem is not only in the scope of benefits, but the maintenance needs of allowances which are set by Title XIX; and therefore, it's a federal responsibility.

And if you're talking about doing away with categories and covering more people, I would say, if you're going to use the

same maintenance need standards, please don't. Because this is to the disadvantage of many, many patients.

I think the people who set up the maintenance need budgets might have been thinking in terms of short-term medical care, where the share of costs that the family is supposed to pay would be spent over a period of months, they could make this payment over a period of months. But, if you are aware of the many, many patients that have chronic expensive long-term medical needs for more than one member of the family which, I think, was very well demonstrated today by Mr. Barratt, that this share of costs cannot go on and on and on indefinitely without working into a tremendous medical and social problem for the family.

We have been very limited in making long-term good medical social plans for patients who have rehabilitation service, for instance, or who are ready for discharge and really should not be returned to their former living plan. But because of the share of costs, the family just cannot provide for the medical care, based on this share of costs. So they have to take the patient back home which works a hardship on the patient and on the family--and also, repeats coming back to the hospital which costs more than would this other. So it really is a hardship.

So we would like to say, we realize there is a cost factor, that the maintenance needs allowance is working a tremendous hardship on a great many people.

Thank you.

HEARING OFFICER LEE: Thank you very much.

Mrs. Thompson, did you want to make an additional comment?

MRS. VERNEICE THOMPSON: Yes. I'd appreciate it if you'd let me. I wasn't really thinking very clearly, in answer to your question about the consumer involvement with the service delivery.

I think that it should be mandatory that all hospitals and agencies and clinics who are utilizing money under this program, that it should be mandatory that the recipients serve on advisory committees and on boards of directors. And, I think, until we come to that, we're really not going to get the service that's really relevant to the group that's being served.

I appreciate you letting me come back, and saying that.

HEARING OFFICER LEE: I appreciate your comment. It's a very important point, and one that has not been made up to now.

Is there anyone else here who would like to make a statement, before we close the hearings?

MR. BRONSTEIN: I would like to make a statement, a statement in behalf of the general medical insurance --

HEARING OFFICER LEE: Would you come up to the microphone again.

MR. BRONSTEIN: I would like to take this opportunity to speak to the general insurances. I think Mr. Barratt, one of the gentleman speakers to you before me, he mentioned that it is horrible that we are not able to develop an effective medical insurance, we're too busy saying -- if I were able to give my own

thoughts to this -- the basic reason why we cannot come to effective medical insurance is because most people don't want the very fair system. And man who works all his life, who has a sense of personal responsibility to the society, he doesn't want to receive welfare. He wants only to receive something for what he has paid for.

Like, in my case, the private insurance system is completely -- proved completely unreliable. I pay in tremendous amounts of money since 1953, premiums to so-called nonprofit organizations, insurance companies, like Blue Cross, since 1953 continuously. I think this whole thing is a multi-million dollar racket, exploitation of the employed people. As soon as somebody gets employment, he becomes part of the so-called medical group insurance with certain benefits, which I realize, he has to pay for private insurance, it is true. All these insurance companies are insurance clouds who make all this insurance a fraud. For example, one trouble is, you don't get the right to accept your insurance coverage if you terminate an employment; it doesn't matter what reason, you might be forced to leave, like I had to do many years ago. I had to leave New York, I had to terminate my New York employment, because of asthma condition in my family. During all the time, I had not realized I was not covered fully by effective medical insurance system. That the people, the people to the public welfare system -- a man who works his life, he doesn't want to receive welfare. He has been willing to pay

his premium at the time he is able to pay the premium, able to work and to earn money, his earning power --

HEARING OFFICER LEE: That's been of the advantages of the Medicare program, and it's been one of the reasons that people have favored extending that approach, such as the need for the permanent and totally disabled --

MR. BRONSTEIN: This is only a suggestion in general to the medical insurances we have, most people are today covered by private medical insurance companies, but if somebody, for some reason, has to terminate his job, he loses his insurance coverage sudden, it's up in the air. He has to look around, he looks for assistance to the state, to the government. Why?

HEARING OFFICER LEE: This is a problem, and I think it's a -- you have identified it, it's certainly one that I think we are aware of. And Medicaid has met a certain part of that, Medicare has met a certain part of that need. There are other people who don't fit into either of these programs --

MR. BRONSTEIN: Mr. Chairman, I'm sorry, I don't want to mix up Medicare with private insurers. If I may correct you, I understand that an American insurance company system is a system in which I paid my premium, in which I am covered for ten years from now when I'm not, perhaps, able to work, perhaps, I give up a job, I'm not covered by a company. Like the Blue Cross, I pay since 1953 continuously my premium to Blue Cross.

HEARING OFFICER LEE: You've made that point, Mr. Bronstein

several times. We do understand the difference between this program and Medicare; that the private insurance program --

MR. BRONSTEIN: What I wanted to initially -- a kind of federal, private federal insurance, medical insurance in which everybody can pay his premium, but the federal government takes care of that premium; at the time, the federal government can give you the coverage. All right, you are sick now, we, in turn, the premium we took, the liability from you, we pay you -- not from a welfare fund, not Social Security -- besides Social Security, I say, complete private medical insurance.

HEARING OFFICER LEE: Well, this type of approach has been proposed by others, and I'm sure it will be considered.

Thank you very much.

MR. BRONSTEIN: You are welcome. It is only a suggestion.

HEARING OFFICER LEE: Yes; thank you.

Anyone else?

(No response.)

HEARING OFFICER LEE: If not, we want to thank you, and the reporter, particularly, for her patience and skill.

Thank you all for coming.

(Whereupon, the hearing was adjourned at 4:40 p.m.)

THE FOLLOWING STATEMENTS

WERE NOT PRESENTED

AT THE HEARING BUT

WERE SUBMITTED FOR INCLUSION

IN THE RECORD

STATEMENT ON MEDICAID

by Lester Breslow, MD, MPH
President, American Public Health Association

for Hearing Conducted by Secretary of HEW
San Francisco, California
December 27, 1968

Medicaid has expanded the opportunity for medical care of the poor in two important directions: (1) it recognized the necessity of large-scale funding by the Federal government, to overcome the inadequacies of State and local funding of medical care for the poor; and (2) it enhanced flexibility in providing such care, by abandoning the long-standing practice of limiting medical care for the poor to local governmental facilities. Medicaid encouraged use of the private sector as an alternative means of providing needed care.

Medicaid, however, has failed to satisfy the reasonable expectations of the American people, in several respects:

(1) <u>It has failed to extend medical care to the poor throughout the country</u>.

More than three years after the passage of the Federal legislation, approximately one-fifth of the states still had

not taken action to participate in any degree. The wealthiest states, such as California and New York, have benefitted the most because of their ability to provide the required matching funds. The poorest states--with the greatest need--have benefitted the least, because they cannot raise sufficient matching funds.

(2) It has failed to improve the quality of medical care for the poor.

In fact, Medicaid has bolstered the worst features of American medical care, by pouring hundreds of millions of dollars into situations which physicians concerned about quality know represent poor practice. State and local welfare administrators have tended to purchase and pay for more of the same kind of care that poor people were obtaining previously. The personnel and facilities in neighborhoods where poor people obtained care were often inferior, and Medicaid offered no inducement to improve; it simply financially supported what was present.

Medicaid was supposed to provide "mainstream" care for the poor, rather than segregated care. Actually, it has strengthened by tremendous financial support a backward eddy

in American medical care, namely, care by poorly qualified practitioners such as those in urban communities who do not keep up their skills by contact with hospitals or other agencies of medical progress.

For example, in Sources, published in 1968 by the Blue Cross Association, J. N. Tuck observes that the AMA News summed up its finding from a survey of Medicaid, "To say the programs have generally improved the medical care rendered to the poor would be an overstatement." Tuck further notes: "An even bleaker report comes from a University of Chicago study, which found that 70 per cent of Cook County's caseload was handled by 100 of the 1,700 physicians listed as available. Only 40 of the 100 had hospital affiliations. And just 73 'mass production' medical men handled more than half of all physician services rendered to 285,000 welfare recipients, for which these doctors were paid in 1967 $1.5 million, an average of $21,000 each."

(3) It has failed to remove the stigma of indigency from medical care for the poor.

Medicaid still forces patients "to barter their dignity for their health." In the two years since Yerby made this now

famous indictment of indigent medical care, our entire system of welfare assistance, including its medical aspects, has come under sharp criticism from many sources. Voices from the ghetto and from taxpayers associations, from social theorists and from the medical profession are attacking it with increasing force.

(4) It has failed to establish a stable system of financing medical care for the poor.

In many parts of the country, the vagaries of Medicaid budgeting have made political headlines almost from the outset of the program. Difficulties in determining eligibility and wild estimates of cost continue to plague all those concerned about the program. These troubles are being reflected back into the halls of Congress. Throwing more of the burden back onto State and local government, of course, would only lead to further disruption of care and discontent.

To overcome these serious defects in Medicaid, the Federal government should take the following steps.

(1) Adopt as national policy that Federal support of medical care for the poor is designed to improve their health, not to supplement a welfare assistance program. A corollary

of this principle is to place primary responsibility for administration in health, rather than in welfare agencies.

(2) Establish a stable system of financing medical care for the poor which:

(a) really extends such care equally throughout the country

(b) overcomes the inequities among State and local resources for financing the care

(c) relates the budgeting to clear definitions of population to be served, services to be provided, and costs based upon reasonable levels of payment.

Contrary to the Medicaid situation, characterized by failure in all these respects in providing medical care for the poor, the Medicare program for the elderly has largely succeeded in achieving these aims.

(3) Incorporate into health programs for the poor a national legislative framework for establishing standards of quality similar to that of Medicare. This is essential to overcome the appalling lack of standards that has resulted in wastage of tremendous amounts of money and entailed poor care in Medicaid. Essentials in assuring quality are a system of certification of providers, a data system and peer

review of professional work.

(4) Require a data system for Federally-supported medical care of the poor that will:

(a) identify on a statewide basis individuals who are eligible for services (in many parts of the country, even this elementary step has not been accomplished)

(b) permit determination of expenditures on a reasonably current basis

(c) establish norms of service by various types of providers

(d) identify individual providers who deviate markedly from these norms, thus raising questions of quality and abuse of the program

(e) facilitate peer review of professional service, coupled with appropriate administrative reporting and action

(f) permit evaluation of the effects of the program on the health of those served.

(5) Support research on the health care delivery system on a scale consistent with the more than $10 billion which the Federal government is now involved in spending annually for the health care of the elderly and the poor.

Commitment of even 2-3 percent of that amount annually for research and demonstration efforts, aimed at achieving greater efficiency and quality in health care, would be a good investment, as exemplified in private industry generally and in other aspects of governmental endeavor.

JOHN A. BURNS
GOVERNOR

WM. G. AMONG
DIRECTOR OF SOCIAL SERVICES

STATE OF HAWAII
DEPARTMENT OF SOCIAL SERVICES
P. O. Box 339
Honolulu, Hawaii 96809

December 20, 1968

Mr. Charles H. Shreve
Regional Director
Department of Health, Education
and Welfare
50 Fulton Street
San Francisco, California 94102

Re: Public Hearing on Medicaid

Dear Mr. Shreve:

We should like to thank you for the invitation extended to us for a short presentation on Medicaid at the San Francisco public hearing on December 27th. We are unfortunately not able to send a representative, so we should like to take this opportunity to express our views regarding Medicaid and its administration.

Generally, we believe Title XIX is a remarkable piece of social welfare legislation which contains many innovative features for the establishment of a sound program of health services for low-income families. Its implementation on the Federal level could not have been better accomplished than by the able staff of Social and Rehabilitation Services. However, the nationwide progress for full implementation of the Title XIX provisions has been spotty and uneven, the chief cause being the fiscal problems of many states. We are generally satisfied with the effectiveness of Medicaid here in delivering health services to the segment of population for whom it had been intended.

The recommendations which follow are mostly in relation to changes which we think could contribute to simplification of Medicaid administration by single state agencies:

1. It is recommended that Title XIX be amended to eliminate the requirement that the medically needy be related to the categorical assistance programs (Titles I, IV, X, XIV or XVI) in the determination of eligibility for medical assistance. Such a change will not only benefit states by simplifying the administration of the program but could also help create equity for other low-income families in states where general assistance is non-existent.

2. We believe the Title XIX provision relating to "buy-in" of Supplementary Medical Insurance for recipients 65 and over should be further amended to give states an option to convert the method of payment for the monthly SMI to medical vendor payment. This optional provision will enable the maintenance of a single vendor method of payment for SMI in states where the medically needy is also included in the buy-in.

3. The income ceiling established for Federal financial participation for the medically needy under Public Law 90-248 appears to result in greater harm than good when its effect is considered on a nationwide basis. While it will accomplish the desired objective of reducing Title XIX matching funds for states with liberal income levels, it will also force poorer states (because of low average AFDC payments) to keep their income level for the medically needy depressed far below that of the "Federal poverty level". We believe equity can be achieved only when a uniform income ceiling is established on a nationwide basis.

4. We believe there is an urgent need for SRS to issue a clear statement of policy with respect to recipient's utilization of available community medical care resources. Public Law 90-248 contains a mandatory provision for free choice of agencies, organizations and persons of the healing arts who are licensed under the state laws. Will this provision take precedence over the requirement that recipients utilize actually available medical care resources first? If yes, the free choice provision will weaken the Federally subsidized Title V programs in many states.

5. It is recommended that SRS and SSA jointly keep state agencies informed of major changes made in Medicare's regulations, billing forms and procedures. The lack of communication with state agencies on this matter makes it extremely difficult for us to maintain satisfactory coordination of Medicare and Medicaid. It also causes confusion to Medicare-Medicaid patients and providers.

We are not very familiar with the major problems involved in administering Title XIX on a national scale. Our comments and recommendations are based on our experiences in administering a local program but we hope you will find these helpful.

Aloha and sincerely,

WILLIAM G. AMONG
Director

cc: Miss Gene Beach
Associate Regional
Commissioner for Medical Services

CALIFORNIA SOCIAL WORKERS ORGANIZATION INC.

2527 Forbes Avenue
Santa Clara, Ca. 95050
December 24, 1968

Charles Shreve, Regional Director
U. S. Department of Health, Education, and Welfare
50 Fulton Street, Room 427
San Francisco, Ca. 94102

STATEMENT FOR DHEW HEARING ON MEDICAID, DECEMBER 27, 1968, SAN FRANCISCO

California Social Workers Organization is a voluntary professional association of social workers employed in governmental and private agencies. Many of our members are directly engaged in administering public assistance aid and services and in determining eligibility and providing social services for the medically needy. We are in a position, therefore, to evaluate Medicaid from the administrative point of view as well as the effects of Medicaid on the patients.

WE RECOMMEND that the goal of comprehensive medical care for substantially all of the poor and near-poor by 1975 be retained and implemented. The following examples illustrate the individual benefits available through California's program. It is noteworthy that each also represents a long term saving to the taxpayers through prevention of continued dependency or reducing the need for more expensive care:

Mr. A. applied for AFDC for his family on the basis of his own incapacity. His hernia was so disabling that it prevented his passing physical examinations required prior to employment. Six weeks after surgery provided through Medicaid he had a job and was supporting his family.

Mr. B was again able to support his family, who had been on AFDC, following extensive dental care which restored his appearance and increased his health and employability.

55-year-old Mrs. C. was so crippled with arthritis that she required nursing home care. After her physician did corrective surgery on her feet and she had postoperative physical therapy through Medicaid, she is now able to live with relatives in greater comfort and on $175 per month less public expense.

An emotionally disturbed child is maintained with his family, rather than in an expensive institution, because he and his parents are able to receive outpatient psychiatric care through Medicaid.

Thousands of examples could be cited. Such care is unquestionably expensive, but the lack of it would be far more costly.

PRESIDENT
W. Wilson Murray
4360 Miramonte Place
Riverside, 92501

VICE PRESIDENT
Jean Champommier
1316 Raven Street
Ventura, 93003

SECRETARY
Sylvia Cassinelli
1144 Fourth St., Apt. 342
Santa Rosa 95404

TREASURER
Hal Kinser
1140 Mills Avenue
Modesto, 95350

WE RECOMMEND that Medicaid eligibility be based on need alone and that the element of "linkage" or relationship to the aid categories for Federal financial participation be dropped as soon as possible. Comprehensive high quality health care for all the people must be a high priority goal for the United States. This means that full cooperation of the medical and allied professions must be demanded to train and involve aides, technicians, physician assistants and other para-professionals to give direct medical services under professional supervision. The benefits of this kind of system, used by our armed forces, could very well be made available to the civilian population.

WE RECOMMEND Federal investigation of the costs and efficiency of the various state plans of Medicaid administration and payment for services. Adoption of the most effective system should be required. Our experience with fiscal intermediaries indicates that there simply must be a better way. For larger California localities, we believe that local eligibility checking and local payment would be faster and more efficient. These methods were tested and worked well for the predecessor vendor payment medical assistance program in California.

WE RECOMMEND that no changes be made in the quality or reimbursement for care between Medicare and Medicaid. Setting up the potential of "second class" Medicaid patients should be carefully guarded against by DHEW and the Congress.

WE RECOMMEND that a more vigorous Federal effort be made to provide public information about Medicaid. This could be accomplished by a Federal requirement that a specified small percentage of administrative costs be used for public information purposes. Material for Radio and TV spots could be prepared by the Federal agency in much the same way that Social Security Retirement, Disability, and Medicare Benefits are publicized.

WE RECOMMEND that the lien and recovery provisions of Title XIX remain as they are with no greater latitude to be given to the states. No further real or psychological obstacles should block the receipt of medical care from those who need it.

WE RECOMMEND retention of open-end authorization for Medicaid appropriations. All states should be required to adopt the program, including services for the medically needy. 100% Federal payment and Federal administration for a limited number of years might be tried as an incentive for the less affluent states.

In general, we believe that Medicaid in California has been of immense benefit. We believe that the administrative problems can be solved. We believe that a strong public information program would be of great benefit in creating public support and understanding in the place of confusion and misinformation that has handicapped the program in the political arena.

Mary L. Charles

(Mrs.) Mary L. Charles, Chairman
Legislation and Social Action Committee

AMERICAN ASSOCIATION OF BLOOD BANKS

Central Office • Suite 1322
30 North Michigan Avenue
Area 312, 782-1977
Chicago, Illinois 60602

Office of the President

Suite 20
4600 North Habana Avenue
Tampa, Florida 33614

December 23, 1968

Mr. Charles H. Shreve
HEW Regional Office
50 Fulton Street
San Francisco, California 94102

Dear Mr. Shreve:

I have been informed that a hearing has been scheduled in San Francisco on December 27 to receive suggestions on ways of improving the Medicaid program. The American Association of Blood Banks is very much interested in the Medicaid program and we have one recommendation to make.

The American Association of Blood Banks recommends that reconsideration be given to paragraph 3 B (15)(c), Whole Blood, as published in Social and Rehabilitation Service Interim Policy No. 19, "Amount, Duration and Scope of Medical Assistance".

This Association as well as the American Medical Association, American Hospital Association, College of American Pathologists and others, support the concept of voluntary blood donations from persons to replace blood used by a relative or friend, to establish protection against future blood needs for themselves and their families, or to fulfill a community responsibility.

The original Medicare Bill (Title 1, H. R. 1) was amended to provide for a deductible in an amount equal to the cost of the first three pints of whole blood furnished for an individual during a spell of illness. As stated in the Report of the Ways and Means Committee (House Report No. 213, 89th Congress, First Session), this deductible provision was included "in the interest of the voluntary blood replacement programs which encourage donations of blood by waiving charges for blood which the patient arranges to replace".

The blood deductible provision of the Social Security Act was subsequently amended by Public Law 98-248, 90th Congress, January 1968, to provide for a deduction equal to the first three pints of whole blood or equivalent quantities of packed red blood cells.

This recognized that important blood components are only derived from whole blood. Most hospitals and community blood banks also place a monetary incentive or replacement fee on blood components to encourage patients to seek replacement donors since the fee is refunded or credited to the patient's account upon receipt of the blood donation(s).

Recently, Thomas M. Tierney, Director, Bureau of Health Insurance, informed this Association of a proposed change that will require the Medicare patient to also assume the participation fee or service charge for the first three pints of blood furnished if the patient is capable of arranging for replacement of the blood and chooses not to. This policy change, when implemented, will provide an additional incentive for the patient to obtain replacement of his blood needs.

The payment for whole blood or blood components removes the responsibility from the patient to recruit replacement donors from among their family or friends. Since you cannot transfuse dollars, payment makes blood banks more dependent on paid donors or commercial sources of blood to supplement their requirements. Such a trend does not assure a safe, adequate and economical blood supply and is detrimental to the public interest.

The services provided by blood banks are unique since people are the only source of human blood and the blood banks must depend on the willingness of individuals to give blood to meet the needs of patients requiring transfusions. Although blood may be paid for, payment cannot assure that blood will be available when required unless sufficient incentive is provided for individuals to make blood donations. It was for this purpose that the AABB developed the enclosed brochure "Supply, Demand and Human Life", which you will note is endorsed by the Public Health Service, Department of Health, Education and Welfare.

The need for blood in the United States is increasing at the rate of 10-12 percent a year and there is a need for more voluntary blood donors. While patients covered by the Social Security Act may themselves be ineligible to give blood, it should be remembered that the majority have familied or friends who are eligible, or often belong to business, fraternal or social groups which maintain donor club accounts with various blood banks. Also, through the mechanism of the AABB National Clearinghouse Program, replacements can be recruited anywhere in the United States to transfer to the patient's account.

The Association strongly recommends that careful consideration be given to amending paragraph 3 B (15)(c), Whole Blood, Interim Policy Statement No. 19, to align this regulation with the blood deductible provision of Medicare and thus require the patient to replace the first three pints of blood or equivalent quantities of packed red blood cells.

We are submitting a statement rather than ask a witness to appear at the hearing since you will probably have more witnesses at the hearing than time to hear them. If it is desirable from your standpoint, however, to have a witness appear in person, we will be glad to arrange for one. If the submission of this statement is adequate however, we would appreciate having it incorporated in the transcript of the hearing.

Sincerely yours,

F. C. Coleman, M. D.
President
American Association of Blood Banks

FCC/mb

Mr. & Mrs. Jose M. Collaco
259-14th Ave.
San Francisco , California 94118

RL

December 14, 1968

Charles H. Shreve
Regional Director
Department of Health
Education and Welfare
50 Fulton Street
San Francisco, California 94102

Re: Hearing on Federal Aid
to Medically Indigent
to be held Friday Dec.27,1968

Dear Mr. Shreve,

We would like to present our views on the above program.

As most Insurance Companies do not cover the full cost of medical care especially when it comes to an illness or injury of long duration, we believe that arrangements be made also for payments of amounts not covered by the individual's group or medical insurance, in order to avoid financial difficulty to the individual's family.

We believe that every individual with a low income should be eligible to Medi-Cal even though they are covered under a group plan at their place of employment, because if the Employer decides to discharge the employee for any reason which the employee is unable to contest, he is left without income and without medical coverage.

While the individual's group plan is in force, the cost of medical care could be carried by the Insurance Carriers of Medi-Cal and the individual's Insurance Carrier.

As Health is the most important factor in everyone's life, we would consider it a good idea to put everyone under Medi-Cal, but that may jeopardize the profits of many Insurance Companies. The premiums paid for medical insurance by the individual, could be paid to State or to the Federal Government, as we are paying for our taxes.

We believe that Our Federal and State Governments are here to help and we are prepared to do our share by voicing our opinion as to what can be done so that everyone can have Medical Care.

If we could have Socialized Medicine and pay our taxes for it, we believe that it will benefit the majority of the people, because many individuals are afraid to seek medical attention, unless they are really sick, because they are afraid to, due to the high cost of medical care, in our country.

We hope that the decision at the hearing will favor Medicaid.

Very truly yours,
Jose M. Collaco

Mr. & Mrs. Jose M. Collaco
33-39 0516

UNIVERSITY OF CALIFORNIA, LOS ANGELES

BERKELEY · DAVIS · IRVINE · LOS ANGELES · RIVERSIDE · SAN DIEGO · SAN FRANCISCO SANTA BARBARA · SANTA CRUZ

SCHOOL OF PUBLIC HEALTH
LOS ANGELES, CALIFORNIA 90024

December 20, 1968

Charles H. Shreve, Regional Director
Department of Health, Education, and Welfare
50 Fulton Street
San Francisco, California 94102

Dear Mr. Shreve:

Attached is a statement for the Medicaid hearing on December 27, 1968, prepared at the suggestion of Dr. Milton I. Roemer in response to your telegram to him dated December 13.

I have been on the staff of the U.C.L.A. School of Public Health as a public administrative analyst since January, 1968. For six years prior to this I was chief of the Medical Care Research Bureau for the California Department of Health Care Services and the Department of Social Welfare.

I hope the statement will be of some value in helping to solve the problems of our medical care programs.

Sincerely yours,

Foline E. Gartside

FEG:td

(Mrs.) Foline E. Gartside

IS MAINSTREAM MEDICINE THE BEST ANSWER FOR MEDICAID?

Statement Prepared by Foline E. Gartside, Public Administrative Analyst,
School of Public Health, University of California at Los Angeles.

The Medicaid program has been referred to as the "sleeper" clause in the Social Security Act Amendments of 1965, meaning that it came into being with little public awareness of its potential for large expenditures of public funds. Since then, its burgeoning costs have given rise to considerable alarm, and in state after state, to restrictions in benefits and/or eligibility standards. Subsequent Federal legislation, has in fact, placed income limits for Federal participation in health care costs of individuals and families at amounts considerably below generally accepted "poverty levels."

There is no question that even in a country so wealthy as ours, continuous and intensive scrutiny needs to be given to how we spend our tax dollars. It is to the question of how we organize our health care services to the poor that I wish to address this brief statement.

It is remarkable, that in a culture so conscious of the principles of "cost effectiveness" as ours, so little attention has been given to the cost effectiveness of our health care system or lack of system. This is equally true of course with reference to the delivery of service to the rich, as well as the poor. Yet it is generally assumed, that if the governmental programs somehow channel the poor into the "mainstream" of medical care available to the rich, the problems of the poor with respect to health care will be solved.

Such assumption avoids two fundamental questions: (1) is the

"mainstream" of fee-for-service, free choice medical practice actually accessible to the poor; (2) apart from accessibility, is it a means of providing the most effective, efficient and flexible means of meeting the needs?

With respect to accessibility, there is little need to belabor the fact that doctors tend to locate where the poor aren't; that population density of the ghettos, though under-represented by doctors, far exceeds that of other areas; and that transportation to middle and upper-class medical centers is sparse and expensive, even were there no psychological bariers to such cultural interchange. In the maps of Los Angeles County attached to this statement, for example, the Figure I shows the concentration of low-income families residing in the center and southeastern portions of the county. Figure II dramatically illustrates the heavy concentration of private practice physicians almost exactly ringing this central core of people.[1] Such a pattern is a common phenomenon of our cities. In rural areas, the problem is reversed: physicians tend not to locate in sparsely populated areas, creating a different but no less real problem of accessibility.

It has been argued that the availability of sufficient remuneration will result in more equitable spreading of physician availability, in the manner of classical market-place economics.

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1) Source: Wood, Ralph, "Physician Participation Under the California Medical Assistance Program in Los Angeles County, "*Medical Care Resources and Utilization Project Report No. 7*, State of California Office of Health Care Services, Sacramento.

If this is so, then apparently Medicaid has not offered sufficient inducement to result in appreciable change in the pattern of physician availability. It is true, that under Medi-Cal (Medicaid in California) the proportion of Los Angeles County physicians participating in the program increased over the percent active in the previous program for public assistance medical care, but this seems largely due to the provision of inpatient care outside of county hospitals, rather than to any general increase in the involvement of physicians in ambulatory care. Although three-fourths of Los Angeles County physicians treated one or more Medi-Cal patients during 1966, ten percent of the physicians received over 50 percent of all Medi-Cal physician payments in that county.(1

There are other indications that the market-place free-choice system has not appreciably affected the pattern of medical care services to the poor in California. A study of the use of county hospital out-patient department service in Los Angeles found that it fell off immediately after the beginning of Medi-Cal, but soon recovered, stabilizing at about 95 percent of the pre-Medi-Cal level.(2

It seems evident that payment of "usual and customary" fees to physicians, even with no limitation on choice by the Medi-Cal recipient, is insufficient to propel the recipient into "mainstream" medical care, whatever those advantages might be. Can comprehensive medical care of

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1) Ibid, P.45

2) Kisch, Arnold I. and Gartside, Foline E. "Use of a County Hospital Outpatient Department by Medi-Cal Recipients, *Medical Care*, Vol. VI, No. 6, November-December, 1968.

high quality be made accessible to the poor in other ways? The experience of the Office of Economic Opportunity in the establishment of neighborhood health centers providing comprehensive medical care under high standards of performance indicates it can be done. The Watts Neighborhood Health Center, for example, born of the travail of riot and belated recognition of agony, now serves over 20,000 people, half of whom are Medi-Cal beneficiaries.

The development of a team approach to provision of health care services is not new. There are many indications that the joining together of a number of physicians with different specialties to provide a full range of services to their patients not only enriches the quality of service available to the patient, but also makes optimum use of ancillary personnel, equipment, and physicians, and thus provides service less expensively than in solo practice. The slow growth of group practices, however, especially in low income areas, indicates that they are not easily forthcoming without help. Medicaid cannot move alone in this. What is needed is the coordination of health planning, not alone for the poor but for all the people, along lines envisioned by PL 89-749.

So far we have been talking largely in terms of the accessibility of physician services, and somewhat incidentally, of the protection of standards of care.

In hospitals of good standing, the role of surveillance in the form of utilization and tissue review committees is accepted. In ambulatory care by solo practitioners, such a mechanism is generally

not feasible. Some interesting experiments are being made, notably in the San Joaquin Medical Care Foundation of California, where the Foundation, composed largely of the County Medical Society, monitors all Medi-Cal physician claims under a capitation fee arrangement. Such a system probably is not readily adaptable to large scale implementation. In an organized setting for ambulatory as well as inpatient care, however, the monitoring of quality through peer review similar to that of hospitals can be systematically maintained, buttressed by standards for participation in the governmental programs.

It is not enough simply to pour money into a static health care system in the hope that dollars will solve the problem merely by bringing poor people into the "mainstream" of American medicine. The mainstream isn't the only route. There are other and quite possibly better ways. In summary, these are:

1. Hospital outpatient departments, which could and should be expanded and improved.
2. Private group practices, which should be encouraged.
3. "Neighborhood Health Centers" supported by the Office of Economic Opportunity and other sources.

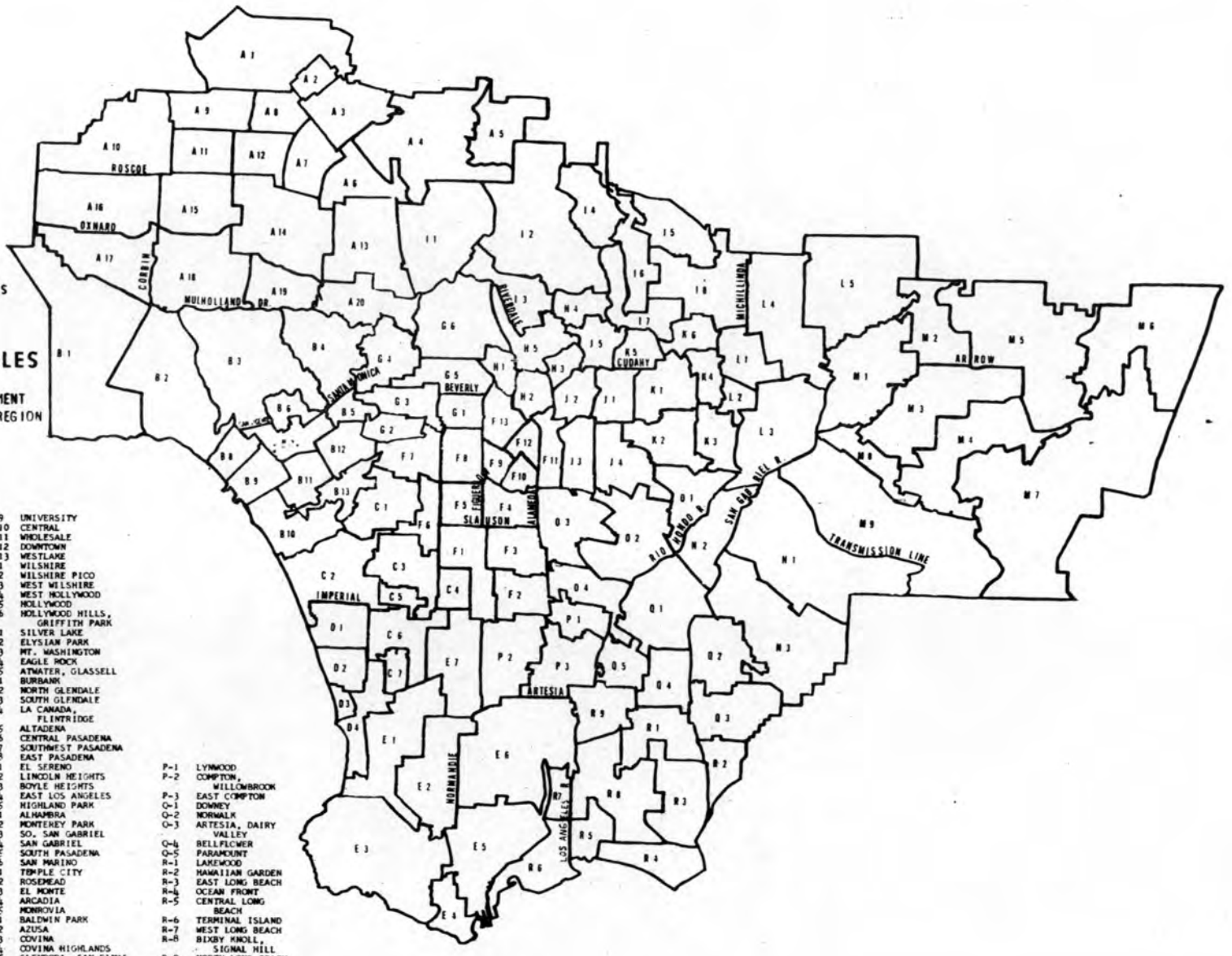
Increased use of these organized locales for medical care, with built-in quality promotion, could be considered a deviation from the "mainstream" in the short run. But in the long run this would change the character of the mainstream, so that it may become a stream of greater purity, quality, and economy than we now have.

STUDY AREAS

BASED ON 1960 CENSUS TRACTS

COUNTY OF LOS ANGELES

BASE MAP PREPARED BY RESEARCH DEPARTMENT
WELFARE PLANNING COUNCIL, LOS ANGELES REGION



A-1	SYLMAR	F-9	UNIVERSITY		
A-2	SAN FERNANDO	F-10	CENTRAL		
A-3	PACOIMA	F-11	WHOLESALE		
A-4	SUNLAND	F-12	DOWNTOWN		
A-5	TUJUNGA	F-13	WESTLAKE		
A-6	SUN VALLEY	G-1	WILSHIRE		
A-7	PANORAMA CITY	G-2	WILSHIRE PICO		
A-8	MISSION HILLS	G-3	WEST WILSHIRE		
A-9	GRANADA HILLS	G-4	WEST HOLLYWOOD		
A-10	CHATSWORTH	G-5	HOLLYWOOD		
A-11	NORTHRIDGE	G-6	HOLLYWOOD HILLS, GRIFFITH PARK		
A-12	SEPULVEDA				
A-13	NORTH HOLLYWOOD	H-1	SILVER LAKE		
A-14	VAN NUYS	H-2	ELYSIAN PARK		
A-15	RESEDA	H-3	MT. WASHINGTON		
A-16	CANOGA PARK	H-4	EAGLE ROCK		
A-17	WOODLAND HILLS	H-5	ATWATER, GLASSELL		
A-18	ENCINO, TARZANA	I-1	BURBANK		
A-19	SHERMAN OAKS	I-2	NORTH GLENDALE		
A-20	STUDIO CITY	I-3	SOUTH GLENDALE		
B-1	MALIBU, CALABASAS	I-4	LA CANADA, FLINTRIDGE		
B-2	PACIFIC PALISADES				
B-3	BRENTWOOD, BEL AIR	I-5	ALTADENA		
B-4	BEVERLY HILLS	I-6	CENTRAL PASADENA		
B-5	BEVERLY, LA CIENEGA	I-7	SOUTHWEST PASADENA		
B-6	WESTWOOD, SAWTELLE	I-8	EAST PASADENA		
B-7	WEST LOS ANGELES	J-1	EL SERENO	P-1	LYNWOOD
B-8	NORTH SANTA MONICA	J-2	LINCOLN HEIGHTS	P-2	COMPTON, WILLOWBROOK
B-9	SOUTH SANTA MONICA	J-3	BOYLE HEIGHTS	P-3	EAST COMPTON
B-10	VENICE, DEL REY	J-4	EAST LOS ANGELES	Q-1	DOWNEY
B-11	MAR VISTA	J-5	HIGHLAND PARK	Q-2	NORWALK
B-12	PALMS	K-1	ALHAMBRA	Q-3	ARTESIA, DAIRY VALLEY
B-13	CULVER CITY	K-2	MONTEREY PARK	Q-4	BELLFLOWER
C-1	BALDWIN HILLS	K-3	SO. SAN GABRIEL	Q-5	PARAMOUNT
C-2	WESTCHESTER	K-4	SAN GABRIEL	R-1	LAKEWOOD
C-3	INGLEWOOD	K-5	SOUTH PASADENA	R-2	HAWAIIAN GARDEN
C-4	EAST INGLEWOOD	K-6	SAN MARINO	R-3	EAST LONG BEACH
C-5	LENNOX	L-1	TEMPLE CITY	R-4	OCEAN FRONT
C-6	HAWTHORNE	L-2	ROSEMEAD	R-5	CENTRAL LONG BEACH
C-7	LAWNDALE	L-3	EL MONTE	R-6	TERMINAL ISLAND
D-1	EL SEGUNDO	L-4	ARCADIA	R-7	WEST LONG BEACH
D-2	MANHATTAN BEACH	L-5	MONROVIA	R-8	BIXBY KNOLL, SIGNAL HILL
D-3	HERMOSA BEACH	M-1	BALDWIN PARK	R-9	NORTH LONG BEACH
D-4	REDONDO BEACH	M-2	AZUSA	S-1	NORTH COUNTY
E-1	WEST TORRANCE	M-3	COVINA	S-2	CATALINA
E-2	EAST TORRANCE	M-4	COVINA HIGHLANDS		
E-3	PALOS VERDES	M-5	GLENDORA, SAN DIMAS		
E-4	SAN PEDRO	M-6	CLAREMONT, LA VERNE		
E-5	WILMINGTON	M-7	POMONA		
E-6	DOMINGUEZ	M-8	LA PUENTE		
E-7	GARDENA	M-9	INDUSTRY		
F-1	SOUTH VERMONT, GREEN MEADOWS	N-1	WHITTIER		
		N-2	PICO RIVERA		
F-2	WATTS	N-3	LA MIRADA, SANTA FE SPRINGS		
F-3	FLORENCE, GRAHAM				
F-4	AVALON	O-1	MONTEBELLO		
F-5	EXPOSITION PARK	O-2	BELL, BELL GARDENS		
F-6	LEIMERT	O-3	HUNTINGTON PARK, MAYWOOD		
F-7	WEST ADAMS				
F-8	SANTA BARBARA	O-4	SOUTH GATE		

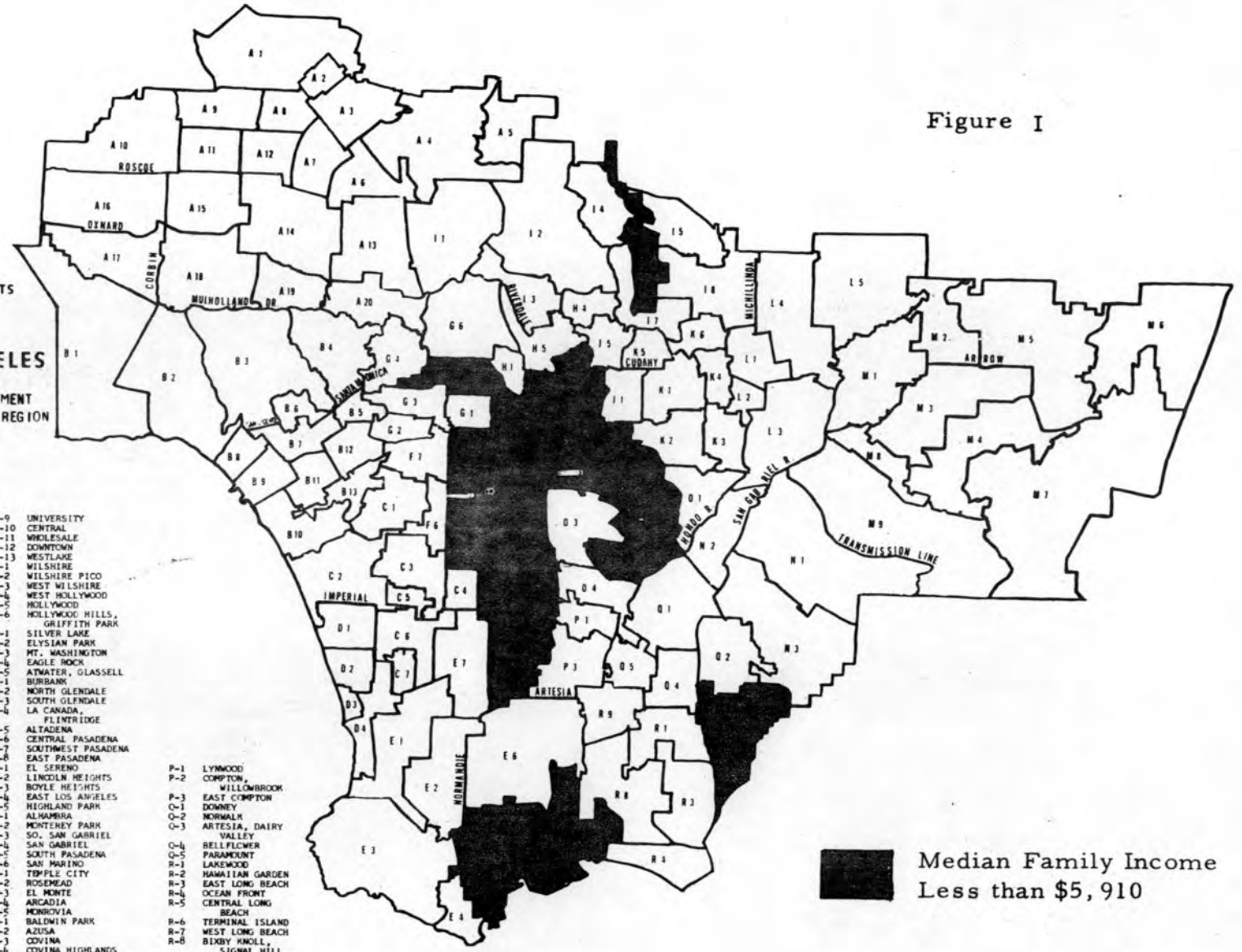
Figure I

STUDY AREAS

BASED ON 1960 CENSUS TRACTS

COUNTY OF LOS ANGELES

BASE MAP PREPARED BY RESEARCH DEPARTMENT
WELFARE PLANNING COUNCIL, LOS ANGELES REGION



Median Family Income
Less than $5,910

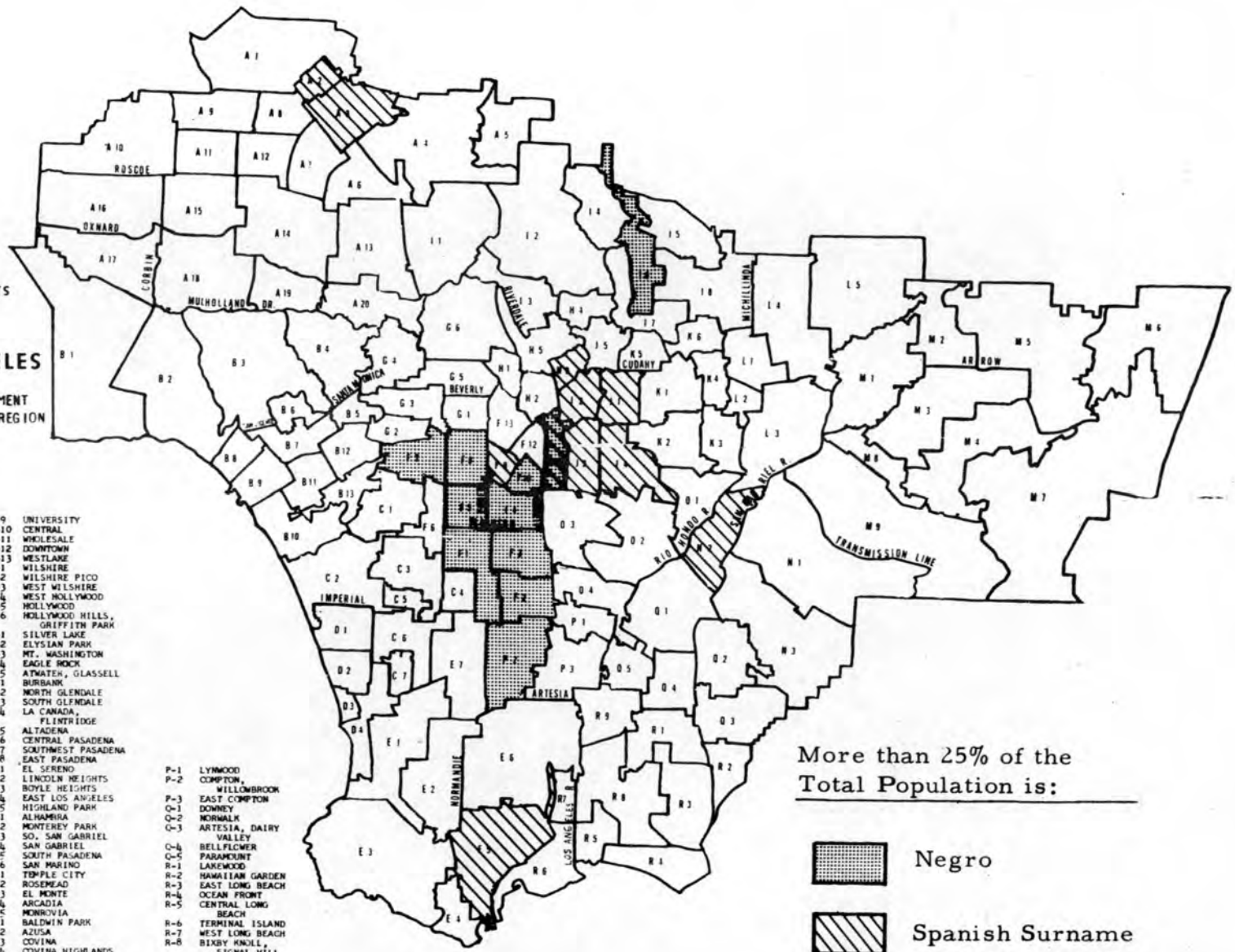
A-1 SYLMAR
A-2 SAN FERNANDO
A-3 PACOIMA
A-4 SUNLAND
A-5 TUJUNGA
A-6 SUN VALLEY
A-7 PANORAMA CITY
A-8 MISSION HILLS
A-9 GRANADA HILLS
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A-11 NORTHRIDGE
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B-10 VENICE, DEL REY
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C-3 INGLEWOOD
C-4 EAST INGLEWOOD
C-5 LENNOX
C-6 HAWTHORNE
C-7 LAWNDALE
D-1 EL SEGUNDO
D-2 MANHATTAN BEACH
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D-4 REDONDO BEACH
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F-1 SOUTH VERMONT, GREEN MEADOWS
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F-4 AVALON
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F-7 WEST ADAMS
F-8 SANTA BARBARA
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F-10 CENTRAL
F-11 WHOLESALE
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F-13 WESTLAKE
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K-3 SO. SAN GABRIEL
K-4 SAN GABRIEL
K-5 SOUTH PASADENA
K-6 SAN MARINO
L-1 TEMPLE CITY
L-2 ROSEMEAD
L-3 EL MONTE
L-4 ARCADIA
L-5 MONROVIA
M-1 BALDWIN PARK
M-2 AZUSA
M-3 COVINA
M-4 COVINA HIGHLANDS
M-5 GLENDORA, SAN DIMAS
M-6 CLAREMONT, LA VERNE
M-7 POMONA
M-8 LA PUENTE
M-9 INDUSTRY
N-1 WHITTIER
N-2 PICO RIVERA
N-3 LA MIRADA, SANTA FE SPRINGS
O-1 MONTEBELLO
O-2 BELL, BELL GARDENS
O-3 HUNTINGTON PARK, MAYWOOD
O-4 SOUTH GATE
P-1 LYNWOOD
P-2 COMPTON, WILLOWBROOK
P-3 EAST COMPTON
Q-1 DOWNEY
Q-2 NORWALK
Q-3 ARTESIA, DAIRY VALLEY
Q-4 BELLFLOWER
Q-5 PARAMOUNT
R-1 LAKEWOOD
R-2 HAWAIIAN GARDEN
R-3 EAST LONG BEACH
R-4 OCEAN FRONT
R-5 CENTRAL LONG BEACH
R-6 TERMINAL ISLAND
R-7 WEST LONG BEACH
R-8 BIXBY KNOLL, SIGNAL HILL
R-9 NORTH LONG BEACH
S-1 NORTH COUNTY
S-2 CATALINA

STUDY AREAS

BASED ON 1960 CENSUS TRACTS

COUNTY OF LOS ANGELES

BASE MAP PREPARED BY RESEARCH DEPARTMENT
WELFARE PLANNING COUNCIL, LOS ANGELES REGION



A-1	SYLMAR	F-9	UNIVERSITY	P-1	LYNWOOD
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A-11	NORTHRIDGE	G-6	HOLLYWOOD HILLS, GRIFFITH PARK	R-3	EAST LONG BEACH
A-12	SEPULVEDA	H-1	SILVER LAKE	R-4	OCEAN FRONT
A-13	NORTH HOLLYWOOD	H-2	ELYSIAN PARK	R-5	CENTRAL LONG BEACH
A-14	VAN NUYS	H-3	MT. WASHINGTON	R-6	TERMINAL ISLAND
A-15	RESEDA	H-4	EAGLE ROCK	R-7	WEST LONG BEACH
A-16	CANOGA PARK	H-5	ATWATER, GLASSELL	R-8	BIXBY KNOLL, SIGNAL HILL
A-17	WOODLAND HILLS	I-1	BURBANK	R-9	NORTH LONG BEACH
A-18	ENCINO, TARZANA	I-2	NORTH GLENDALE	S-1	NORTH COUNTY
A-19	SHERMAN OAKS	I-3	SOUTH GLENDALE	S-2	CATALINA
A-20	STUDIO CITY	I-4	LA CANADA, FLINTRIDGE		
B-1	MALIBU, CALABASAS	I-5	ALTADENA		
B-2	PACIFIC PALISADES	I-6	CENTRAL PASADENA		
B-3	BRENTWOOD, BEL AIR	I-7	SOUTHWEST PASADENA		
B-4	BEVERLY HILLS	I-8	EAST PASADENA		
B-5	BEVERLY, LA CIENEGA	J-1	EL SERENO		
B-6	WESTWOOD, SAWTELLE	J-2	LINCOLN HEIGHTS		
B-7	WEST LOS ANGELES	J-3	BOYLE HEIGHTS		
B-8	NORTH SANTA MONICA	J-4	EAST LOS ANGELES		
B-9	SOUTH SANTA MONICA	J-5	HIGHLAND PARK		
B-10	VENICE, DEL REY	K-1	ALHAMBRA		
B-11	MAR VISTA	K-2	MONTEREY PARK		
B-12	PALMS	K-3	SO. SAN GABRIEL		
B-13	CULVER CITY	K-4	SAN GABRIEL		
C-1	BALDWIN HILLS	K-5	SOUTH PASADENA		
C-2	WESTCHESTER	K-6	SAN MARINO		
C-3	INGLEWOOD	L-1	TEMPLE CITY		
C-4	EAST INGLEWOOD	L-2	ROSEMEAD		
C-5	LENNOX	L-3	EL MONTE		
C-6	HAWTHORNE	L-4	ARCADIA		
C-7	LAWNDALE	L-5	MONROVIA		
D-1	EL SEGUNDO	M-1	BALDWIN PARK		
D-2	MANHATTAN BEACH	M-2	AZUSA		
D-3	HERMOSA BEACH	M-3	COVINA		
D-4	REDONDO BEACH	M-4	COVINA HIGHLANDS		
E-1	WEST TORRANCE	M-5	GLENDORA, SAN DIMAS		
E-2	EAST TORRANCE	M-6	CLAREMONT, LA VERNE		
E-3	PALOS VERDES	M-7	POMONA		
E-4	SAN PEDRO	M-8	LA PUENTE		
E-5	WILMINGTON	M-9	INDUSTRY		
E-6	DOMINGUEZ	N-1	WHITTIER		
E-7	GARDENA	N-2	PICO RIVERA		
F-1	SOUTH VERMONT, GREEN MEADOWS	N-3	LA MIRADA, SANTA FE SPRINGS		
F-2	WATTS	O-1	MONTEBELLO		
F-3	FLORENCE, GRAHAM	O-2	BELL, BELL GARDENS		
F-4	AVALON	O-3	HUNTINGTON PARK, MAYWOOD		
F-5	EXPOSITION PARK	O-4	SOUTH GATE		
F-6	LEIMERT				
F-7	WEST ADAMS				
F-8	SANTA BARBARA				

More than 25% of the Total Population is:

- Negro
- Spanish Surname
- Both of the above

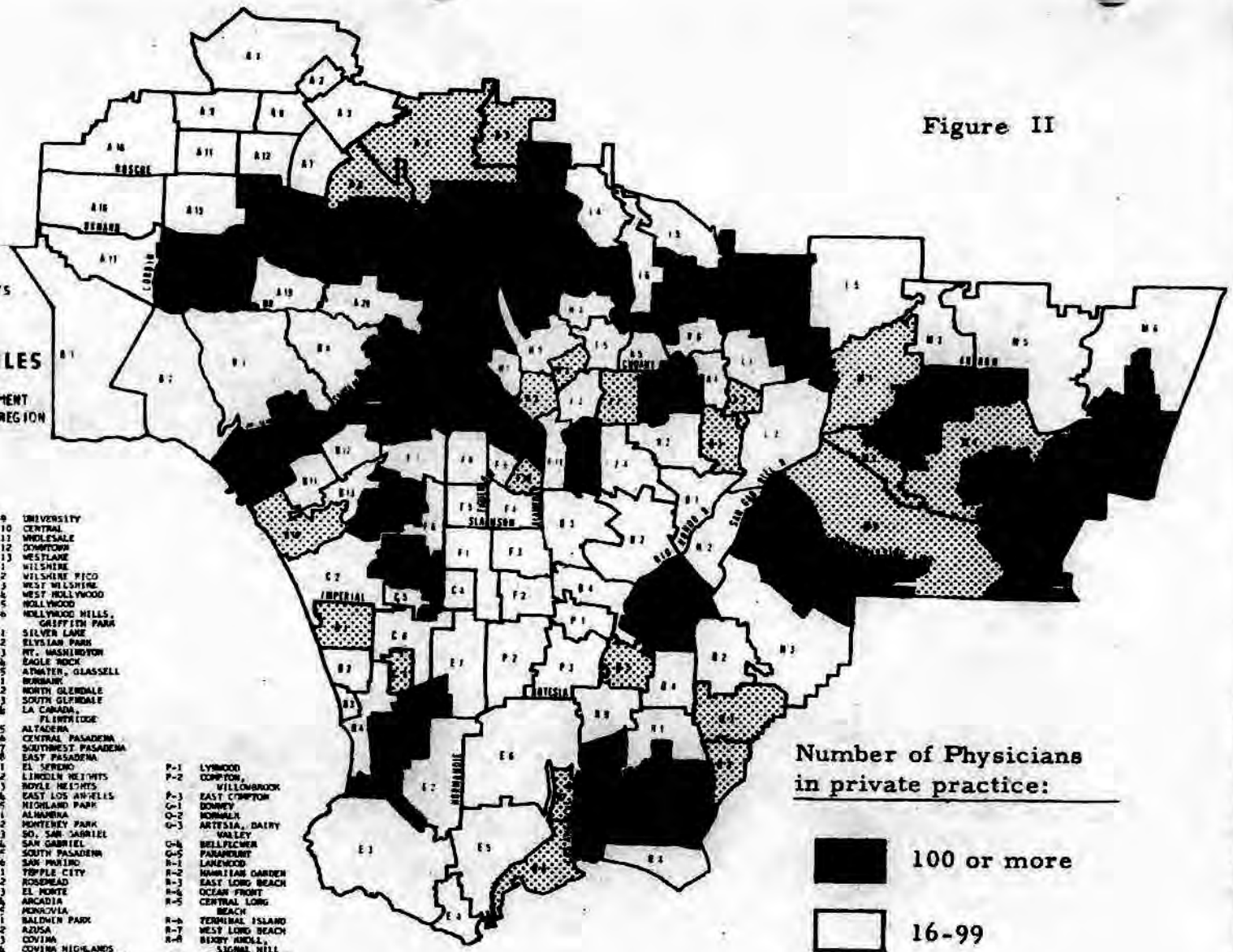
Figure II

STUDY AREAS

BASED ON 1960 CENSUS TRACTS

COUNTY OF LOS ANGELES

BASE MAP PREPARED BY RESEARCH DEPARTMENT
WELFARE PLANNING COUNCIL, LOS ANGELES REGION


ANTELOPE
SAN GABRIEL
SAN GABRIEL
SAN GABRIEL

TELEPHONE 786-0484

State Assistance for the Medically Indigent

3660 BAKER LANE • RENO, NEVADA 89502

MEDICAL REVIEW COMMITTEE
CHARLES D. LANNING, M.D., CHAIRMAN

RICHARD C. SHERETZ, M.D.
MEDICAL ADMINISTRATOR

NELSON B. NEFF
ADMINISTRATOR

December 24, 1968

Charles H. Shreve, Regional Director
Department of Health, Education and Welfare
50 Fulton Street
San Francisco, California

Dear Mr. Shreve:

Thanks for your invitation to attend the San Francisco hearing December 27. I will not be able to attend but submit the attached paper for your consideration. I am especially anxious to receive a transcript of the hearings and papers submitted.

Very truly yours,

C. A. Heckethorn
Program Coordinator

CAH:dkf

Enc.

CHANGES IN MEDICAID - TITLE XIX

There are many instances when the Ratio of Charges to Charges Applied to Cost reimbursement formula to hospitals has created inequitible results.

It is inappropriate for the state or any individual to pay more for medical services than the private individual. A more practical formula would be to pay:

The lesser of bill charges or RCCAC as determined under the Title XVIII formula.

STATE ASSISTANCE FOR THE MEDICALLY INDIGENT - NEVADA
C. A. HECKETHORN - PROGRAM COORDINATOR

DEC 24 1968

RD
ARD

STATE OF UTAH

OFFICE OF THE GOVERNOR
SALT LAKE CITY

CALVIN L. RAMPTON
GOVERNOR

December 20, 1968

Mr. Warren Thompson
Assistant Regional Director
Department of Health, Education,
and Welfare
Regional Office VIII
Federal Building
1961 Stout Street
Denver, Colorado 80202

Dear Warren:

Pursuant to your telephone notification that hearings would be held in California and Texas on December 27 regarding the Title IX Program, the enclosed statement from the Executive Director of Utah's Department of Health and Welfare represents the current attitude and feelings of the operating divisions of the state of Utah at the current point in time.

I feel that the key point is summarized in paragraph 3 of the letter indicating that the demands upon our financial resources imposed by extending the Title IX Program to comply with the existing regulations and recommendations of SRS study teams are far beyond our capabilities.

As indicated in Director Holbrook's last paragraph he would like to have this statement available to individuals taking testimony for such use as they may wish to make of it.

I hope this submittal will be of some value to you.

Sincerely,

Kenneth C. Olson
State Planning Coordinator

KCO:b

Enclosure

10863

CALVIN L. RAMPTON
Governor

COORDINATING COUNCIL
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J. Leonard Love-Vice-Chairman
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STATE OF UTAH
DEPARTMENT OF HEALTH AND WELFARE
Room 221, State Capitol
Salt Lake City, Utah 84114

WARD C. HOLBROOK
Executive Director

DIVISION OF HEALTH
DIVISION OF WELFARE
DIVISION OF CORRECTIONS
DIVISION OF MENTAL HEALTH
DIVISION OF INDIAN AFFAIRS
DIVISION ON AGING

December 18, 1968

The Honorable Calvin L. Rampton
Governor, State of Utah
Room 210, State Capitol
Salt Lake City, Utah 84114
BUILDING MAIL

Dear Governor Rampton:

In response to your telephone conversation concerning the meeting to be called by representatives of the congress in California and Texas, where consideration will be given to our problems growing out of the Title XIX Medical Program and particularly things that we think need adjustment. Our main concern is the overall cost of the program, and the strain it puts on the budget of the state to provide the many services, and to pay for the scope and duration of the services demanded by qualifying recipients. There is no doubt but what both scope and utilization exceeds that which the private paying patient would demand in the way of health care. Consequently, the answer we need above all others is, "How can we have positive and firm control over the scope of coverage and utilization.

This could best be handled by the establishment of a system of firm priorities and of utilization control. For example, if there is not enough money to buy all the medical services that welfare recipients and non money payment poor in the community demand, will we spend our money in keeping a person alive in a terminal stage of illness at a cost of $60 a day, more or less, and not provide dental care, eye care, etc., for children who cannot see the black board or who are too uncomfortable to participate in ordinary school activities on a satisfactory level. There is no question in our minds but what many doctors keep patients in the hospital, or in nursing homes, who could well be in their own home with an occasional call by a doctor or a trained nurse. Persons, once in the hospital, are never left without attention; whereas, when money is not available to meet the needs of children, they seldom come up for attention.

One other area of great concern to us grows out of a study recently made of the Utah program by a team from the federal agency known as the Program Review and Evaluation Project. This was carried forward in Utah early in October. A copy of the letter transmitting this report to us which stated the deficiencies of the Utah program is attached. The Denver office of Health, Education, and Welfare wants a firm statement

as to our intention to comply with regulations and recommendations of the team. This, it is estimated, would lead to a total cost increase of the program if we would do all the things suggested of at least fifty percent (50%). To request from the next legislature fifty percent (50%) more money for this program than is required to carry it as it now exists would, we believe, result in losing the entire Title XIX operation in Utah.

Though the goals set by the federal agency and the criteria used by the PREP team that made the Utah study are highly desirable and can be fully justified by those with deep interest in seeing to it that the medical needs of the poor are met; it is, nevertheless, impractical at this time. We consider that this state has moved ahead in the last ten years as fast as can possibly be expected and that another ten years should be allowed to reach the goals set forth in their report. We are answering the letter from the Denver office and expressing this view to them. Whether or not our position will be an acceptable one, we do not know; but in view of the attitude of the congress and the problems we could have with our own legislature, we think that the taking of time is essential.

It would be very helpful if the congress or the state legislature would spell out in as much detail and with equal firmness the things that <u>should not</u> be done under the Title XIX Program as has been the case, relative to the things that shall be done. For example, the middle-class family is often under the necessity of saying to the doctor, "this far we can go and no further in paying for medical care for a family member," and the doctor respects their wishes and acts accordingly. In fact, the doctor may initiate such consideration. This seems never to happen when the same people, taxpayers, are supporting patients served by Medicaide and Medicare. Can not the legislative bodies see the magnitude of this facet of the problem and officially speak the communities position and not leave it for a doctor being well paid for not promoting the making of such a difficult and vital discussion, or for a young caseworker to intervene?

We do not consider it necessary to have representation at either Dallas or Los Angeles but would like to have this statement with the attachments available to the committee.

Sincerely yours,

Ward C. Holbrook

Ward C. Holbrook
Executive Director

WCH:lr

Attachments

OREGON OPTOMETRIC ASSOCIATION

AFFILIATED WITH THE
AMERICAN OPTOMETRIC ASSOCIATION

P. O. Box 298
McMinnville, Oregon

Medicaid Public Hearing, San Francisco, Dec. 27, 1968

Organized optometry in Oregon feels that the Department of Health, Education and Welfare is to be highly complimented in its activities of this past year in implementing Public Law 89-97, Title XIX. In view of the highly complex problems of administering a program that encompasses all states in the Union, much progress has been made to date.

Optometry throughout the United States feels that it has a rightful place in Title XIX. In view of the importance of vision and visual care to all aspects of our population, you have done much to bring optometry into the mainstream of federally sponsored health programs. There has been a tendency at state levels to ignore or remain uninformed about the importance of good vision in vital areas such as accident prevention, achievement in school, vocational productivity, etc. We believe that Title XIX, which cuts through all state boundaries, will do much to bring a realization of the need for the involvement of optometry in health programs to make sure vision programs are not shunted aside in the struggle for priority attention to other areas of health.

We strongly recommend the Regional Offices consider the terminology of item 12 in P.L. 89-97, "eyeglasses prescribed either by a physician skilled in disease of the eye or by an optometrist, whichever the individual may select." All other items refer to services. The interpretation has been, and should be, "vision services" or "vision care services". This affords the recipient the full scope and benefit of all vision services that can be afforded to give quality vision care to the public.

It is also necessary to re-emphasize the importance of discretionary precautions to allow worthy recipients the first quality health care that is the intent of the law. As a further safeguard that this intent is carried out, the concept of reasonable fees for all vendors of health care must be stressed.

Optometry in Oregon stands ready to do all it can to implement the intent of P.L. 98-97, which is to provide high quality vision care to those unable to pay for it.

Earle L. Hunter, O.D.

Earle L. Hunter, O.D.
Chairman, Public Health and Optometric Care Committee
Oregon Optometric Association

RD

1352 Versailles Ave.
Alameda, California

December 20, 1968

Charles H. Shreve, Regional Director
H. E. W. Regional Office
50 Fulton Street
San Francisco, California

Dear Mr. Shreve:

The Alameda Time Star newspaper suggested that you were soliciting opinions concerning the medicaid program because you are holding hearings on December 27th.

I am very severely handicaped with multiple sclerosis but able to maintain myself with social security disability payments and a little money accumulated when I was able to work.

When medicare was passed, they did not include the handicap under 65 even though we are getting social security payments. I receive no help with my increasing medical expenses. Because of rising medical costs any future hospitalization will cause me to become medically indigent. At the present time, I would be able to pay for medical hospitalization insurance, but due to my disability, I am not insurable.

I noticed that the newspaper article said it was expected that nine and a half million people would receive medical assistance during the coming fiscal year. A number of us handicap will undoubtedly be joining this group adding to your ever increasing cost of the program.

I was wondering at the coming meeting if some thought could be given to helping people keep off the medical assistance program by providing some type of insurance that could be paid for with one's own money. I belong to two recreation programs for the physical handicap, and there are a number of people in my position. We want to be self-sufficient, but it is tempting when you are about to be hospitalized to spend or transfer to relatives any money you have.

We handicap here in Alameda do not anticipate any changes in the coming year to include us under medicare, and if we have to wait until we are 65, we will be in a very bad position if medical costs continue to rise.

Sincerely,

Miss Vera LeVine
1352 Versailles Ave.
Alameda, California 94501

CLASS OF SERVICE
This is a fast message unless its deferred character is indicated by the proper symbol.

WESTERN UNION TELEGRAM

W. P. MARSHALL
CHAIRMAN OF THE BOARD

R. W. McFALL
PRESIDENT

SYMBOLS
DL = Day Letter
NL = Night Letter
LT = International Letter Telegram

The filing time shown in the date line on domestic telegrams is LOCAL TIME at point of origin. Time of receipt is LOCAL TIME at point of destination

SFA069 305P PST DEC 26 68 PRA323 619 SW 11th Ave 1968 DEC 26 PM 3 11
PR LLA239 PDB 3 EXTRA PORTLAND ORG 26 235P PST 97205
CHARLES H SHREVE, HEW REGIONAL OFFICE
50 FULTON ST SFRAN 94102
PLEASE MAKE THIS STATEMENT PART OF THE RECORD OF THE PUBLIC HEARING ON MEDICAID TO BE HELD IN SAN FRANCISCO DECEMBER 27TH 1968. WE WILL NOT BE ABLE TO ATTEND IN PERSON. WE STRONGLY BELIEVE THAT THOSE PERSONS WHO BECOME ELIGIBLE FOR THE OEDICAID PROGRAM SHOULD BE (1) PROVIDED WITH HEALTH CARE IN A MANNER THAT WILL NOT SET THEM APART FROM ANY OTHER SEGMENT OF OUR POPLATION, AND (2) PROVIDED WITH A HEALTH CARE PROGRAM WICH WILL GIVE THEM SOUND QUALITY COVERAGE WE ALSO BELIEVE THESE GOALS CAN BE ACHIEVED MOST ECONOMICALLY AND EFFICIENTLY BY UTILIZING THE SKILLS, EXPERIENCE AND FACILITIES OF THOSE WHO HAVE ADMINISTERED PRIVATE HEALTH PREPAYMENT PROGRAMS
OREGON PHYSICIANS SERVICE SOLOMON MEASHE EXECUTIVE VICE PRESIDENT

SF1201 (R2-65)

state of nevada

DEPARTMENT OF HEALTH, WELFARE AND REHABILITATION
WELFARE DIVISION
201 SOUTH FALL STREET - CARSON CITY, NEVADA 89701

24 December 1968

Mr. Charles H. Shreve
Regional Director
Department of Health, Education
and Welfare
50 Fulton Street
San Francisco, California 94102

Dear Mr. Shreve:

Thank you for your invitation to attend and testify at a Regional Meeting in San Francisco on December 27, 1968. I regret that I am unable to attend due to previous commitments. Notwithstanding, the State of Nevada would like to go on record as favoring a major change in the Title XIX legislation.

Section 1905(a) defines "medical assistance" but includes two restrictions "except that such term does not include:

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

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

Nevada feels quite strongly that these exclusions in Title XIX of the Social Security Act deny medical care to many otherwise eligible persons simply on the basis that they are the wards of a public agency. For example, children who are wards of the State by a court order are eligible for medical assistance under Title XIX if they are placed in a private institution but are ineligible if they reside in the State Children's Home. Other children, who by court order have been placed in the custody of public officials through no misdeed of their own, are provided medical assistance under Title XIX if they are placed in private homes but they are denied medical assistance

under Title XIX during the time they are placed in a public institution awaiting placement in a private home.

The second part of the restriction relates to care and services for individuals in institutions for tuberculosis and mental diseases unless the individual is 65 years of age or over. Nevada feels very strongly that psychiatric hospital care, in particular, should be provided to all of the age groups whether it be given in a public or private hospital. When hospitalization for mental diseases are required, the best care can be provided in the institution that specialized in this kind of care. Nevada would recommend most highly that mental and tuberculosis treatment in mental and tuberculosis facilities, both public and private, be authorized under the Act.

The foregoing is Nevada's recommendation for consideration. We feel that the adoption of these suggestions would go a long way towards truly adding a number of people to the mainstream of medicine.

Very truly yours,

George E. Miller

GEORGE E. MILLER
STATE WELFARE ADMINISTRATOR

GEM/WM/mm

CALIFORNIA COUNCIL for HEALTH PLAN ALTERNATIVES

1870 OGDEN DRIVE
BURLINGAME, CALIF. 94010
(415) 697-0500

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Western Conference of Teamsters

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Sailors Union of the Pacific

December 26, 1968

Charles H. Shreve
Regional Director
Department of Health, Education,
and Welfare
50 Fulton Street
San Francisco, California

Dear Mr. Shreve,

With reference to our exchange of wires on December 16, our Council is pleased to have the opportunity to submit the attached statement to the San Francisco hearing on "Necessary and Desirable Changes in Medicaid."

It has not been possible for us to prepare and mail the statement in time for you to receive it on the hearing date, December 27. Therefore, our Administrative Secretary, Dave Williams, will contact you or the presiding department official on the hearing date in San Francisco, for further advice on the most appropriate method of submitting our statement.

Yours very truly,

Einar O. Mohn

Einar O. Mohn
Chairman

Department of Health, Education, and Welfare
Washington, D. C.

Public Hearing on "Necessary and Desirable Changes in Medicaid, Title XIX, as well as in Regulations, and Administration."

Board of Supervisors Chambers
City Hall
San Francisco, California

Friday, December 27, 1968

Statement Submitted by

California Council for Health Plan Alternatives
1870 Ogden Drive
Burlingame, California, 94010

Einar O. Mohn, Chairman

Statement Presented by

Dave Williams
Administrative Secretary
California Council for Health Plan Alternatives

December 27, 1968

My name is Dave Williams, and I am Administrative Secretary of the California Council for Health Plan Alternatives. Our Council includes the top elected officials of the major labor unions and organizations in the state, who came together, formed the Council, incorporated it, and have now funded it, in order to find practical answers to precisely the kinds of problems you are meeting to consider here today.

Most of our Council members have been negotiating health care programs, some of them for sizeable memberships, for 15 or 20 years. We have learned some lessons by hard experience, and our Council was formed to handle the resulting problems. We might as well list the main problems at the outset, because we know you will recognize them.

We have learned that neither money, nor ingenious arrangements for handling it, will by themselves assure good health care. We have learned the hard way that medical inflation, in part, is the product of irresponsibility of group purchasers who dump millions of dollars into the so-called "mainstream" without demanding a voice in how medical resources are used and organized. We have come to realize, to our present regret, that while our dollars have been feeding the inflationary fires, they have been doing very little to stimulate more efficient use of resources. While we have learned to bargain hard to remove the financial barriers to good medical care for the sick, it has taken us much longer to learn that we must also bargain to meet the needs of our members to stay healthy. More seriously, we have come to a belated realization that we ourselves have contributed to the growth and entrenchment of a system of delivering health services that is not only plagued by rigidities, but is basically incompatible with the level of health education and life styles for many in our population.

In short, we are presuming to advise you from a backlog of experience which we imagine is not only very similar to your own, but which probably parallels it exactly. In terms of the purposes of this hearing, we see two primary problem areas that define for us the most pressing needs:

1. Failure to devote sufficient attention and resources to the problem of organizing health care services to make them more effective.

The government programs, both federal and state, have been preoccupied with the problem of removing financial barriers so that covered individuals could move into the "mainstream" of health care service. In the process, the government programs, like the labor-management programs, have tended to increase demand beyond the present capacity of our health resources, as they are presently organized and used. If the federal government is to make good on the initial

promise of Medicare and Medicaid, to bring more individuals into the mainstream of health care, then it must find ways of making mainstream care more efficient, by encouraging the reorganization of health care services. In particular, it must see that delivery systems are developed to overcome the kinds of problems faced by the underprivileged and by many workers in obtaining quality medical care.

The need for reorganization is urgent particularly at the level of state Title XIX programs. For the poorest and most underprivileged in our society, the concept of "mainstream" health care can become a mockery if we do not develop medical delivery systems that penetrate the socio-economic environment in which health care problems not only thrive, but help to perpetuate the poverty cycle.

In its legislative and administrative approach to the Title XIX programs, the federal government should not only encourage better organization of existing health care services, but should take the initiative in sponsoring new delivery systems in major metropolitan centers. The primary guideline for such new systems should be accessibility of quality health care services, not only for acute care needs, but more importantly, for preventive care and for the maintenance of health. Such systems should be specifically designed to create new benchmarks for the maintenance of health, even at the risk of under-emphasizing the more spectacular performances in the acute care ampitheater, where the spotlight shines brightest on the stars of the practitioner firmament.

Some hesitant first steps have already been taken in the direction of such experimentation with delivery systems. The OEO programs have opened their clinic doors to a neighborhood concept of health care, involving new ways of educating people about health, and involving a new and much more direct level of contacts between the skilled practitioners and the people in the community being served. Some multi-phasic screening programs have been developed not only to determine needs, but more importantly, to establish regular health care contacts, to provide needed education services, and to integrate "mainstream" medical services so that they may be used to preserve health. Some hospitals have indicated a new interest in keeping people well by seeking new ways of organizing outpatient services. Some organizations, like the Council for Health Plan Alternatives, have indicated their interest in working with other groups, including government groups, on direct service programs that might mix covered populations always isolated in the past in their own exclusive program "boxes." (The lines of program exclusivity are always drawn with respect to financial considerations and never with respect to the health care needs of human beings.) Programs mixing such previously exclusive categories of people could be extremely worthwhile not only to make needed new services available, but also to make more efficient neighborhood or community use of existing health facilities and manpower.

We believe there is widespread interest in such experiments with new health care programs, to the extent that they are designed to develop new delivery systems. The federal government has available to it a wide variety of ways and means to stimulate such interest, and to build on it. For instance, hospitals and other health facilities must now cooperate in implementing the federal comprehensive health planning law. In reimbursing health facilities for services rendered through Medicare and Medicaid, the government should not permit allowances to be made for depreciation of facilities and equipment unless individual health facilities are in fact planning to provide services needed by the community, and are in fact coordinating their plans through the comprehensive health planning mechanism of their community. If this approach were carried one step further, the depreciation formula might serve as an appropriate vehicle to promote and stimulate new delivery systems, initiated by those hospitals (or other health care provider groups) willing to reach out to their communities, and prepared to maintain high quality standards in the process.

Beyond the possibility of stimulation through financial devices, the creation of quasi public health centers to better fulfill the initial promise of the government programs could help to meet our urgent needs for health care bench marks. We believe that the bench marks concerning organizational issues are the most important. Those concerning costs might be of most immediate concern, and certainly should not be neglected. However, we wish to re-emphasize our opinion that no relevant cost data for use as a comparative bench mark will be forthcoming from any system that accepts all present "mainstream" criteria as the only relevant criteria to use in building more effective and efficient health care programs. We think there will finally be no way of coming to grips with cost problems in a framework that ignores the basic health care organizational issues. That is our present framework, and pursuing it will guarantee continued pre-occupation with inflation, with budget and appropriations problems, with the juggling of benefit levels and cost sharing formulas, and with endless arguments about extending coverage to groups that should long since have been covered.

In short, continuation of the predominant current of "mainstream" health care policies, which are associated now with both the government programs and the labor-management programs, will guarantee our continued preoccupation with all of the secondary symptoms of the ailing patient, whose primary malady is to be found in the limitations of existing delivery systems, in our failure to recognize the limitations, and in our failure to be concerned enough about the resulting problems to devote adequate resources to the development of new systems.

With respect to the second primary problem area that defines for us our most pressing needs, we turn now to more specific consideration of California's Title XIX program.

2. Failure of the federal government to prohibit the separation of fiscal and program administration of the state Title XIX programs.

Many in California originally viewed the Title XIX programs as more innovative than Medicare, in that a wide range of experimentation at the state level was not only permitted but was actively encouraged. Today, there is growing concern that new departures, if they are forthcoming, may have to come from Washington. In this concern, there is more than a little sense of frustration and even defeatism. It stems partly from the failure to control the inflationary impact of the MediCal program, but it stems even more from the administrative mechanism developed to carry out the program.

Our experience with the program in California has led us to believe that the imposition of the fiscal intermediary device has created an often impenetrable blanket of fog, which sometimes obscures the operations and responsibilities of the principal providers of care, and which sometimes obscures the operations and responsibilities of the state administrators. We believe that this cumbersome administrative device has diluted and restricted legitimate public understanding of, response to, and control over this essential program. Instead of facilitating efficient administration, the division of fiscal and program responsibility has served only to water down both responsibilities. Most important of all, the split administration has made it more difficult for any interested group to obtain authorization for new programs of an experimental nature, and more difficult even for the state administrators to give needed leadership to this objective.

At present, the only MediCal experimental program of note is the San Joaquin County Foundation prepayment project, which has potential for developing new monitoring and surveillance techniques, but which excludes the medically needy and the OAS recipients, and which does not yet extend to hospital care. There are no MediCal sponsored experiments designed to promote more efficient use of California's limited health manpower resources. There are no MediCal sponsored experiments designed to facilitate the development of new delivery systems which would bring needed services directly to the most disadvantaged people in our most troubled urban centers. There has been very little MediCal encouragement to university hospitals, other teaching institutions, or county hospitals, to establish comprehensive care programs that would reach MediCal recipients in greatest need. There has been very little MediCal effort to develop programs that might cross the traditional lines of existing program "jurisdictions." The prevailing philosophy is that MediCal is for public assistance recipients only (or, at most, those "linked" to a category); labor-management programs are for union members only; OEO programs are of primary interest to various Washington agencies; and county general assistance programs can take care of all problems not handled in other programs.

With continuation of the present high level of MediCal cost inflation, there is an increasingly dangerous trend in California toward use of the fiscal intermediary to guarantee payments to providers, while the government part of program administration is oriented more and more toward limiting program use--by more prior authorization procedures, more stringent eligibility determinations, more reliance on proof of indigency, and more "orders of priority" which are not for increasing benefit levels or coverage, but for reducing them. In other words, the program stands in increasing danger of turning backward to the poor law traditions from which it was derived, rather than forward to a new definition of need as the chief determinant of the health care which should be rendered.

While the major problems are unmet in California, and largely unapproached by any experimental programs of note, we do have a great deal of attention to "prepayment" as the final answer to all experimentation. Prepayment is old hat to those who have been involved for some time in labor-management negotiated programs. We know there is no magic in further development of still another financial arrangement which leaves the "mainstream" methods of delivering care unchanged and unchallenged. We know that prepayment will guarantee "mainstream" reimbursement whenever a "mainstream" health care service is rendered. But we also know that payment guarantees have little or nothing to do with the way services are organized to make their rendering more effective in meeting the health needs of our citizens, and more efficient in stretching the financial resources of our government, as it is called upon to pay more and more of the guaranteed bills.

Our greatest need in California is for guarantees of more effective health care for individuals in need of such care, and not for more guarantees that mainstream provider bills will be paid at mainstream prices. The relevant guarantees must be developed not in terms of categories or links to categories, but in terms of human needs. MediCal and other government programs cannot afford, either in terms of dollar cost, or in terms of the leadership now demanded in the health care field, to tie to past rigidities associated with particular delivery systems. Above all, the appropriate governmental agencies, both federal and state, cannot afford to entrench their programs in past concepts and ways of doing things, to the point that we cannot even hope to get the needed experimentation to show the correct way to needed innovations.

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1968 DEC 27 AM 2 12

SFB033 125A PST DEC 27 68 PRA028
PR LLEO18 NL PDF 9 EXTRA PORTLAND ORG 26
CHARLES SCHREVE, .75 DLY, DLR EARLY AS POSSIBLE, REGIONAL DIRECTOR
HEALTH EDUCATION AND WELFARE CARE SUPERVISORS CHAMBERS CITY
HALL CIVIC CENTER SFRAN [illegible]
I AM BEGINNING MY EIGHTH SESSION IN THE OREGON LEGISLATURE,
FOUR OF WHIRH HAVE BEEN AS CHAIRMAN OF THE PUBLIC HEALTH AND
WELFARE COMMITTEE. I REGULARLY ATTEND THE STATE WELFARE MEETINGS
AND WORK WITH THE DEPARTMENTS OF HEALTH AND WELFARE DURING
THE INTERIMS. I AM DEEPLY CONCERNED OVER REGULATIONS IN TITLE
19 WHICH I CONSIDER TO BE UNFAIR TO OREGONS NURSING HOMES,
PARTICULARLY THAT PART WHICH CALLS FOR DIVISION OF SKILLED
AND INTERMEDIATE HOMES. FOR INSTANCE, THE REGULATION CALLING
FOR FULL TIME REGISTERED NURSES AND LICENSED PRACTICAL NURSES
IS UNREALISTIC AND [illegible]NDS FURTHER CONSIDERATION. OREGONS NURSING
HOME PROGRAM I [illegible]STANDING AND I BELIEVE WE ARE ALREADY GIVING

SF1201(R2-65)

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PR LLE018/2ND

1968 DEC 27 AM 2 12

THE KIND OF CARE CONGRESS HAD IN MIND WHEN SETTING UP THE REGULATIONS . FOR INSTANCE, IN 1957 I BELIEVE WE WERE THE FIRST STATE TO LICENSE NURSING HOME ADMINISTRATORS-WITH STRICT QUALIFICATIONS. OUR LICENSING PROCEDURE (THROUGH THE DEPARTMENT OF HEALTH) AND REGULATIONS SET BY THE LEGISLATURE, WELFARE DEPARTMENT AND STATE FIRE MARSHALL GUARANTEE GOOD HOMES. I REALIZE THE FEDERAL GOVERNMENT MUST SET UP PROGRAMS EFFECTIVE IN ALL 50 STATES, BUT IT IS UNFAIR NOT TO MAKE ALLOWANCES FOR STATES SUCH AS OREGON WHO ARE ALREADY GIVING EXCELLENT CARE THROUGH STATE LAWS AND REGULATIONS. GOOD HOMES ARE BEING PENALIZED BECAUSE OTHER STATES HAVE BEEN DELINQUENT IN THIS CAUSE. MANY OF THE HOMES TO BE PENALIZED ARE TAX PAYING PRIVATE HOMES WHICH KEEP THEIR DOORS OPEN TO WELFARE PATIENTS AND GIVE THEM THE SAME EXCELLENT CARE GIVEN PRIVATE PATIENTS. CAN YOU HELP IN

SF1201(R2-65)

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PR LLE018/3RD

1968 DEC 27 AM 2 12

ANY WAY? I AM CONTACTING MEMBERS OF CONGRESS, AS I BELIEVE IT IS OUR DUTY TO TAKE AN INTEREST IN THE PROGRAMS FOR WHICH WE WORKED AND PRAYED AND CORRECT THEM, IF NECESSARY. MAY GOD BLESS YOU, YOUR ASSOCIATES AND LOVED ONES IN THE NEW YEAR

STATE REPRESENTATIVE GRACE OLIVER PECK PHONE 234-2773 2324 SOUTHEAST IVAN PORTLAND OREGON 97202.

SF1201(R2-65)

Addressograph Multigraph Corporation

3400 ELVAS AVENUE, SACRAMENTO, CALIFORNIA 95813 • 916 452-6941

SACRAMENTO BRANCH

December 24, 1968

Mr. Charles H. Shreve
Regional Director
Department of Health, Education
and Welfare
50 Fulton Street
San Francisco, California 94102

Dear Mr. Shreve:

Please enter the attached material as testimony in the public hearing to be conducted in San Francisco on December 27, 1968 regarding methods of improving the Title XIX Program.

Additional and more complete information can be provided by Mr. J. G. Roberts, Addressograph Multigraph Corp., 1200 Babbit Road, Cleveland, Ohio.

Sincerely,

ADDRESSOGRAPH MULTIGRAPH CORP.

J. W. Whitlow
Account Representative
Addressograph Division

JWW:mg
Enclosure

PRODUCED IN U.S.A. BY MULTILITH OFFSET

TITLE XIX PROGRAM TESTIMONY

Submitted for hearing

December 27, 1968 - San Francisco, California

ADDRESSOGRAPH MULTIGRAPH CORP.
1200 Babbit Road
Cleveland, Ohio

Without exception, providers of service, beneficiaries and administrators indicate that improvements are necessary to the procedures now employed in administering the Title XIX Program.

One prominent area is that of "paper work handling".

A. Administrators are plagued with the certification of eligibility and identification of beneficiaries as they move from area to area within their jurisdiction -- and, the maintenance of their "master eligibility file".

B. Beneficiaries object to the apparent unnecessary red tape in receiving the services which are available to them under the Program.

C. Providers of service object to the volume of paperwork, the lack of uniformity of claim forms, and the undue time necessary to receive their payments for services rendered.

We recommend that several bold steps be taken to improve the paperwork procedures necessary to administer the Title XIX Program.

1. Beneficiary Identification. We recommend the issuance of an embossed plastic identification card to every beneficiary eligible for benefits of the Program. The "pouch type" card offers a simple and efficient method of identifying the beneficiary, together with the ability of re-certification on a monthly basis. (A "check stub", prepared as a by-product of the monthly cash assistance payment process, is inserted in the permanent embossed plastic pouch).

2. Claim Forms. It is our firm recommendation that uniformity be established in the claim forms used by all states participating in the Program. Although coverages under Programs vary from state to state, it is felt that standardization and uniformity of claim forms would aid tremendously in both claim preparation and claim processing. An 80 column tab card form, with the necessary number of carbon copies, is universally used today. A "standard claim form" of this type would offer the Program the benefits of mechanized writing and optical scanning which are employed by so many large business establishments today.

3. Vendor Claim Preparation. It is proposed that each provider of service utilize a small imprinting device to mechanically prepare the standard claim form. The beneficiary's embossed plastic identification card, together with a "Vendor Identification Card" and "Service Provided Card" will produce a complete, accurate and legible claim form. All necessary parties receive a copy of the claim form, with one copy being forwarded to the proper administering state agency or fiscal intermediary for processing.

4. Claim Processing. The claim forms received from the providers of service can be introduced to optical scanning devices. The resulting media is then available for direct entry to the computer system to provide rapid and accurate vendor payments.

In summary, we urge --

Beneficiary Identification,
Standardized Claim Forms,
Mechanized Claim Preparation
and
Optical Scanning of Claim Forms

be considered as one complete and inseparable area

for great potential improvement in the Title XIX Program, with the embossed plastic identification card -- the key element.

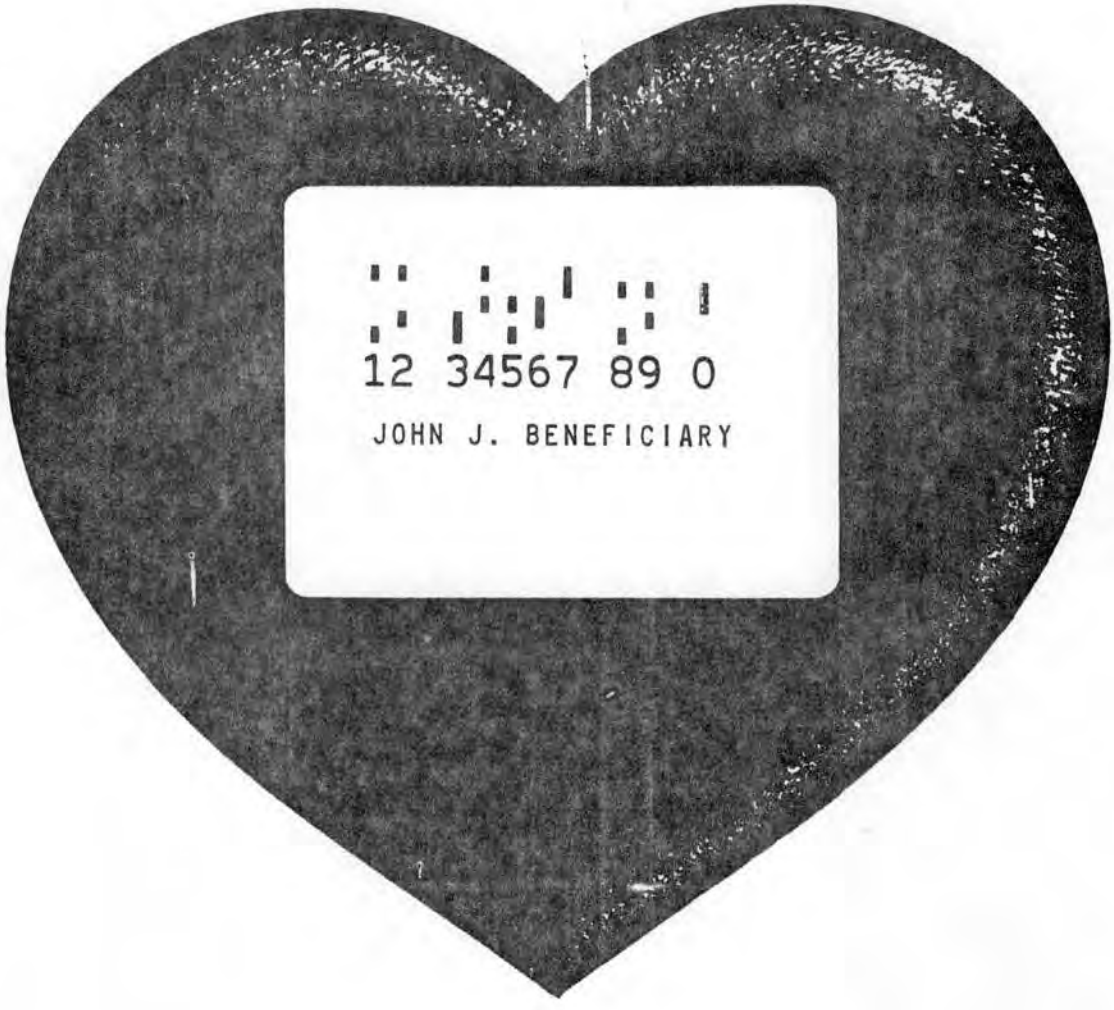
Descriptive material describing the systems that we have recommended follows these pages.

More complete information and assistance in implementing the recomendation that we have submitted can be obtained from Mr. J. G. Roberts, A-M Corp., 1200 Babbit Road, Cleveland, Ohio.

Purpose and scope of A-M automated systems for claims processing

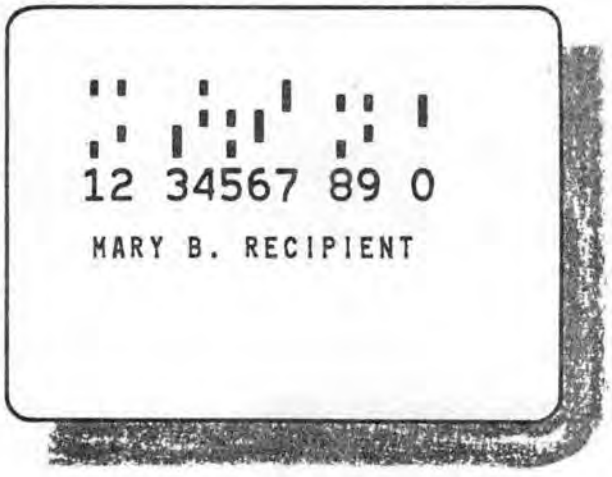
FOR YOUR STATE TITLE XIX PROGRAM

- ✔ A system that captures accurate information on claims forms at the source.
- ✔ A system that automatically converts the source documents (claims form) to an EDP format for updating of records for "Vendor/Provider Payments and Recipient/Beneficiary Records."
- ✔ A system that eliminates the need for manual conversion of source documents and the inherent high costs and inaccuracies associated with such systems.
- ✔ A "People Oriented" system that will gain immediate acceptance and support from "Providers" because:
  - **A.** It simplifies procedure for filling out claims forms.
  - **B.** Claims are processed faster—the Provider is paid faster.
  - **C.** It reduces duplicate or exception handling of claims due to inaccurate or incomplete preparation of the claims document at the Provider location.



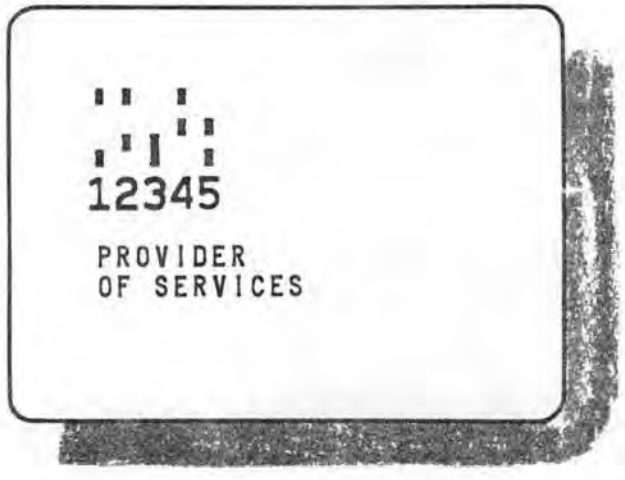
The A-M Self-Writing Plastic Identification Card is the heart of the system. The embossed information will always write legibly and accurately.

Plastic cards to be used in the system



RECIPIENT / BENEFICIARY* CARD

To be carried by the Recipient and presented to the Provider when a service is rendered and a claim form initiated.



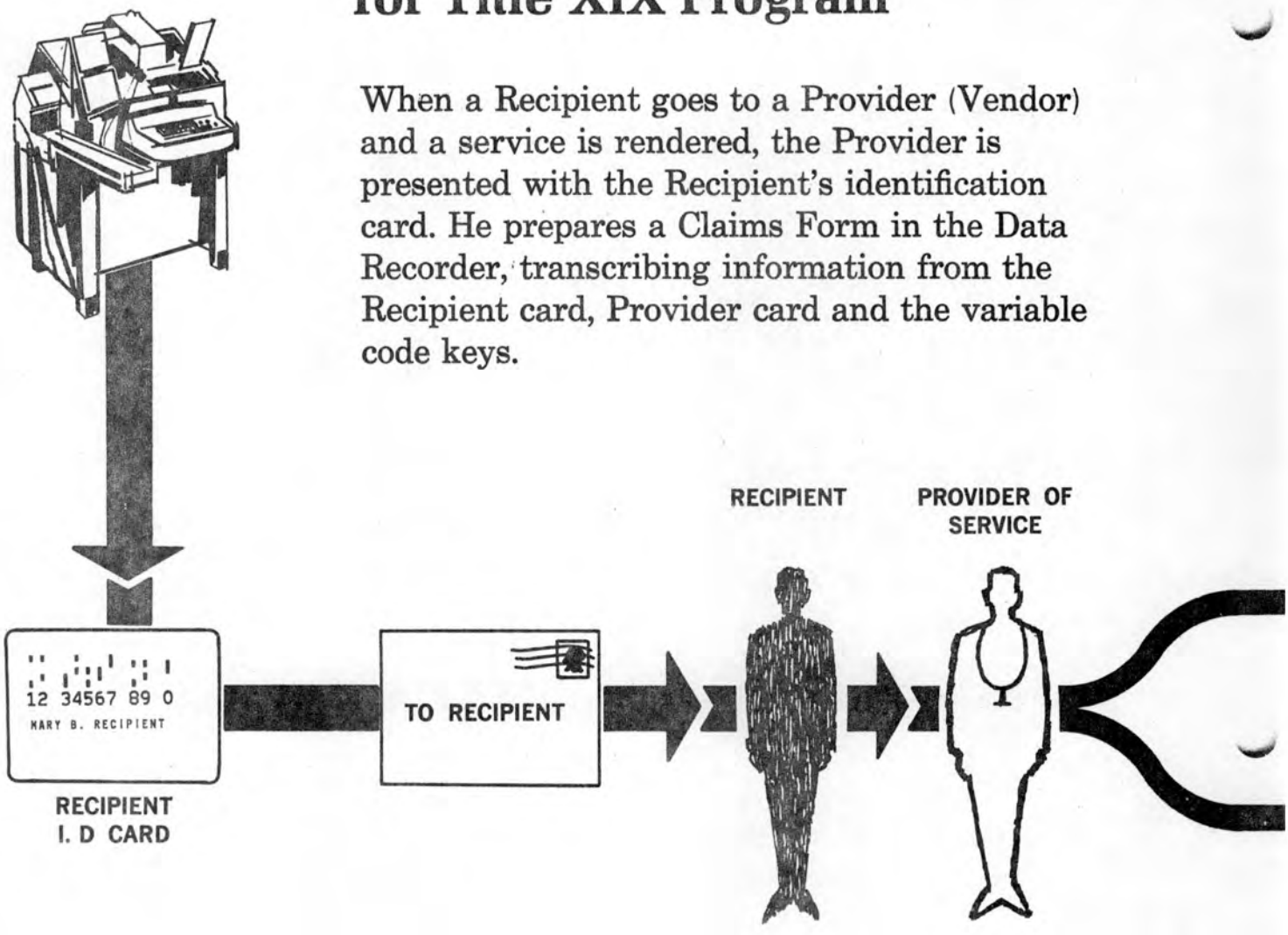
PROVIDER CARD

To be kept in the Data Recorder at the Provider location. Prints Provider name and number as a by-product of writing Recipient information on the claims form.

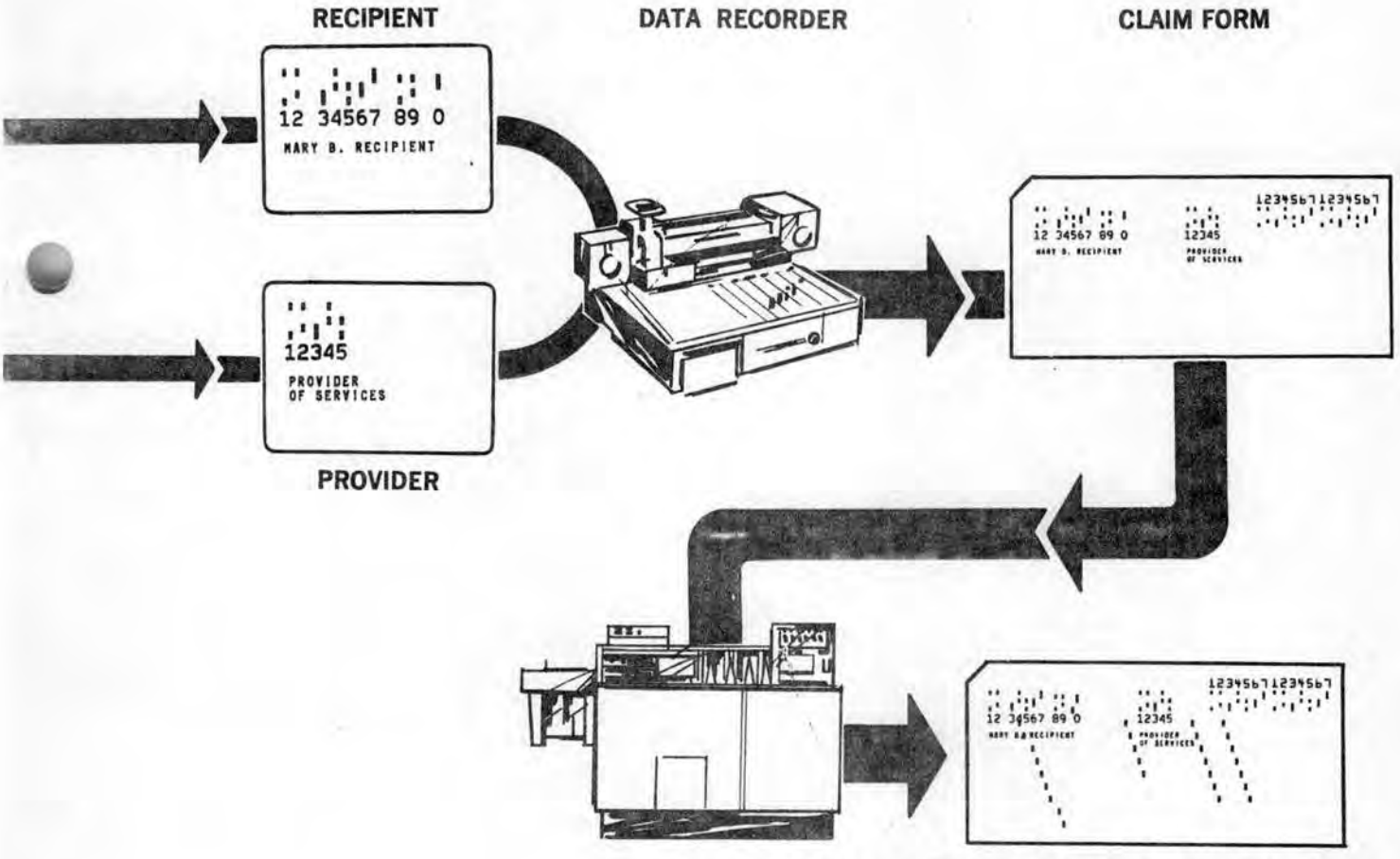
*Hereafter referred to as Recipient Identification Card.

A representative A-M system for Title XIX Program

When a Recipient goes to a Provider (Vendor) and a service is rendered, the Provider is presented with the Recipient's identification card. He prepares a Claims Form in the Data Recorder, transcribing information from the Recipient card, Provider card and the variable code keys.



The Recipient plastic identification card is generated centrally on an automatic Graphotype that can be operated by: punched paper tape, punched cards or electric typewriter keyboard.

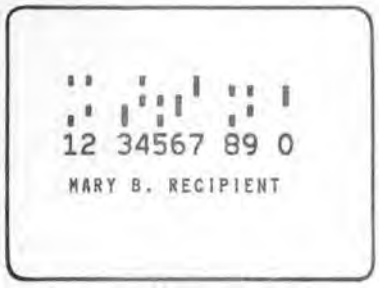


CLAIMS PROCESSING DIVISION

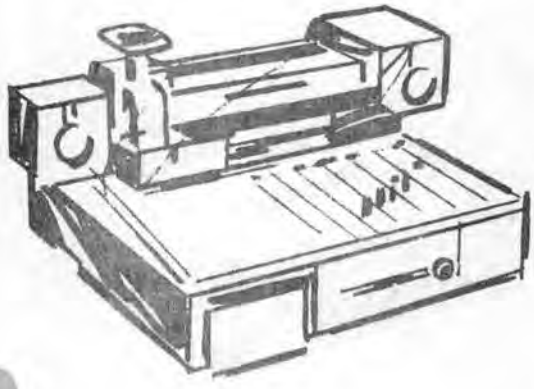
(State Department of Welfare and/or Fiscal Intermediary)

An A-M optical scanner will read, punch and verify claim forms at high speed, thereby providing accurate machinable claims documents for entry to the Central Processing Unit.

Primary Components



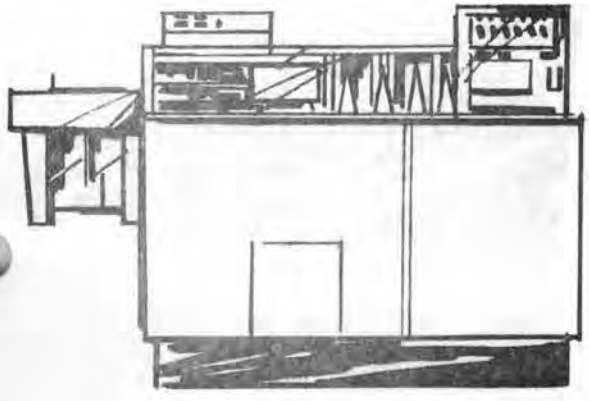
A durable, attractive PLASTIC Identification Card that cannot be successfully altered. A functional identification card that will write information with 100 per cent accuracy and assured legibility.



Low Cost Data Recorders that imprint information from the plastic cards and the variable data keys in both human sensible and machine readable language.



A complete line of Graphotype machines to emboss plastic cards manually or automatically.



Optical Scanning Equipment that reads claims forms prepared at the source and converts them to an EDP format. All documents are scanned, punched and verified at high speed without the high cost and inaccuracies associated with manual conversion methods.

Benefits of the A-M system

TO PROVIDERS OF SERVICE

A. Simplified Procedure for Initiating Claims Forms

B. Claims are processed faster and, therefore, the Provider is paid faster.

C. Fewer claim forms are returned to the Provider due to inaccurate or incomplete information.

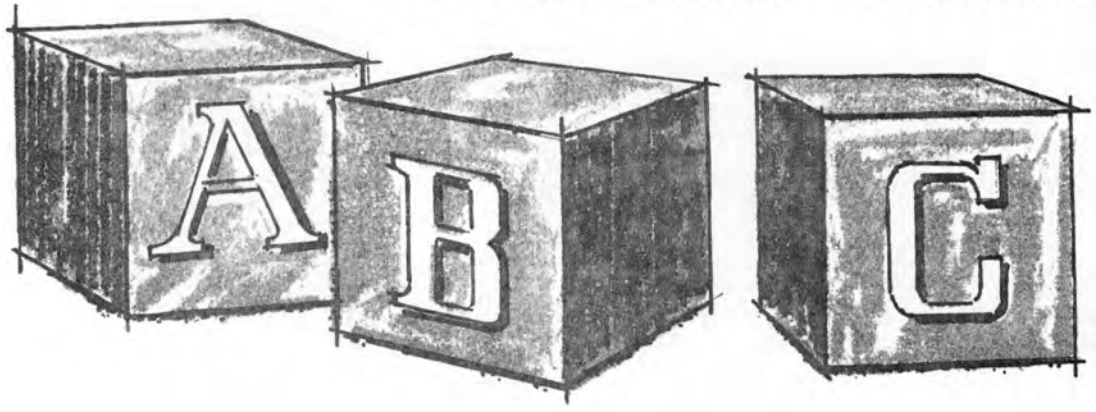
TO STATE DEPARTMENT OF WELFARE AND / OR FISCAL INTERMEDIARY

A. Accurate, legible and complete claim forms are received at the Central Claims Processing location

B. Substantially reduced time lapse between claim preparation and Vendor/Provider payments.

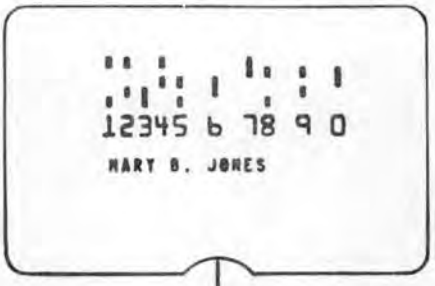
C. Reduced operations' expense of claims processing.

Fast · Accurate · Economical



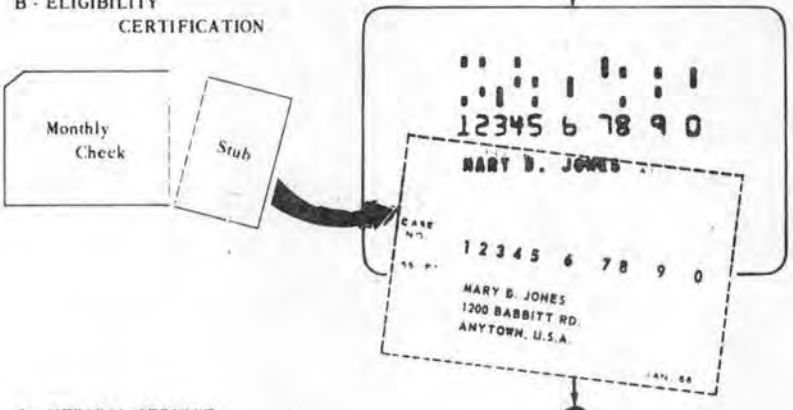
PROPOSED CERTIFICATION PROCEDURE
(TITLE XIX)

A - IDENTIFICATION



a) An embossed Plastic Pouch Identification Card is issued to all eligible recipients.

B - ELIGIBILITY CERTIFICATION



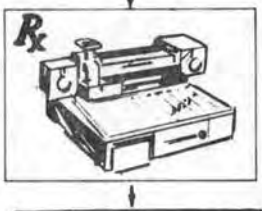
b) The monthly check stub is inserted in pouch as proof of continued eligibility.

C - MEDICAL SERVICE



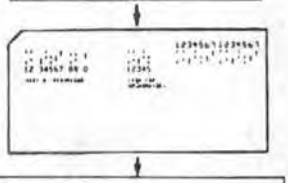
c) The recipient presents his Identification Card when applying for medical services eliminating any question of eligibility.

D - ID ELIGIBILITY RECORDING



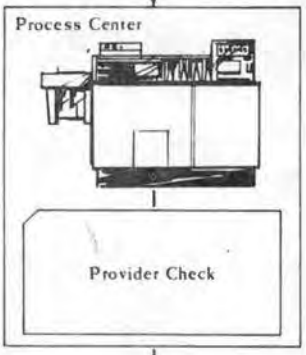
d) The provider places the Identification Card in the Imprinter, and automatically writes a multi-part claim form.

E - CLAIM FORM



e) All of the necessary billing data is recorded accurately and legibly in a matter of seconds.

F - AGENCY or AGENT ACCOUNTING



f) Machine imprinted claims forms are suitable for computer processing. Fewer claim forms are returned due to inaccurate or incomplete information.

G - AGENCY or AGENT PAYMENT

g) Substantially reduced time lapse between claim preparation and provider payment.

H - PROVIDER

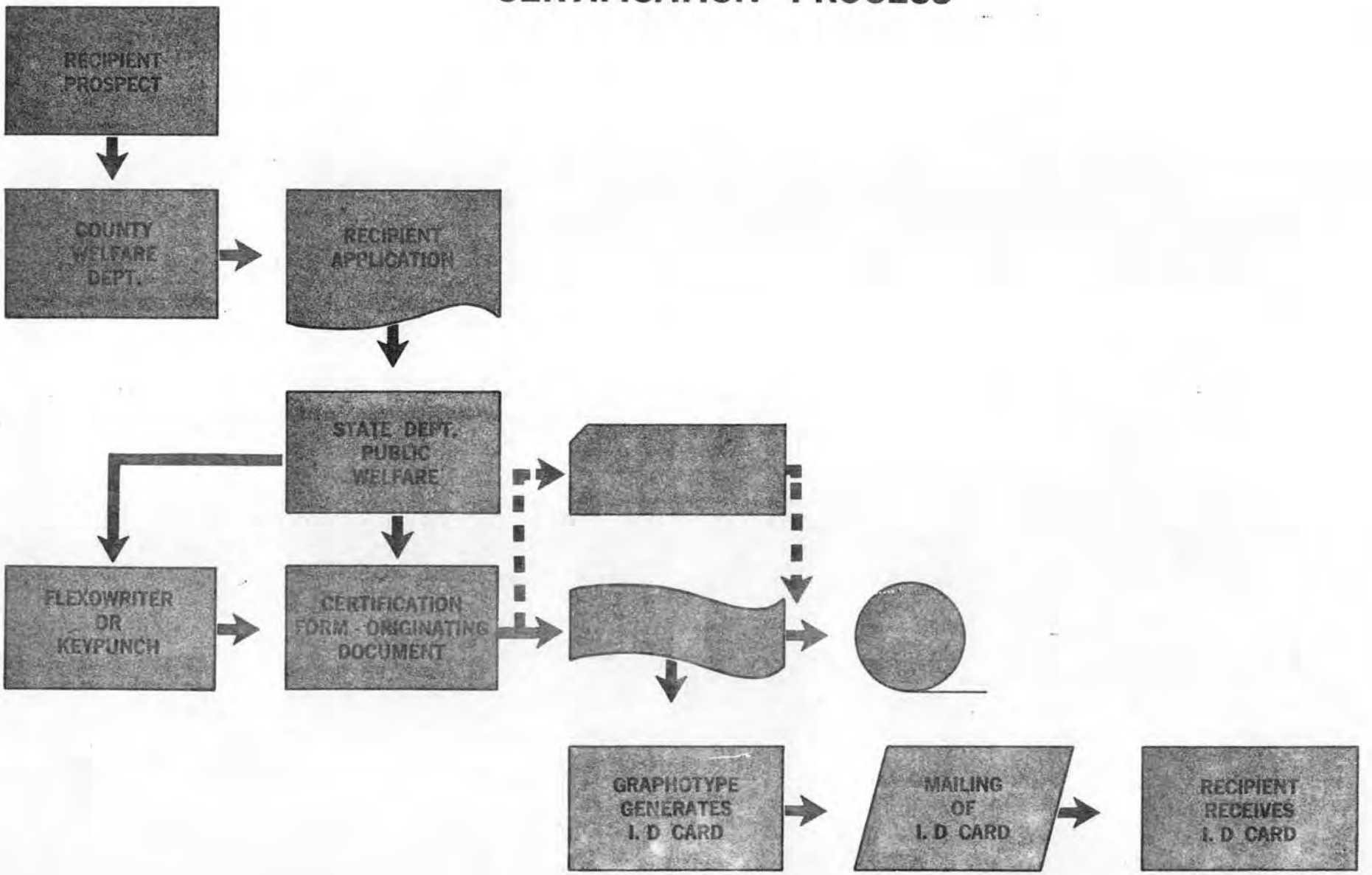


h) Provider receives check promptly.

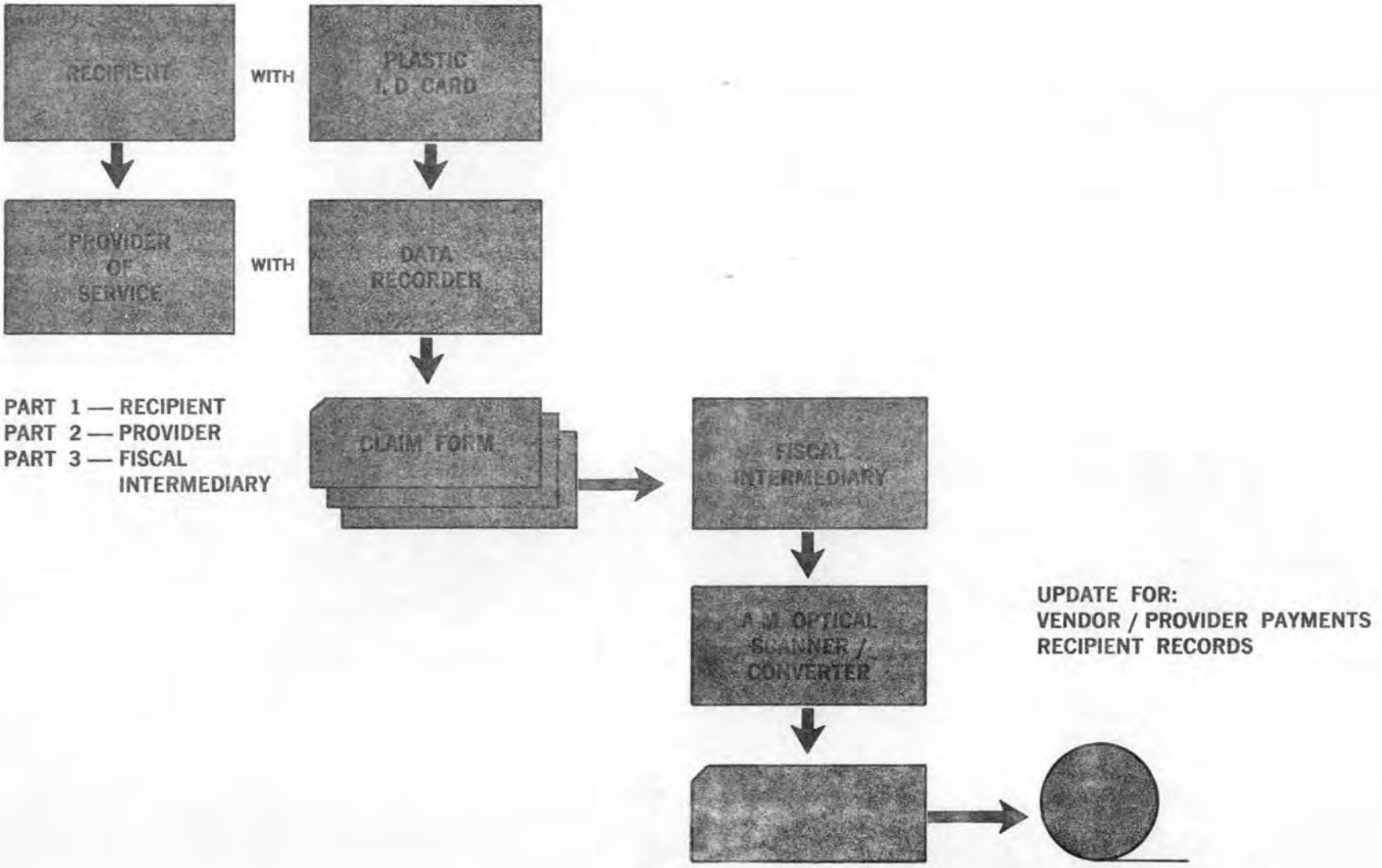
ADDRESSOGRAPH division
CORPORATION
...helping people communicate

TITLE XIX BASIC FLOW CHARTS FOR PAPERWORK FLOW AND PROCESSING

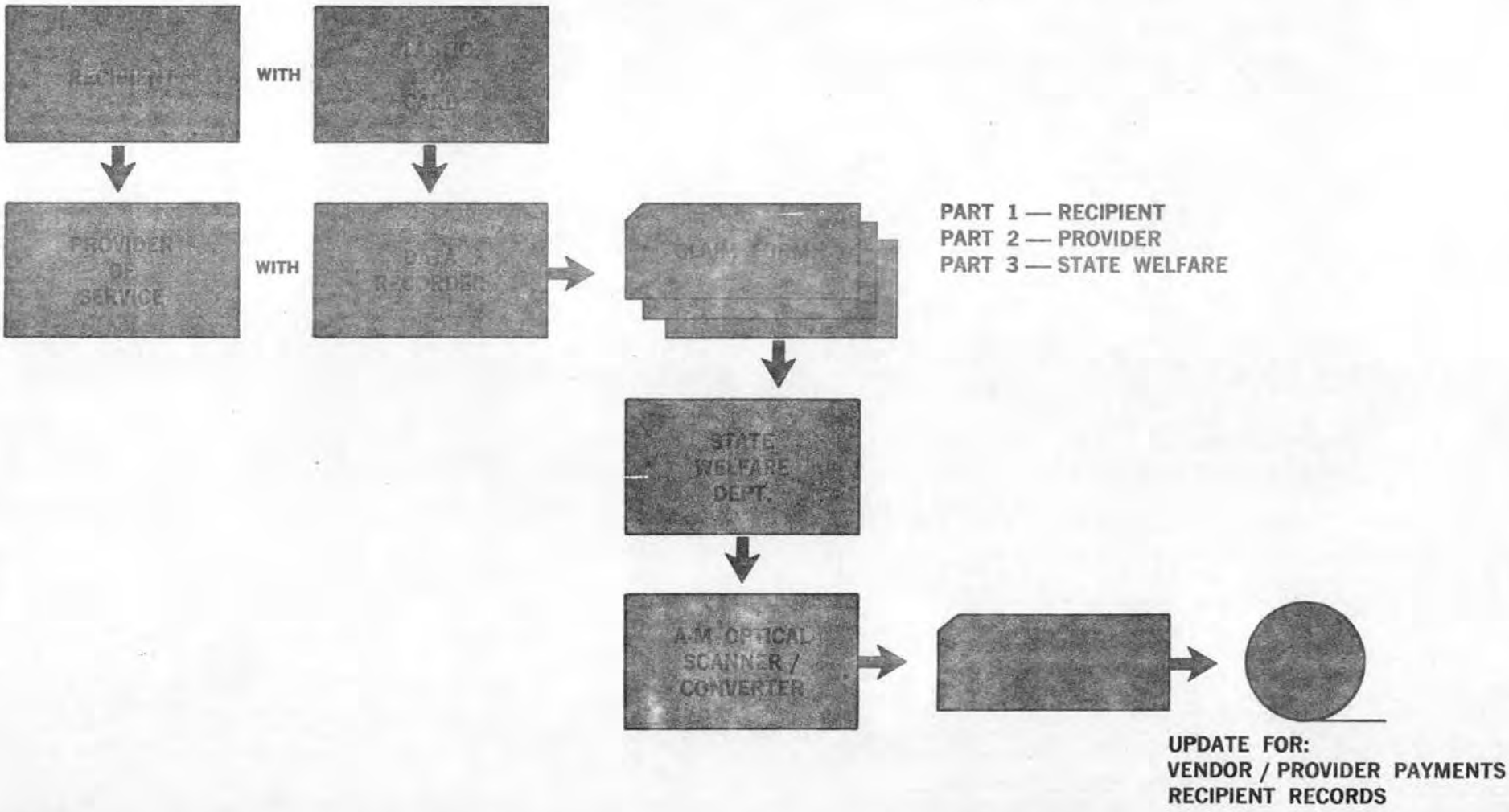
CERTIFICATION PROCESS



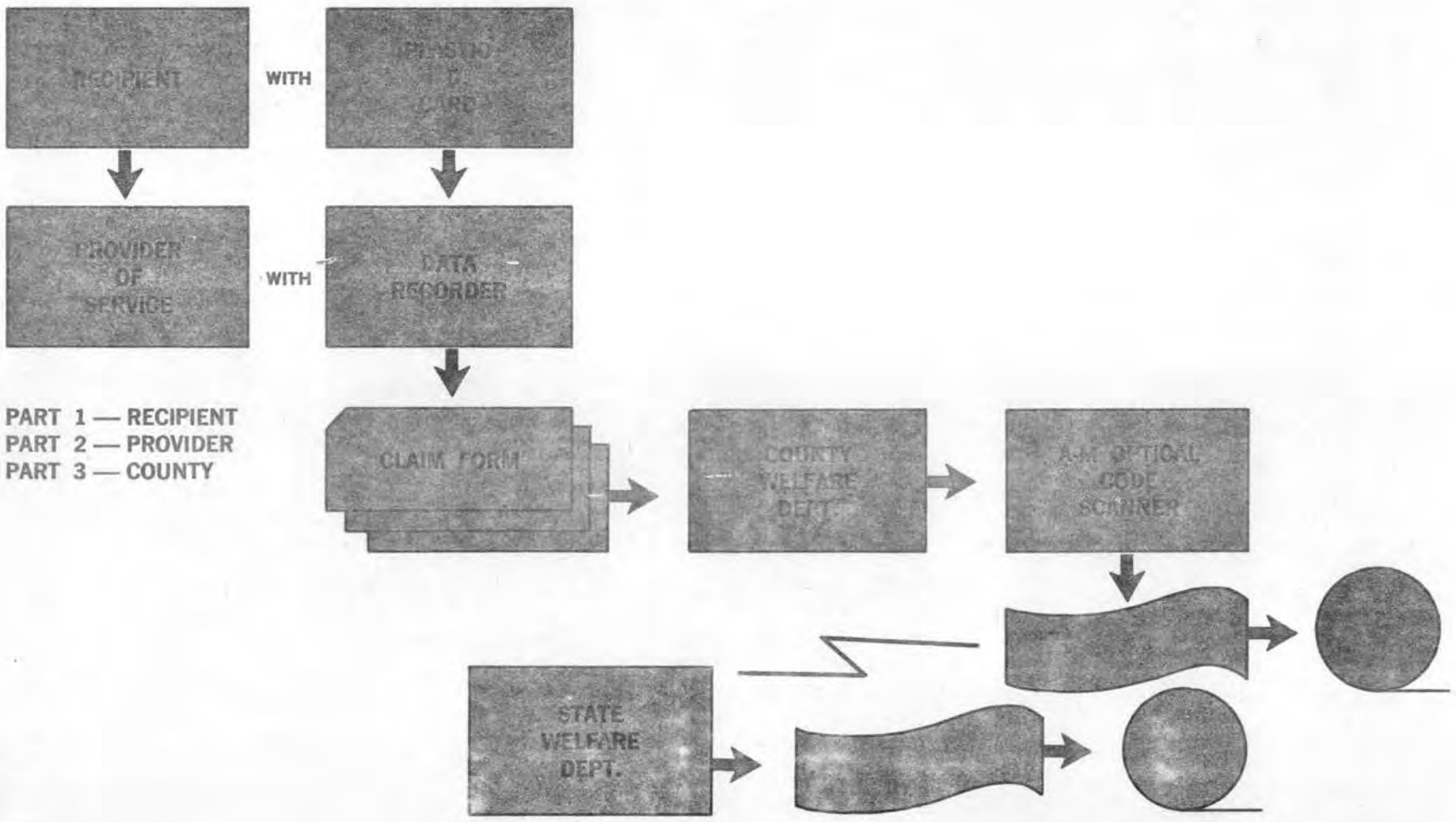
CLAIMS PROCESSING AND PAPERWORK FLOW... WHEN UTILIZING A FISCAL INTERMEDIARY



CLAIMS PROCESSING AND PAPERWORK FLOW WHEN STATE DEPARTMENT OF PUBLIC WELFARE WILL PROCESS ALL CLAIMS, VENDOR AND WELFARE PAYMENTS ON A CENTRAL STATE COMPUTER



CLAIMS PROCESSING AND PAPERWORK FLOW WHEN EACH COUNTY WILL MAKE WELFARE PAYMENTS, VENDOR/PROVIDER PAYMENTS AND KEEP RECIPIENT RECORDS.



R. I. DEPARTMENT OF SOCIAL WELFARE
MEDICAL CARE IDENTIFICATION

1 WASHINGTON AVE., PROVIDENCE, R. I. 02905

A 12345
RICHARD ROGERS
036 14 1234

The person named hereon is eligible for medical services and supplies prescribed by the attending physician in accordance with the regulations of the Office of Medical Service, Department of Social Welfare.

LOUISIANA DEPARTMENT OF PUBLIC WELFARE

MEDICAL CARE IDENTIFICATION CARD

The person named below is eligible for vendor payment for medical care and medications prescribed by the physician or medical facility named below, in accordance with the regulations of the Department of Public Welfare.

CASE NUMBER
0421 002424 | 000

JOHN DOE

00212 JANE DOE
DOCTOR'S NAME

STATE OF CONNECTICUT
STATE WELFARE DEPARTMENT
IDENTIFICATION CARD

Void

098-B-008427-0M

SADIE LUUTINE

SEE REVERSE SIDE

MEDICAL CARE IDENTIFICATION PASS
DISTRICT OF COLUMBIA GOVERNMENT
USE OF THIS PASS IS LIMITED – SEE OTHER SIDE

VOID – VOID

M 000

05 19 1934

BETTE HOUSTON

03 68 08 68

00456302280

LOUISIANA

(1) 0000 00000000 50 60
000000 18 16 CASE
JOHN B PATIENT
99 PATIENT
00000 JOHN B DOCTOR DOCTOR
NUMBER & NAME

BROWNS THRIFT C
OPELOUSAS LA
24142
VENDOR

7839014

(10) I hereby certify that the medication shown has been dispensed by a person legally qualified to do so; that the charge is not in excess of the established maximum schedule; that the price is no more than that charged to the general public for the same item; and that this bill has not previously been submitted. I agree to adhere to the published regulations of the Louisiana Department of Public Welfare concerning vendor payments for medication.

Signature of Vendor or Authorized Representative

(11) FOR USE ONLY BY NURSING HOMES.

I hereby certify that the medication herein billed has been received.

Signature of nursing home operator or authorized representative.

(12) For State Office Use Only When a Bill is Returned To Pharmacy.

THIS BILL IS IN ERROR AS INDICATED BELOW:
( ) SEE RED CHECK.
( ) REFILLED AFTER 90 DAYS.
( ) SPECIAL APPROVAL NEEDED FOR DRUG ITEM-SEE BOOKLET.
PAGES 5 & 6, No._____.

TYPE OR PRINT

MAIL CARD COPY TO:
LOUISIANA DEPT. OF PUBLIC WELFARE
BOX 4065
BATON ROUGE, LA. 70804

(2) DRUG NAME & FORM DISPENSED		(3) STRENGTH
(4) MANUFACTURER	(5) QUANTITY	(6) PRICE
(7) Date of Service	(8) RX NO.	(9) Date Orig. RX

PATENTED SPEEDITAB MOORE BUSINESS FORMS, INC. BU

RHODE ISLAND

A 12345
JOHN DOE
UOU 11 22222

NAME OF RECIPIENT

CASE NO. CHILD NO.

L 34
MEADOWCREST PHARM
212 214 MILLETT AVE
RIVERSIDE R I
NAME & ADDRESS OF PHARMACY

PATIENT NAME IF DIFFERENT FROM ABOVE

INVOICE NO. 036000

DATE OF SERVICE | SEX | AGE

EXACT COPY OF ORIGINAL PRESCRIPTION:

MFG. NO.

PRIOR AUTHORIZATION NO:

Rx TELEPHONE

Rx REFILL NUMBER 1 2 3 4

Rx No. | DATE OF ORIGINAL PRESC.

DIRECTIONS:

COST | CHARGE

NAME OF PRESCRIBING PHYSICIAN LICENSE NUMBER

IDENTIFICATION | AMOUNT AUTHORIZED

PRE - AUDIT | AUTHORIZATION

OFFICE USE

IN PUBLIC ASSISTANCE-MEDICAL SERVICES AN AUTHORIZATION FOR PAYMENT FOR DRUGS (REFILL OR PURCHASE) (OVER)

MOORE BUSINESS FORMS, INC. BU

CONNECTICUT

WELFARE CASE NO. (As shown on Medical Services Card) (1-12)
752-7-527527-52

PROVIDER NO. (13-18)
25725

IF PATIENT IS CHILD, PRINT NAME (Last, First) (25-32)

INVOICE NO. (19-24)
A 17576

NAME OF BENEFICIARY OR SUPERVISING RELATIVE (Last, First, Initial) (25-32)
JOHN L RECIPIENT

NAME OF PHARMACY
ANY DRUG STORE

DATE Rx FILLED (33-36) MO. / DAY / YR.

PHARMACEUTICAL MFRS. CODES:
1. Abbott Lab
2. Lederle Lab
3. Eli Lilly
4. Merck, Sharp and Dohme
5. Smith, Kline and French
6. Squibb
7. Wallace Lab
8. Warner Chilcott
9. Other

Rx FILE NO.	1. Orig. (✓) (54)	2. Refill (✓) (54)	IF REFILL, DATE OF ORIGINAL PRESCRIPTION MO.	DAY	YR.	PHYSICIAN'S NARCOTIC NO.	Quantity	Strength	PRESCRIPTION	MFR'S CODE (55-56)	CHARGE (73-79)
1.											$
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3.											
4.											
5.											

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APPROVED BY (Welfare Dept.)

TOTAL $

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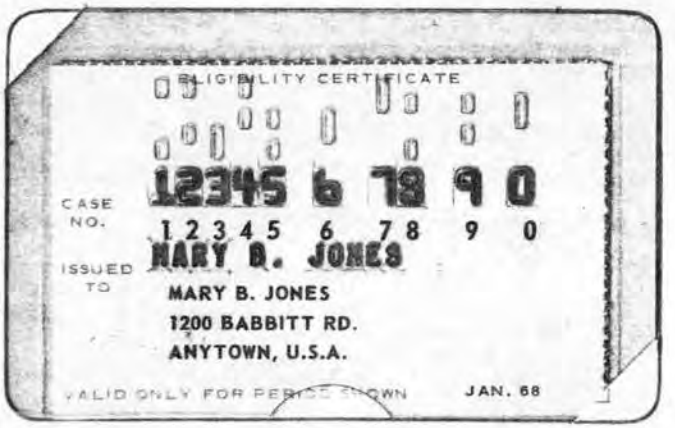


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DAVID N. TALBOTT
Assistant Executive Secretary

December 20, 1968

Mr. Charles H. Shreve, Regional Director
Department of Health, Education and Welfare
50 Fulton Street
San Francisco, California

Dear Mr. Shreve:

The invitation to make a presentation at the regional hearing which was called by Secretary Wilbur Cohen of the Department of Health, Education and Welfare for Friday, December 27, 1968 in San Francisco, although on short notice, was greatly appreciated. The implementation of Title XIX of Public Law 89-97 has generated much concern throughout the nation, and therefore, some basic principles need to be developed.

It is the belief of this Association that:

1. Comprehensive health care under Title XIX should be delivered through the existing structure for providing medical and related services.

2. The payment for such care should be through the utilization of existing voluntary health insurance prepayment plans.

This Association has advocated the use of graduated income tax credits for the purchase of health insurance from the presently available prepayment plans with emphasis on the use of local plans. Under the income tax credit system which we are proposing, there would be an actual reduction in tax for many of our medically needy. For the categorically needy, we propose the issuance of vouchers designated only for the payment of voluntary health insurance premiums.

To demonstrate the practicality of such a plan, the physicians of the Clackamas County Medical Society (Oregon City, Oregon) have approved a plan whereby the State Public Welfare Commission and its Clackamas County affiliate, beginning January 1, 1969, will purchase medical and related services for their recipients through the Physicians' Association of Clackamas County, a Blue Shield Plan founded in 1932. Under this plan, welfare patients will be cared for within the mainstream of our present medical care system. A complete outline of this plan will be presented at the Regional Health Care Cost Conference to be held in San Francisco, January 15-16, 1969 under the sponsorship of the Social Security Administration.

It would be appreciated if this statement would be included in the record of the hearing scheduled for Friday, December 27, 1968 in San Frncisco.

Very truly,

J. Richard Raines

J. Richard Raines, M.D.
President

JRR:db

cc: Senator Wayne Morse
Senator Mark O. Hatfield
Representative Edith Green
Representative Al Ullman
Representative Wendell Wyatt
Representative John R. Dellenback
Mr. Robert W. Packwood

State of Colorado

DEPARTMENT OF INSTITUTIONS

JOHN A. LOVE
GOVERNOR

STATE SERVICES BUILDING
DENVER, COLORADO 80203

DAVID A. HAMIL
DIRECTOR

December 23, 1968

AIRMAIL

Mr. Charles H. Shreve
HEW Regional Office
50 Fulton Street
San Francisco, California 94102

Dear Mr. Shreve:

It is my understanding that you will conduct hearings about the experiences with the Medicaid program on December 27. Since I will not be able to attend in person, I would like to take this opportunity of sharing a few thoughts with you, reflecting my limited experience as Chief of the Mental Health Division of the Colorado State Department of Institutions.

While Colorado will not implement the Medicaid program until January 1, 1969, and at that time only in relation to categorical recipients, we have had experience with the Long amendment since January of 1966. Since that time the State of Colorado has collected roughly 2½ million dollars in federal funds, all of which has reverted into the state general fund. Since our program dealing with geriatric problems was fairly far advanced at the time of the implementation of this program, not much further improvement in the hospital program for patients over 65 was possible. Community mental health programs have shown some progress in the last three years, but not proportional to the expenditures of the federal government under the Long amendment. In view of the accelerated inflationary trends of the past few years, a comparison with fiscal 1965 really does not make much sense. It would be quite possible for any state to show a 30% increase in dollar expenditure and at the same time to demonstrate that actual program has fallen behind by a few percentage points.

The point that I am trying to make is this: If the provisions of the Long amendment truly represent a maintenance of effort clause, then Congress should in some way modify the language of this section and realistically assure that the states in fact will comply with this requirement. The present provision clearly does not accomplish this job.

A second area of concern is the exclusion of hospitals other than general hospitals from reimbursement for the provision of inpatient services for psychiatric patients. It is clear that the intent of Congress was to prevent too large a drain on the treasury, if all hospitals, including state hospitals, had become eligible for reimbursement; Congress apparently failed to see the contradiction between the Medicaid legislation and Public Law 88-164. As you know, comprehensive community mental health centers can be operated by or be affiliated with portions of state hospitals or private psychiatric hospitals. In my own State of Colorado, four out of seven community mental health centers are affiliated with decentralized portions of state hospitals, and one private psychiatric hospital in the Denver area has just received a large construction grant under the provision of this act. I am particularly concerned about the future of this last mentioned hospital. Within 51 months after beginning of operations, their federal staffing grant will have expired. While other community mental health centers affiliated with a general hospital can count on Title XIX funds, this specialized mental hospital is excluded from such benefits. The Conference of the Region 8 Mental Health Authorities in 1966 recognized this situation and brought it to the attention of the National Institute of Mental Health. To our knowledge, no definitive action has been taken to correct this inequity. Our proposal at that time was to specifically include all inpatient services which were part of a bona fide community mental health center. I believe that this approach still represents the best possible compromise and would tend to give further impetus to the development of comprehensive community mental health centers through combination of services in whatever form that may exist in a particular community.

A third issue that concerns me, as well as all commissioners of mental health that I have had occasion to talk to, is the fact that the Medicaid program makes no clear provision for partial hospitalization. I am aware that an attempt is being made to cover partial hospitalization under the heading, "Outpatient Hospital Services." However, this approach also leads to complications and I believe a clear recognition by Congress that partial hospitalization is a separate and useful modality of treatment, not only for psychiatric patients but for other patients as well, would be more useful.

Finally, it has come to my attention that psychiatric aftercare services involving home visits are excluded from the benefits under the heading, "Home Health Services." It is my understanding that the rationale for this exclusion consists of the fact that the professional, such as a public health nurse in visiting a psychiatric patient, generally does not engage in certain physical activities such as changing of bandages, etc. If this is true, and I have this only second hand, I would consider this a very narrow interpretation of the law.

Sincerely yours,

Hans M. Schapire, M.D., Chief
Mental Health Division

HMS:dd
cc: Mr. Ray Craig
Mr. Harry C. Schnibbe

HAWAII MEDICAL ASSOCIATION
510 South Beretania Street - Room 201 - Telephone 567-702 - Honolulu, Hawaii 96813
Mabel L. Smyth Memorial Building

December 24, 1968

Mr. Charles H. Shreve
Regional Director
Department of Health, Education & Welfare
50 Fulton Street
San Francisco, California

Dear Mr. Shreve:

Re: Title XIX Public Hearing

The Hawaii Medical Association has had a very good relationship with the State Department of Social Services, which is doing an excellent job of administering Title XIX in Hawaii. Differences and misunderstandings have been resolved on a local level. The greatest problem in Hawaii, and probably elsewhere, is that many of the members of the State Legislature do not understand why the budget for the care of the indigent and medically indigent continues to rise year after year. It would seem to us that a nationwide educational program should be developed to make clear the Government's position relative to providing first-class medical care to all citizens, regardless of their ability to pay. The costs of such a program have been grossly underestimated from the very beginning and a more realistic attitude needs to be developed. If we are to eliminate class-bias in health care, the funds have to be appropriated to give the indigent and medically indigent the same opportunities as those who pay their own bills.

Very truly yours,

R. Varian Sloan

R. Varian Sloan, M.D.
Secretary

RVS:ph
cc: Robert M. Miyamoto, M.D.
George H. Mills, M.D.
Clifford T. Druecker, M.D.
Richard D. Moore, M.D.

12-14-68

RD

Dear Mr. Shreve!

I am a disabled person, and have been since May 1965- I'm not old enough for Medi-care- but get Social Security disability, $145.00 per month- State welfare gives me $140 per month as of Dec. 1ST- before that I was getting $100.00 per mo. ATD- So as you can see, I, myself, and many other totally disabled persons are trying to live on a very small allowance. according to the papers, the president is going to try and raise Soc. Sec. payments- The last time this was done it was deducted from what we were getting from ATD, and in my case, and I suppose many others- I ended up getting less (40 cents) than I had been getting before- 40 cents may not mean much to some people, but to me its 3 meals of Hamburger patties for instance- Secondly, Medicaid does NOT pay for many medicines. Being a thyroid victim I must have Proloid, and it was removed from the list last Mo. I have Vertigo very badly, and Med. Dramamine this they do not pay for, I cannot afford to get the last bit excited because it can, and does, cause blackouts, and causes heart to pound badly (my heart skips beats all the time) for this I take Miltrate, this too is not on the list. I have spastic muscles and for this I take Vit. B1- not on list- So you can see that there very little to live on- (in other words I'm a mess) my telephone is very necessary to

(D. St. Claire)

me as 2 live alone - its a matter of life and death to me - And the fee went up this month it was 390 plus tax its now 465 plus tax - as you know food is terribly high - ever since the clerks strike prices kep climbing, and the Mgr. at Safeway told me they would be going up again because of the Warehousemens strike - 2 can't go put out $200 at once for food coupons because that would leave me flat, and if some emergency came up 2'd be stuck, so 2 just buy from day to day - Its really rough on us poor stepchildren of Welfare - its always, mentally retarded - Aided and elderly, but for the ATD's nothing, they forgot to mention us when they pass laws to help people - 2 realize there are a lot of Welfare cheats - people are getting Welfare who have never paid or ever will pay taxes. 2 worked [redacted] for 31 years, paying taxes in this State, 2'm also a Native 4th generation - (that makes me a Minority) So please Sir. if Soc. Sec. is raised - DON'T LET THEM TAKE IT OUT OF OUR ATD - We need it

Thank you for listening

Joanne St. Claire
214-A-Bonview
San Francisco
Calif -
AT-2846

RD

Jerzy M. Szyfer
531 Hyde Street,Apt.2
San Francisco,California 94109

December 16,1968

Mr. Charles Shreve
Regional Director
Health Education & Welfare Depatment
50 Fulton Street
San Francisco,California 94102

Dear Mr. Shreve:

With reference to the Press anoucement that on December 27, 1968 a hearing on Federal Aid to Medically Indigent will be held in San Francisco and that the opinions on this subject are welcome from the recipients of Medi Cal, I am submiting my unfortunate experience.

I am a victim of cancer,recipient of Social Security Disability Insurrance but to young to be eligible for Medicair, on March 14,1966 I filed an application for the Medi Cal program with the Social Services Department in San Francisco.

Since then I have been pushed around by investigations,declarations and even been requested to resign from Medi Cal program,under a thread,by an "Senior Social Worker". Instantly I mailed a letter to Mr.Born which was ignored,so I made my own threads to go to the Court which of course produced an answer. On September 29,1966 I have been informed of my eligibility for the Medi Cal program and later on an ID-card has been mailed to me,which card I received every month.

In November 1966 I filed-in an application for dental works,which application was destroyed due to our illustrious Governor's "fiscality". After the "economies" in the Medi Cal have been overruled I filed the second application. This time my application got simply lost. I contaced again Mr.Born but the answer came through my doctor(D.D.S.) that a third application was necessary. On July 19,1968 I filed the third application which promptly was refused on July 31,1968. The refusal was based on "guide lines" and not on my medicall necessity. I refused to comply with to save my face from disfugiration and trayed to contact again Mr.Born. My letter was ignored therfore I took the liberty to address you and through your courtesy the Department of Health Care Services in Sacramento. On November 8,1968 I was instucted by Dr.Westmoreland to file again an application,the fourth this time,to the office of Dr.Romick. On November 12,1968 the applicatio with X-Rays has benn filedin and I hope that this time will not get lost and will get a favorable decision.

It is exactly two years as I am striving to get medicall help.

Unfortunately,the whole case has an other,and I would say,

Mr. Shreve:

66666

AN UGLY CHAracter of stisfying litle egos of "Social Workers" and teir bigness of positions.

To illustrate,after I voiced my dissent to the decision of Dr.Yee, believe or not,but my ID*-card has been revoked and only after direct order from Dr.Westmoreland I started to receive it again. This is how Social Workers opperate,you get out of line and they stop payments or ID-cards,as it was with me becouse I refused any monetary help,and if ring up the office,nobody knows whot ~~you~~ I am talkin about.

It's hard to believe that nobody in the Social Service Dept. had not enough brains to arrange the ID-cards for poeples like me to be send once or twice a year and not every month, taking in consideration that I don't get any monetary help, but sending once a year they wouldn't had any pressure over me. This is why it's ugly,besides,the so called economy in printing and mailing costs every month.

Their methodes of punishment can be very costly in consequences to both parties.

It's a pity,that the Congress of 1966 failed to include all poeples like me,under the Medicair program,regardless of age and lets hope that the Congress of 1969 will do so,as it is the only and workably and practical solution in which we the recipients will get our medicall aid with dignity.

Respectfully yours,

Jerzy M. Szyfer

California Hospital Association

AFFILIATED WITH AMERICAN HOSPITAL ASSOCIATION

WILLIAM M. WHELAN
Executive Director

SUITE 1011 · 111 PINE STREET · SAN FRANCISCO, CALIFORNIA 94111 · 981-3491

Statement of Samuel J. Tibbitts
on behalf of the
California Hospital Association
to the Health, Education & Welfare Regional Hearing
on Desirable changes in the Medicaid, Title XIX Program
San Francisco, California
December 27, 1968

I am Samuel J. Tibbitts, President of the California Hospital Association, representing 559 licensed hospitals in California. The Association is grateful for the invitation from Mr. Shreve to take part in this hearing on the Medicaid, Title XIX Program.

This Program in California is called Medi-Cal. Our Association actively worked with the California Medical Association, the County Supervisors Association, representatives of organized labor and other consumer and provider groups as well as the State Administration, the Health and Welfare Departments and the Legislature to develop this Program.

The basic concepts are anchored in sound public policy. The program provides a broad scope of needed medical care with free choice of physicians, dentists, and other providers as well as services in hospitals and nursing homes. Nearly all hospitals in California are providing services to eligible Medi-Cal beneficiaries.

Statistical studies show that in fiscal 1966-67, over two million different individuals were eligible for at least one month. Slightly over nine percent of eligible persons in that fiscal year obtained inpatient hospital service in community hospitals and three percent in county hospitals.

Nearly sixteen percent of eligible persons used hospital outpatient services during the fiscal year. The average length of hospital inpatient stay for Medi-Cal patients under 65 in community hospitals was the same as for other patients under 65 in the same hospitals. This study disclosed that a small fraction of the eligible population - about 5.5 percent - accounted for over half of the total expenditures for the year. The average yearly cost of these persons was about $2,400 per person per year. This program covers the needy totally disabled and blind as well as those 65 and over. Their cost of care might be expected to be great.

There have been some growing pains to be sure and some utilization problems. Many of the problems have been identified by the intermediaries and the State and are being corrected. The beneficiary, if questioned, would, we believe, report he appreciates the single standard high quality medical services system in which he now participates.

You requested suggestions for improving the Title XIX Program.

1. We recommend that the categorical linkage requirement of Title XIX be eliminated by the Congress. From a public policy and practical point of view, it produces senseless inequities to have different sets of eligibility requirements and a different scope of medical benefits for the categorical poor and the non-categorical poor. It also produces almost unbelievably complicated financial responsibility relationships between State

and county governments in California. The matter of eligibility determination needs to be simplified and made uniform. Similarly, states should have more voice in the formulation of Title XIX regulations generally. Constructive adjustments in California have been made more difficult by Federal rigidity.

2. We recommend that Congress continue to strengthen the Administration of this Program through experienced fiscal intermediaries or through prepayment.

   The administration of this Program in California by intermediaries has been satisfactory for the State and for the providers. The administrative cost of the Program has been very low - approximately one percent of the total cost of the services paid. From the standpoint of hospitals, the annual final audit system for Medicare, also used for Medi-Cal, provides adequate safeguards against over-utilization and fraud.

3. The Medicare reimbursement formula apparently may not return full costs to all hospitals. We believe many public officials and members of the Congress recognize this fact. We urge that incentive reimbursement studies continue to be sponsored by the government under both Title XVIII and Title XIX. They will provide added safeguards to efficiency and honesty. Approximately forty percent of hospital patient days in California now are being paid by these two programs. We submit it is sound public policy

to promote efficiency and effective hospital management. To the greatest extent possible all patients in hospitals should assume their share of the total cost of hospital care properly related to the cost of their care.

4. It is strongly recommended that the Administration and Congress consider simplification of the hospital payment process for recipients who are eligible under both Title XVIII and Title XIX. The present requirements of Title XVIII are causing delays and complexities which good administration and sound policy dictate should be improved.

These programs have set high standards for hospital services and effective utilization controls. We support these standards and in our own State are also imposing self-education and regulation through a system of peer review, which enables the industry itself to correct over-utilization among participating hospitals.

A program to promote greater hospital management effectiveness is also being sponsored vigorously by the California Hospital Association in an effort to at least flatten out the curve of rising costs. We anticipate that this can be accomplished by more efficient utilization of existing resources.

We believe Title XIX offers unusual opportunities for pilot-project experimentation in the field of preventive medical services. Certainly a great deal can be done to keep medically needy people from getting so

sick that expensive hospitalization is required. Hospital outpatient systems have a proper role to play in this segment of the health care delivery system. California hospitals are seeking ways to work with physicians to provide outpatient services that will improve health and save money.

In conclusion - we think the Title XIX program in general is sound. We would like to see Congress eliminate the categorical linkage requirement and thereby simplify and encourage more uniform eligibility requirements, continue to promote incentive reimbursement for hospitals which operate efficiently, continue to strengthen administration of the program through intermediaries and continue to strengthen development of a single high standard of voluntary health care available for all, whether this care is paid for in whole or in part from public funds. We would also like to see attention given to a simplification of payment for services obtained by persons eligible under both Title XVIII and Title XIX. Finally, we strongly urge that the 1975 goals set in the original legislation, Federal and State, be maintained. We are well started in California. We should not modify the objective of complete care for all poor people by the middle of the new decade. It is not too expensive. It is a good investment in the vitality of our nation.

smc

STATEMENT BY
CHARLES A. O'BRIEN
CHIEF DEPUTY ATTORNEY GENERAL
PRESENTED AT
DEPARTMENT OF HEALTH EDUCATION AND WELFARE
HEARING ON MEDI-CAL PROGRAM
December 27, 1968

Gentlemen, I am happy to appear here today as the representative of the California Department of Justice. I have presented you with a copy of the report on the operation of the Medi-Cal Program which our office issued last month. This report -- aimed primarily at determining the extent of abuse in the program -- will inform you of our basic concerns over present operations of the program.

Since the issuance of the report, we have continued to receive substantial information concerning abuses of the program. This information has come from members of the various medical professions, from persons receiving care through the program, and from persons in government who have been connected with the program.

This new information has not caused us to reconsider any of the statements in our report -- except in one aspect: We may have <u>understated</u> our criticism.

Prosecutions will be initiated in California against the most flagrant violators, but we recognize that this is certainly not a complete answer to the problem. As we emphasize in our report, substantial changes in the administration of the program are required.

Since we issued our report, a medical official in

another state informed us that we could remove the cover from our report, replace it with the name of his state, and reissue it with no other changes. He told us that every problem and every abuse which we discussed are present in his state's program.

From the outset, we have attempted to make it clear that our only goal is to improve -- not to impede -- this program. We consider it an essential program in meeting the medical needs of Californians. We have also emphasized that our discussion of fraud in the program related to only a small percentage of professionals involved in the program.

We estimated that minimally six to eight million dollars annually are being drained from the program by illegal and unethical activities. While admittedly this involves only a fraction of the annual budget and a fraction of the Medi-Cal practitioners, we found that investigation of this problem pointed to very serious problems in the general administration of the program. The consideration of program changes to eliminate cheating led us to consider changes which would improve the entire program. For example, improvement in computer programming to ferret out cheaters leads inevitably to the consideration of new computer procedures to improve overall administration of the program.

I will not attempt today to discuss with you all the findings of our report or the fourteen recommendations which we made for improvement of the program. You have the document.

I would mention one general finding: In our opinion,

a major contributor to the general problems of Medi-Cal administration in Califoria results from the pressure for California to take immediate advantage of the funds available under Title Nineteen. More allowance for cooperative preparation and analysis would certainly have resulted in a better program. In the formulation of future programs, greater efforts certainly should be made to provide for adequate preparation.

Rather than dwell on any particular aspects of our report, I would rather devote the remainder of my time here to answering any questions which you may have concerning our report.

Thank you.

#

REPORT ON MEDI-CAL PROGRAM

BY

CALIFORNIA DEPARTMENT OF JUSTICE

November 6, 1968

THOMAS C. LYNCH, Attorney General
of the State of California

CHARLES A. O'BRIEN
Chief Deputy Attorney General

HERBERT DAVIS
Deputy Attorney General

State of California

M E M O R A N D U M

TO : Herbert Davis
Deputy Attorney General
Los Angeles

DATE: February 5, 1968

FROM : Charles A. O'Brien
Chief Deputy Attorney General

SUBJECT: MEDI-CAL INVESTIGATION

This office continues to receive information concerning widespread abuses of the state's Medi-Cal Program. These alleged abuses include fraud, kickbacks, inflated charges and double-billing by persons providing services under the program.

We have held two meetings in San Francisco to explore this problem and have concluded that it merits investigation. Since the bulk of the Medi-Cal expenditures are in Southern California, any investigation should properly be directed from the Los Angeles office. It is assigned to you, as head of our Health Plan Registration Unit.

In conducting this investigation, our aim should be to improve -- not to impede -- this program. Medi-Cal is an essential state program, which is allegedly being hampered by fraud and mismanagement. Our primary effort should be to determine the extent of fraud -- if any -- and the possible remedies, either through criminal prosecution or administrative action. We should also be prepared to make recommendations to improve the management of the program, if our investigation discloses areas requiring improvement.

Chas O'Brien

CHARLES A. O'BRIEN
Chief Deputy Attorney General

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State of California

M E M O R A N D U M

TO : CHARLES A. O'BRIEN
Chief Deputy Attorney General

DATE: November 6, 1968

FROM : Office of the Attorney General
Herbert Davis - Los Angeles

SUBJECT: REPORT OF MEDI-CAL INVESTIGATION

INTRODUCTION

On February 5, 1968, the Attorney General ordered an investigation of the California Medical Assistance Program (Medi-Cal).

The investigation was based upon information received in this office from numerous persons which indicated extensive fraudulent activities and other abuses by persons participating in the Medi-Cal Program.

The Medi-Cal Program commenced on March 1, 1966. For the fiscal year ending June 30, 1967, Medi-Cal paid approximately $600,000,000 to 70,000 vendors who provided services to 1.5 million persons eligible to receive benefits under the program. It is estimated that Medi-Cal will spend around $800,000,000 in the current fiscal year.

Of the money spent under the Medi-Cal Program, approximately fifty per cent is paid by the federal government with the state and counties contributing the remainder of such funds.

Our investigation indicates that illegal and unethical activities of persons providing services under Medi-Cal are siphoning millions of dollars annually from the program. Poor administration of the program has contributed to further needless expenditure of money by Medi-Cal.

The vast scope of the program precludes any precise estimate of the total amount of funds paid out due to poor administration of the program, outright fraudulent activities and the excessive providing of services.

Our investigation leads us to conclude that six to eight million dollars annually is being drained from the program by illegal and unethical activities of various professionals involved in Medi-Cal. This would not include funds paid out in error and as a result of faulty administration.

The primary abuses of the program involve submission of false claims, kickbacks, and overservicing.

In February 1967, Governor Reagan appointed a Task Force to review the administration of the Medi-Cal Program. This committee recommended changes which would allegedly save Medi-Cal $90,000,000 annually.

The Office of Health Care Services, which administers Medi-Cal, estimates a total of 2.5 million dollars in overpayments have been made to individual practitioners since the inception of the program. For the fiscal year ending June 30, 1968, vendors voluntarily returned 1.5 million dollars in overpayments. Thousands of dollars in overpayments are still voluntarily being returned each month.

In addition to the violations of the laws and regulations of Medi-Cal by the vendors, the investigation disclosed that an effective enforcement program to discover, investigate and deter such activities does not exist.

The complex nature of Medi-Cal and the large numbers of participants -- both vendors and recipients of health care services -- prohibited a thorough investigation by the Department of Justice into

the conduct of each individual vendor suspected of engaging in unlawful or unethical activities. The investigation was therefore conducted primarily to determine the nature of abuses being engaged in under the program.

This report does not attempt a complete "white paper" on the Medi-Cal Program. It does attempt to identify the problems and supply new guidelines -- especially in the area of enforcement -- which will result in savings for the taxpayers by curtailing the current amount of abuse.

In preparing this report we recognized the problems confronted by Health Care Services in administering a program which was hastily conceived and implemented. The necessary planning and research needed for the effective operation of the worthy goal of the Medi-Cal Program unfortunately did not accompany the initial enactment of the program. This is certainly not the fault of Health Care Services.

There is a lesson here for both the state and federal governments. The enactment of federal legislation which requires immediate response from the states to take advantage of federal funding is laden with peril, as well as with token prosperity. Unprepared and without sufficient analysis, the states are rushed into formulating programs which are both essential and ill-considered. There should be an effort by both federal and state governments to transform such programs into more meaningful and fruitful cooperative actions.

////

SUMMARY OF RECOMMENDATIONS

1. Establish an Effective Investigating Unit
2. Improve Procedures to Expedite Suspension Proceedings
3. Publicize Existence and Actions of Investigating Unit
4. Establish Liaison with Professional Licensing Boards
5. Improve Communication Between Organizations Participating in the Administration of the Program
6. New Regulations
7. Review Procedure of Processing Claims
8. Improve Use of Computers
9. Review Claims on a Local Basis
10. Post Examination of Claims
11. Controlling the Cost of Drugs
12. Scope of Benefits
13. Third Party Liability
14. Purchase of Appliances

THE INVESTIGATION

I Background

Medi-Cal became effective on March 1, 1966. The program was placed under the supervision of the Health and Welfare Agency which established the Office of Health Care Services (HCS) to administer the program.

Prior to Medi-Cal's enactment, the State of California provided health care services to indigents through a variety of different programs known as Public Assistance Medical Care and Medical Assistance to the Aged. These programs were administered by the various counties in the state. Administration of these programs involved determining eligibility of recipients, authorizing vendors to provide health care services and receiving, reviewing and processing claims of vendors for payment. (Some counties contracted with California Physicians' Service to assist them in administering the program.) Professional consultants were used by the counties to assist in reviewing claims and to authorize requests to provide services.

Medi-Cal was passed in response to Title 19 of the Social Security Law which provided that the federal government would share on a 50-50 basis in the cost of California's new program including services then being financed entirely by the state or county. This permitted the unification of all major governmental health care systems which provided care for the indigents into a single system financed by the state, counties and federal government.

The state contracted with California Physicians' Service (Blue Shield) and Hospital Service of California and Hospital Service of Southern California (Blue Cross) to act as fiscal intermediary agents. As a result of these contracts the processing of

claims for payment was largely shifted from the counties to Blue Shield and Blue Cross, although county consultants were still retained to grant requests for prior authorization.

Blue Shield is responsible for processing claims of individual vendors (e.g., physicians, dentists, etc.). All claims are processed by Blue Shield in their San Francisco office.

Blue Cross is responsible for processing claims of institutional vendors (e.g., nursing homes, hospitals, etc.). Claims in Northern California are processed in Oakland. Claims in Southern California are processed in Los Angeles.

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II Vendor Abuses

The investigation revealed that vendors are engaging in unlawful activities and are also bilking the program by providing excessive services to beneficiaries.

(1) Unlawful Activities

The methods by which vendors participating in Medi-Cal engage in unlawful activities can be classified into two main categories: Submission of false claims and kickbacks.

(a) Submission of false claims

This occurs when vendors request payment for services which they have never rendered or falsify information on claims (e.g., knowingly request excessive reimbursement). The submission of a false claim for payment is a felony. (Penal Code section 72.) The acceptance of payment upon a false claim would also constitute the crime of theft.

(b) Kickbacks

Vendors violate Medi-Cal regulations when they agree to give or accept kickbacks -- money or other forms of unearned consideration -- in return for the opportunity to provide services to Medi-Cal beneficiaries. Such activity is a ground for suspension from the program. Depending upon the type of vendor it might also be ground for a criminal prosecution or disciplinary action against his license.

(2) Overservicing

While some vendors have cheated Medi-Cal by engaging in unlawful activities, others have taken advantage of the program by providing excessive and unnecessary services for the primary purpose of obtaining greater reimbursement under the program. Overservicing

is grounds for suspending a vendor from participating in the Medi-Cal Program.

Discussed herein are various types of abuses by vendors which were found to be prevalent under the program. In describing these abuses we recognize that they may in fact be engaged in by only a small number of providers. Nevertheless, the extent to which they do occur and the millions of dollars drained from the program by such activities merit their exposure to the public and to appropriate public agencies.

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A. Nursing Homes

There are approximately 1,000 nursing homes licensed by the State of California. This class of vendors receives approximately $140,000,000 a year for providing services under the Medi-Cal Program. Except for hospitals this is the largest portion of Medi-Cal funds paid to any single class of vendors.

The maximum fee paid to nursing homes for caring for a Medi-Cal beneficiary is $14.00 a day. This fee is based on a formula which determines the homes' "cost of operation."

The investigation revealed that nursing homes are engaging in numerous activities which violate the laws and regulations governing Medi-Cal.

(1) Many nursing homes require beneficiaries or their relatives to pay money "under the table" to secure admission of the beneficiary into the home. Such payments are often required not just upon the initial admission of the beneficiary but also for each month the beneficiary is kept in the home.

A Medi-Cal regulation provides that vendors under the program shall not, in addition to being reimbursed from Medi-Cal, collect or demand reimbursement from beneficiaries or from other persons on behalf of beneficiaries.

(2) Medi-Cal beneficiaries in nursing homes receive $15.00 per month from the county for incidental expenses (e.g., cigarettes, candy, etc.). In many homes this money is maintained by the nursing home on behalf of the beneficiary.

The investigation has disclosed that some nursing homes misappropriate this incidental expense money which they maintain on

behalf of beneficiaries. In one case, for example, it was found that a nursing home was in possession of some $2,000 which belonged to persons who either died or who were discharged from the home.

(3) Several nursing homes have been found to be submitting claims to Medi-Cal for services rendered to patients who either died or who had been discharged from the home prior to the period covered in the billing.

One home, for example, received $3,000 for rendering services to patients who had in fact died prior to the date of the alleged services.

(4) Another abuse which was found relates to the receipt of duplicate payments by nursing homes. This can occur in situations where the fiscal agent accidentally makes the duplicate payment or where the nursing home submits a duplicate payment hoping to be paid twice. In either situation the unethical vendor retains the duplicate payment without notifying the fiscal agent.

We have already noted that HCS itself estimates that approximately 2.5 million dollars in overpayments have been made to all types of vendors.

Duplicate payments also occur where a nursing home has patients who are eligible to receive benefits from both Medi-Cal and Medicare. While Medi-Cal is only supposed to pay that amount which Medicare does not cover, the submission of duplicate claims under both welfare programs often results in the nursing homes getting paid in full from both Medi-Cal and Medicare. One nursing home, for example, received a duplicate payment of approximately $50,000 by billing in this manner.

Nursing homes may also receive duplicate payment in another manner. A home is reimbursed by Medi-Cal for providing a service, yet it also bills and receives payment for this same service from the patient or his relatives. Many persons receiving Medi-Cal benefits do not know that the services they are billed for have already been paid by Medi-Cal.

(5) The investigation revealed that it is common practice for nursing homes to require vendors with whom they deal to give kickbacks in order to provide their services to persons in the nursing home.

In some instances the kickbacks ranged as high as 35% of the fee received by the vendor.

Kickbacks are prohibited by Medi-Cal regulations. Nevertheless, it is a common practice for vendors such as pharmacists, therapists, X-ray technicians and laboratory clinics to give kickbacks in order to obtain business from nursing homes.

(6) Nursing homes often provide services to their residents which are greatly in excess of the services actually needed. Such overservicing is cause for dropping a nursing home from the Medi-Cal program.

(a) Our investigation indicated that some nursing homes order drugs far in excess of the quantities required by their residents. This situation can occur since physicians often prescribe continuous medication for persons in the homes and the homes determine when to

order the medication. For example, one nursing home had a patient who was to take three pills a day. A prescription of 100 pills would have lasted an entire month. The home, however, ordered three prescriptions, each for 100 pills, during this one month.

The temptation of this abuse is enhanced in those situations where there is either common ownership between a nursing home and pharmacy or some kickback arrangement between the home and a pharmacy. Common interests in nursing homes and pharmacies are, in fact, becoming more prevalent under the welfare program.

(b) Another method by which excessive services are provided is where nursing homes have arrangements with vendors such as physicians, dentists, optometrists, podiatrists, etc., which permit them to examine persons in the home whether or not their services are required or requested.

Indications of "mass examinations" by such vendors have been observed by county consultants throughout the state in the course of their processing requests for prior authorization. Persons in the home seldom object to such examination since they are not usually required to pay for such services.

(c) Information has been obtained which indicates yet a third method by which excessive services are provided by nursing homes. This relates to the situation where a nursing home attempts to "qualify" Medi-Cal patients for Medicare. Since nursing homes receive greater reimbursement for persons who are eligible for Medicare than they do for persons eligible for Medi-Cal it is to their benefit to have a patient classified as a Medicare patient.

To be eligible for Medicare benefits while in a nursing

home the patient must have been hospitalized for a period of three days. A former administrator of a nursing home has alleged that some nursing homes have an arrangement with hospitals whereby Medi-Cal patients are transferred from the home to the hospital for a period of three days and then returned to the home.

The nursing home benefits by this arrangement since it receives reimbursement at the greater rate from Medicare when the patient is returned to the home. The hospital benefits because it is reimbursed for providing services to the patient which usually include laboratory tests, x-rays, etc. (Under such an arrangement the nursing home or hospital usually has a physician who authorizes the patient to be hospitalized.)

This type of activity not only provides services to a patient which were not needed nor requested, but the question of "eligibility" may determine whether a nursing home will accept a Medi-Cal patient into the home.

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In addition to effecting services provided under Medi-Cal, the unlawful activities of nursing homes also effect services provided under the federal program of Medicare. The activities described also result in a needless expenditure of funds under that program. Indeed, the scope of such unlawful activities was a matter of inquiry before a congressional subcommittee on Long Term Care in 1965. Testimony given before this subcommittee indicated that many of the activities we have described concerning nursing homes are prevalent throughout the nation.

B. Hospitals

The largest share of Medi-Cal funds, approximately $220,000,000 is received by hospitals. Of this amount, $120,000,000 goes to county hospitals. The remainder goes to private and non-profit hospitals.

We concentrated our investigation of hospitals on the profit making variety. There have been no indications that the abuses we are studying are prevalent in public and non-profit institutions.

Generally, we discovered that many of the abuses which we have seen in nursing homes occur equally in hospitals. Such abuses include overservicing, kickbacks and double billing.

These Medi-Cal abuses seem to be predominant in physician-owned hospitals. Since there are no significant differences in the patterns of abuse in nursing homes and hospitals, we will not offer extensive examples of hospital problems.

Our comments on nursing homes clearly indicate the Medi-Cal problems which may be found in hospitals. An audit of just seven hospitals, for example, between March and August 1968, resulted in a recovery of $136,000 by Blue Cross.

C. Physicians

Medi-Cal pays around $95,000,000 a year to 18,000 physicians who participate in the program.

(1) The primary fraudulent activity engaged in by physicians as disclosed by the investigation has been submitting claims for services which were not in fact rendered by the physicians.

One area in particular where this type of activity occurs relates to physicians submitting claims for having examined patients in nursing homes, although such examinations were not in fact performed.

Due to problems which hamper investigative activities into fraudulent activities (discussed infra) the investigation was unable to determine the extent to which this type of conduct occurs.

(2) Overservicing is the major problem concerning physicians in the Medi-Cal Program. This involves services which are not necessary for a patient's well being, but which are provided primarily for the purpose of obtaining additional fees under the Medi-Cal Program.

(a) Examples of activities involving such overservicing include unnecessary examinations, office visits, laboratory tests, x-rays, injections and surgical procedures.

(b) The placement of persons in nursing homes whose physical condition does not require such extensive care is another form of over-servicing.

In Los Angeles County alone during a one-year period of time some 1300 persons were requested to leave nursing homes by county consultants because their physical condition no longer required such extensive care.

(c) Many nursing homes have "house physicians". These are physicians who have an arrangement with nursing homes whereby they

take care of the persons in the home. By having a "captive audience" the physician is able to realize a significant amount of income regardless of the actual need of the individual residents.

Under this type of arrangement however a physician may often compromise his professional judgment to the point where he relies upon recommendations made by the nursing home itself as to services to be given to the patient.

For example, our investigation revealed incidents where physicians signed blank prescriptions which were given to them by the nursing home and which were subsequently completed by the home itself. In one instance, a physician thought he was signing a prescription for a drug when in fact it was filled in by a nursing home for a wheel chair for a patient who was ambulatory. In another case, 75 blank prescriptions signed by a doctor were found in a nursing home. Review of claims by consultants have also given rise to suspicion that it is the nursing home which prepares the forms describing the physical condition of persons who seek admission into the home. The "house physicians" sign such forms although they, in fact, have not examined the patients.

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The determination of whether a physician is providing excessive services is one which usually requires the judgment of other physicians. Claims of physicians are processed for payment by Blue Shield. Blue Shield maintains a Utilization Committee which began functioning in February 1967. One major purpose of this committee is to discover physicians who overutilize the program.

As will be seen later in this report, the current method of reviewing claims submitted by physicians does not maximize the

discovery of abuses. Nevertheless, as of September 30, 1968, the Utilization Committee had discovered approximately 1000 physicians who had engaged in overutilization. As a result the committee either recovered or made adjustments in the doctors' claims to the extent that Medi-Cal realized a savings of approximately one half million dollars.

In addition to the Utilization Committee, physicians who act as advisors for Blue Shield at the county level have saved the program approximately $2,000,000 in just the first six months of this year based upon their review of claims submitted by physicians.

The question of overservicing also arises when doctors receive huge fees from the welfare program. Over 3 million dollars in payments have been made to just 35 physicians in a period of one year, with payments ranging from $70,000 to $131,000 each. Investigation disclosed overservicing by many of these physicians.

Physicians with a financial interest in pharmacies, laboratories and hospitals are also presented with the opportunity of subjecting Medi-Cal beneficiaries to these services although they may not be required for medical reasons. For example, of four hospitals whose claims are under constant review by Blue Cross to determine if excessive services are being provided, all four are owned by physicians.

One blatant example of unnecessary services in a physician-owned hospital concerns a patient who was hospitalized for sixteen days. Ten blood tests, many of them identical, were taken each day the patient was hospitalized. Of the 160 tests taken, not one revealed an abnormal finding. Multiple X-rays of the chest, skull and cervical spine were also taken although here again no abnormality

was ever revealed. This type of overservicing was similarly provided to many other patients in this same hospital.

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D. Pharmacists

There are approximately 4,900 pharmacies in the State of California. For the fiscal year ending June 30, 1967, pharmacies participating in Medi-Cal received 40 million dollars from the program.

Until recently, the formula used to reimburse pharmacies for drugs they dispensed was the cost of the drug, plus 50% of the cost, plus a fee of $1.15. Thus, if a drug cost $1, the pharmacy would receive $1 plus 50 cents plus $1.15, for a total of $2.65.

Under a recent regulation this was changed to the cost of the drug, plus a professional fee of $2.30 per prescription.

The investigation has revealed numerous ways in which pharmacies are engaging in activities which violate the laws and regulations governing Medi-Cal.

(1) HCS publishes a drug formulary which contains instructions as to the manner in which pharmacies are to determine the cost of their drugs when billing the Medi-Cal Program.

Pharmacists are instructed not to charge the state a price which is in excess of the price charged to the public for the same drug. Based upon investigations made both before and since the enactment of Medi-Cal, it appears that a large number of pharmacies are violating this instruction.

This conclusion is based on the fact that prior to Medi-Cal, Los Angeles County (which contains approximately 45% of the pharmacies in the state) maintained a staff of investigators who would make periodic visits to pharmacies to determine if the county was being charged a higher price than the public for the same drugs. This spot-check revealed that a vast majority of the pharmacies visited

were, in fact, selling identical drugs at a lower price to the public than to the welfare program.

With the enactment of Medi-Cal, the staff used by Los Angeles County to do such field audits ceased to exist and HCS does not have personnel who check on pharmacies in this manner. It is therefore highly unlikely that the practice of excessive billing ended with the enactment of the Medi-Cal Program. Indeed, spot-checks which have been made on pharmacies since Medi-Cal revealed that a majority of the pharmacies visited are still charging prices to the state which are in excess of those charged to the public.

There is a special problem involving the difference in drug prices charged to public agencies and private individuals. This involves private health programs which may pay less for drugs than the public welfare program. For example, the United Auto Workers is negotiating a contract under which Blue Shield would cover the expense of drugs purchased by members of the union. Under the proposed contract, the UAW Program would pay less for drugs than the state welfare program.

(2) The drug formulary instructs the pharmacist to dispense the lowest cost item which he has in stock provided that it meets the requirements of the practitioner as shown in the prescription. Many pharmacies are not complying with this instruction. For example, in situations where an inexpensive generic drug could have been dispensed, the patient has been given an expensive brand name drug which resulted in greater reimbursement to the pharmacy under the formula previously described.

Many drugs have both a brand and generic name. A brand name is always more expensive than the generic name drug. Often,

the brand name is as much as two or three times more expensive.

Examples of the difference in price can be seen by a comparison of the cost of some leading brand name drugs with the cost of comparable generic drugs.

Brand Name		Comparable Generic	
Achromycin Caps - 250 mg		Tetracycline Caps - 250 mg	
100--	$11.22	100--	$4.20
Peritrate Tabs - 10 mg		Pentaerythritol Tetranitrate Tabs - 10 mg	
100--	2.50	100--	.65
1000--	22.50	1000--	3.00
Seconal Sodium - 1-1/2 gr		Secobarbital Sodium-1-1/2 gr	
100--	2.16	100--	1.25
1000--	19.92	1000--	8.80
Tedral Tabs		Theophylline, Ephedrine & Phenobarbital Tabs	
100--	3.18	100--	.60
1000--	28.60	1000--	4.65
Noctec Caps - 7-1/2 gr		Chloral Hydrate Caps - 7-1/2 gr	
100--	4.20	100--	1.75

(3) Visits to nursing homes, hospitals, sanitariums and homes of patients revealed that some pharmacies give patients a generic drug but bill the state as though the brand name drug had been dispensed. Under the formula for reimbursement the excessive expenditure made by Medi-Cal due to such false claims can amount to a significant amount of money.

(4) The investigation revealed that pharmacies often purchase drugs in large quantities but bill Medi-Cal at a cost

premised upon a minimum quantity purchase. This results in the pharmacy receiving more than its actual cost for the drug dispensed. Furthermore, Medi-Cal not only pays out excessive money for the cost of the drug, but the excessive expenditure is compounded when this higher cost is used in applying the formula for reimbursement.

Under the formula for reimbursement, a pharmacist is supposed to bill Medi-Cal for his "cost" of the drug dispensed. The drug formulary prescribes that the pharmacist shall apply the maximum allowable wholesale cost or his actual cost, whichever is lower" in calculating the cost of the drug dispensed.

Most pharmacies buy certain drugs in large quantity (e.g., on a thousand lot or gallon basis) so that the cost per hundred or per pint of the drug is cheaper than if purchased in a quantity of hundreds or pints.

Drugs purchased on a minimum quantity basis are more expensive than drugs purchased in large quantities.

The difference in cost when buying small quantities as compared to large quantities can be illustrated by the following examples:

Name of Drug	Cost for 100	Cost for 100 on Purchase of 1,000	Percent of difference
Lanoxin Tabs 25 mg	$1.14	$ .80	42%
Nembutal	2.16	1.62	33%
Butisol Sod. Tabs-1/2 gr	2.15	1.84	17%

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An audit of a single pharmacy's prescriptions paid by the state during a two-month period revealed that the pharmacy overstated its cost of drugs at an average of 38 cents per prescription. During the year, this pharmacy submitted 14,000 prescriptions to Medi-Cal. Applying the excessive cost of 38 cents per prescription, the state may have overpaid this one pharmacy some $5,300 for the year.

(5) It is permissible in California for a pharmacist to fill a prescription which has been authorized by a physician over the telephone. Whenever a pharmacist gets a request from a person other than a physician for a prescription, it is the duty and responsibility of the pharmacist to contact the physician prior to issuing the drug.

Analysis of prescriptions submitted for payment by pharmacies disclosed several situations which indicate that the drugs were probably not authorized by the physician and sometimes never dispensed by the pharmacy. Examples of such situations are described below.

(a) Some pharmacies needlessly dispense multiple prescriptions of the same drug to the same patient over a short period of time. Examination of such prescriptions revealed that if the drug was taken as directed, there was no need to dispense the quantity of drugs indicated on the prescriptions submitted for payment.

For example, a pharmacy might submit for reimbursement to Medi-Cal four prescriptions written for the same patient during a thirty-day period of time. Each prescription was for 30 pills

of the same drug or a total of 120 pills. If the pills were taken as directed in the prescription (e.g., 1 pill twice a day), 60 pills would have been sufficient for the entire month.

This situation also occurs when nursing homes order prescription medicines. In such circumstances, pharmacies often prepare multiple prescriptions to meet the quantity ordered rather than writing a single prescription. Since pharmacies were reimbursed on a basis of cost, plus 50% of cost, plus $1.15 fee per prescription, they were able to obtain greater reimbursement by writing several prescriptions for small quantities of a drug rather than writing one prescription for a larger quantity.

(b) Some pharmacies dispense an excessive number of prescriptions for a particular patient or family on one day, or within a relatively short period of time.

In one case, 15 prescriptions were dispensed to a single family on a given day. The family consisted of a husband, wife and three children. The 15 prescriptions involved only three different medicines. An identical prescription for each member of the family was written for each of the three medicines. (E.g., each member of the family got a prescription for 4 ounces of the same cough medicine; each member of the family got a prescription for 2 ounces of the same antibiotic.)

(c) Misuse of "preprinted" prescriptions is another problem revealed by the investigation. A preprint is a prescription form which is already printed to contain such information as the name of the patient, name of drug, quantity of drug, directions for use, name of doctor and name of pharmacy. Pharmacies prepare

these prescription forms without any request from a physician for such a prescription. Allegedly, they are prepared to improve service to regular customers.

Acutal misuse or temptation to misuse such preprints is patently obvious. A successful criminal prosecution was brought against a pharmacist who used preprinted prescription forms to submit false claims. This pharmacist had never dispensed the drugs indicated on the preprinted forms which he submitted for payment.

In most of the examples mentioned an examination of prescriptions indicated that they were in fact written by the pharmacist as telephone prescriptions. Inquiries were made to physicians whose names appeared on suspicious prescriptions. A majority of the physicians who responded stated that they did not authorize the issuance of the prescriptions.

(6) Nursing homes usually order all the drugs required by persons residing in the homes. This often amounts to the purchase of a few thousand dollars worth of drugs per month. The investigation revealed that many pharmacies are giving kickbacks to nursing homes in order to obtain their business. One pharmacy has even sent letters to nursing homes offering to give discounts for their business.

A Medi-Cal regulation specifically prohibits a vendor from offering an unearned rebate, refund, discount or other unearned consideration as compensation for the referral of business under the Medi-Cal Program.

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Several pharmacies are currently under separate investigations

for engaging in the types of activities we have been discussing. One such investigation has resulted in the filing of a criminal complaint against a pharmacist who requested payments for prescriptions never dispensed.

Although the investigation could not determine the exact amount of money the state is spending due to abuses by pharmacies it is significant to note that an audit of only 39 stores has resulted in a recovery of approximately $132,000. Under the present system these audits arise out of complaints. Complaints involving around 70 other stores have not yet been investigated.

It is estimated by experienced investigators that if routine audits were initiated by Medi-Cal the amount of recovery would probably exceed $500,000 a year.

E. Dentists

Dentists who participate under the program receive about $12,000,000 a year from Medi-Cal.

Unlike physicians who perform whatever services they deem necessary, dentists are required to get prior authorization from dental consultants for any plan of treatment which would exceed $35. Also, unlike physicians, reimbursement to dentists is fixed by a schedule of fees depending upon the dental procedure performed.

Investigation disclosed the following fraudulent activities by dentists.

(1) In order to avoid getting prior authorization, dentists have submitted separate bills, each under $35, directly to Blue Shield for payment of services rendered to a particular patient. The total sum of the bills, however, clearly revealed that the entire single plan of treatment did exceed $35 and should have been submitted for prior authorization.

(2) Submitting false claims. This type of abuse can occur when a dentist seeks payment where he has performed no services. It can also occur where a dentist submits a bill for having performed a specific dental procedure entitling him to a certain reimbursement when in fact he did a different procedure for which he should have received a smaller sum of money.

In one instance, a dentist falsified his claims by putting down the wrong procedure number for his dental work thereby obtaining $60 more than he was entitled to receive on each claim.

(3) Overservicing also exists in the field of dentistry.

(a) Dentists are providing dentures or other prosthetic work under Medi-Cal which would not be provided under normal

circumstances. Such services are being performed primarily because reimbursement can be obtained under the Medi-Cal Program. In one county, twenty percent of the requests for prior authorization are denied because the consultants deem that the proposed dental work is unnecessary.

(b) Examination by dentists of patients in nursing homes is a special area where overservicing exists. Dental consultants throughout the state agree that dental work performed in nursing homes presents a large area of potential abuse.

In one county, more than fifty percent of all requests for prior authorization submitted by a dentist for patients in one nursing home were rejected on the ground that the treatment requested would not be beneficial to the patient. Even where authorization to perform work is denied, however, the dentists are still entitled to receive their fee for making routine examinations, although these examinations are not always requested nor needed.

(c) Just as suspicion of overservicing is raised when large fees are paid to physicians, the same is equally true when big fees are received by dentists. Eleven dentists received close to one million dollars in fees in the year 1967. The activities of many of these dentists are, in fact, suspect by dental consultants at the county level.

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F. Optometrists

Expenditures under Medi-Cal to optometrists are approximately $8,000,000 a year. Optometrists need prior authorization before they can provide lenses or frames to a beneficiary under the program. However, no such authorization is required for an optometrist to perform a routine eye examination.

(1) Fraudulent activities by optometrists have primarily involved requesting prior authorization to provide appliances based upon the submission of false information.

The extent to which optometrists submit false information in requesting prior authorization is indicated by the fact that one county rejects approximately one third of the requests received for prior authorization to provide lenses and frames to patients in nursing homes. Many of these rejections were based on the ground that the information supplied was false.

In one case, for example, an optometrist requested approval for a pair of expensive prescription sun glasses for a patient. Investigation disclosed that the patient was blind. In other cases requests stated that the patients were in possession of old glasses which were in poor condition. Investigation revealed that the patients were in fact in possession of new glasses which they received within six months prior to the latest request.

(2) Optometrists were also found to be providing materials which do not meet the quality specified by the regulations. Several optometrists suspected of providing inferior quality materials are now under investigation.

(3) Optometrists overutilize the Medi-Cal Program by providing unnecessary examinations and by providing lenses and frames which are not needed by the beneficiary.

Once again, investigation disclosed that review of requests for authorization received from optometrists concerning patients in nursing homes are often rejected on the ground that the glasses requested will not be of benefit to the patient.

In several cases, for example, requests stated that the patient was "active, alert and expressed a need and desire for improved vision." Examination of the patients by the optometric consultant however revealed that their physical condition was such that communication with them was difficult, if not impossible, and that the glasses would not be of benefit to the patients.

Another manner of overservicing exists where optometrists replace lenses and also request replacement of frames which are still in good condition.

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CONCLUSION:

In mentioning various types of fraudulent activities and acts of overservicing which are occurring we have only attempted to show some of the more shocking and extravagant abuses. We have not exhausted all of the methods by which every class of vendor can take advantage of the program. Nor have we related every case which is under investigation. Instances of fraud and overservicing, for example, could also be given for vendors such as hearing aid dealers, podiatrists and ambulance services.

In some cases the abuses mentioned may be prevalent among a specific class of vendor. In other cases only a small percentage of the class of vendors involved may be engaging in a particular type of abuse.

The one fact which is certain however is that the abuses mentioned are occurring and have resulted in millions of dollars being needlessly spent since the commencement of the program. Moreover, unless immediate efforts are made to curtail these activities it is likely they will grow in scope and cost to the program.

Our attention is now directed to the type of enforcement which has existed under the Medi-Cal Program for the purpose of discovering and preventing abuses and whether the program of enforcement has been effective in these areas.

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III. Enforcement of Laws and Regulations

We have concluded from the investigation that an effective enforcement program to discover and investigate vendors who are taking advantage of the program does not exist.

Medi-Cal became effective March 1, 1966. It was not until twenty-one months later in December 1967 that HCS hired any trained investigators and then only two men were hired for the whole state.

Whether it was the myriad of problems encountered in getting the Medi-Cal Program operating, or a belief that potential abuses were not significant or would be adequately discovered by the fiscal intermediary agents, the fact is that an effective investigative unit was not initially established and does not exist today.

Since the commencement of Medi-Cal in March, 1966, only twenty-one vendors have been suspended from the program. These few suspensions, in light of the substantial amount of abuses revealed by the investigation, vividly reflect the inadequate enforcement of the program.

Two main problems confront attempts to seek compliance with the laws and regulations governing Medi-Cal.

(1) There is a lack of an effective system to discover those vendors who are engaging in fraudulent activities and over-servicing.

(2) Even after vendors become suspect, proper investigation into the matter is difficult, if not impossible, due to a number of internal problems.

A. Discovery of Abuses

Most abuses are discovered in the course of the fiscal agents processing claims submitted for payment or consultants passing upon requests for prior authorization.

(1) Professional Consultants

The professional consultants in counties throughout the state must give prior authorization before the services of many individual vendors can be provided (e.g., dentists, optometrists, podiatrists, etc.) and part of their responsibility is to discover abuses by such vendors.

Professional consultants had a similar responsibility under the welfare program prior to the enactment of Medi-Cal. Prior to Medi-Cal, however, the consultants would not only get requests for prior authorization, but they would also receive and approve claims for payment after services had been performed enabling them to maintain complete patient and vendor folders. This system permitted comparisons of services rendered with approved requests, and verification of prices charged. By doing so, the consultants were able to detect overservicing and fraudulent activities such as billing for services not rendered, or billing at an exorbitant price.

Under Medi-Cal, the consultants only receive requests for prior authorization. The claims for payment of services rendered go directly to Blue Shield with no copies of the billing going to the consultants. It was the unanimous opinion of consultants with whom we spoke throughout the state that the failure to provide them with billing information has greatly diminished their ability to discover abuses.

In Los Angeles County, for example, the dental consultants were able to either recover from dentists or to adjust requests for authorization to the extent that the welfare program was able to "save" over a million dollars a year prior to the enactment of Medi-Cal. However, since they are no longer receiving claims submitted by dentists for services rendered, they have been unable to maintain complete files and to achieve such savings under the Medi-Cal Program. This county still retains a "bad boy" list of dentists, many of whom receive large fees from the program, whose claims they believe merit careful scrutiny which is not being given under the current method of review.

(2) Blue Shield

Blue Shield, with certain exceptions, receives 70,000 claims a day from individual vendors throughout the state. Since consultants at the county level must give prior authorization before many vendors can provide services, Blue Shield's main concern is to process this huge number of claims for payment. In doing so, the main review is to see if the service and the fee set forth on the claim is allowed under the program. Discovery of abuses by such review is primarily limited to claims submitted by physicians and pharmacists, whose claims are not subject to prior authorization.

Efforts to discover fraudulent activities and acts of overservicing are made by personnel who are trained to examine claims to see if they are justified.

(a) Without maintaining a patient or vendor folder, and by examining claims on an individual rather than group basis, many of the abuses by physicians will not be discovered by the present method of review.

Assume for example that a physician intends to take advantage of the program by requiring a patient to make unnecessary visits to his office. Since the individual claims submitted to Blue Shield for each office visit would appear proper and be processed for payment, the chances of discovering this type of abuse is remote upon a review of claims on an individual basis. This abuse is more likely to be discovered if a number of claims submitted by this physician were reviewed at the same time, or if a patient or vendor file was maintained. Due to the volume of documents involved in reviewing claims of physicians throughout the state, such files are not presently maintained.

As previously noted, the review of claims by the Utilization Committee and county-level advisors to Blue Shield recovered approximately four and one half million dollars in one year from physicians who were providing excessive services. This figure alone is a commentary on the extent of abuse occurring under the program by just one class of vendor. Furthermore, this figure relates only to those excessive activities which have in fact been discovered.

While this type of review has achieved some success in discovering acts of overservicing by physicians, it has not been able to discover numerous other abuses we have mentioned are being engaged in by other vendors. One indication of this is that while Blue Shield has taken action on over 1,000 cases involving Medi-Cal, only 18 cases were deemed significant enough to be sent to HCS with recommendations for suspension.

The Utilization Committee has recently commenced reviewing claims of physicians after they have been paid. This "post-audit" is done by establishing various parameters. This involves determining

services or procedures which indicate overservicing and obtaining, by means of computer, the names of physicians who exceed the "norm" in regard to the performance of such procedures. The selection of one such parameter, for example, resulted in the review of some 20 physicians who performed a certain surgical procedure. Most of the physicians reviewed were found to have performed excessive services in regard to this particular procedure. This method in reviewing claims is too new to be evaluated at this time, although it offers certain advantages which will be discussed later in the report.

(b) The results of the method used in examining claims submitted by pharmacists presents even a better illustration of the inadequacy of the current method of review. We have already mentioned the numerous ways in which pharmacists are known to be abusing the program. Prior to our investigation, action had been taken against only one pharmacist since the enactment of Medi-Cal.

One reason few pharmacists have been investigated is that the review of individual prescriptions submitted for payment will not usually reveal a pattern of abuse. To effectively discover abuses numerous prescriptions of a pharmacist should be analyzed at the same time.

At our request a former pharmaceutical consultant was asked to select at random from Blue Shield's files prescriptions which had been submitted for payment and to analyze them for possible abuses. His examination of claims in this manner developed facts giving rise to several questions as to the propriety of the activities of several pharmacies. Set forth below are some examples of the suspicious activities detected by this type of examination.

(i) One pharmacy submitted 15 prescriptions, all of which were given to one family in a single day. Five of the prescriptions were identical, each being for four ounces of the same cough medicine.

(ii) A pharmacy dispensed in a period of 33 days 300 pills to a single patient. If taken as directed (one pill three times a day) 100 pills would have sufficed for the entire period.

(iii) A pharmacy employing one pharmacist dispensed 290 Medi-Cal prescriptions in a single day. These prescriptions amounted to his being reimbursed $1,190. Many of these prescriptions were preprinted. Around fifty percent of these prescriptions were written by two physicians, one of whom sees 75 to 100 patients a day and prescribes 100 to 125 prescriptions a day. For comparison purposes, a major chain drugstore employing seven pharmacists in a thirteen hour day writes an average of 300 prescriptions a day.

While legitimate reasons could exist to explain the above patterns, the examples illustrate how this type of examination at least reveals activities which may justify additional investigation.

(3) Blue Cross

Blue Cross receives 5,000 claims a day from institutional vendors such as nursing homes and hospitals.

(a) Claims for nursing homes are submitted monthly and primarily set forth the names of persons in the home during the period for which payment is requested. Reimbursement to a home is based on a fixed rate determined by its "cost of operation."

Since county consultants have authorized the admission of persons into homes, the examination of claims for nursing homes by Blue Cross is basically limited to determining if the appropriate

amount of money is being paid. It is therefore highly unlikely that in the processing of such claims Blue Cross will detect the many types of abuses which we have mentioned as being engaged in by nursing homes.

A review of claims, for example, will not determine if nursing homes have submitted false claims, misappropriated patients' money, required kickbacks, or received duplicate payments.

Knowledge of such abuses can only effectively be discovered through periodic audits of nursing homes. Such audits have not been taking place

The combination of lack of audits and the inadequacy of claims review has offered little deterrence to those nursing homes which are tempted to take advantage of the Medi-Cal Program since any unlawful or unethical activities are not likely to be discovered.

(b) The major review performed by Blue Cross relates to claims submitted by hospitals. Examination of such claims is primarily directed toward determining if excessive services were provided. Such claims contain information relating to the diagnosis of patients and the treatment provided to them.

The majority of expenditures to hospitals are made to county and non-profit hospitals. Discovery of excessive services has been associated primarily with profit-making hospitals.

The examination of claims to discover excessive services is performed by persons trained to detect this abuse. The review of such claims was initiated around November, 1967, with a staff of just two persons. This staff has now been increased to six. Two physicians who work part time for Blue Cross also review questionable claims of hospitals under the Medi-Cal Program (as well as claims submitted to

Blue Cross under other government and private contracts).

In the limited time that this review has been going on, abuses have been discovered resulting in a savings of $136,000 to the Medi-Cal Program.

B. Investigative Activities.

Although the present review system makes it difficult to discover abuses, HCS investigators have opened cases for investigation to determine if a vendor might be engaging in unlawful practices.

The difficulty in discovering abuses has been exceeded only by the inability of investigators and consultants to obtain essential information from HCS and the fiscal agents to pursue investigations on specific cases.

Several factors hamper investigative activities.

(1) To prove that a vendor is abusing the Medi-Cal program so that appropriate action may be taken -- be it administrative suspension or criminal action -- it is essential to examine documents submitted by the vendor. In the event of a hearing or trial, witnesses will also be needed to testify. Since we are often dealing with elderly people -- whose health and memory are a legitimate matter of concern -- time is of the essence if any investigation is to be successful.

The fiscal intermediary agents maintain possession of most documents which are pertinent and necessary to any investigation such as claims for services rendered, records of payments made, etc.

Our investigation disclosed that investigators and consultants have not been successful in their attempts to obtain documents and other information from the HCS and the fiscal agents for the purpose of pursuing investigations. The inability to obtain such information within a reasonable period of time not only

makes cases moot because of the passage of time, but has the effect of discouraging the efforts of persons charged with the responsibility of discovering abuses and performing investigations.

One vivid example of the frustration encountered is illustrated by tracing a request made to Blue Shield in September 1967 by the dental consultants in one county. Documents were requested on 15 dentists whose activities were suspicious. As time elapsed without receiving the information, additional letters were written to both Blue Shield and HCS requesting the documents. In December 1967, the consultants were advised of the person to whom the request should be directed. The request was again made to this individual. As of this date, the information has still not been received.

Numerous other examples could be cited where investigators and consultants had to literally wait months before receiving answers to inquiries or documents which were requested. In many instances no responses at all were ever received.

The failure to provide documents may indicate a lack of cooperation and communication between HCS and the fiscal agents, or a lack of interest and concern by these organizations as to the importance of such investigations.

If, for example, requests for documents are not being sent to the proper persons both the fiscal agents and HCS have been aware of the problem long enough to have taken corrective action. If the number of requests for information are too great to enable expeditious replies to all requests, priority should be given to those matters involving investigations.

The delay in sending documents may be due to the fact that the fiscal agents microfilm documents which they process for payment.

In using this procedure it may require some time to locate the proper microfilm and make the necessary copies. This office, for example, requested from Blue Shield documents concerning the activities of one vendor for a period of three months. Giving this matter top priority it still required 235 man hours and three weeks to provide this information at a cost of $800. While this may explain a reasonable delay, it does not justify the failure which has usually been encountered by those persons who have requested documents and other information.

Whatever the reason, the inability of investigators and consultants to obtain documents and other information presents a serious problem and is precluding effective investigation.

In commenting on this problem, it is important to note that Blue Shield has made every effort to cooperate with this office in providing documents which we requested and has often furnished such documents within a reasonable period of time. This would indicate that the ability to provide documents is not the basis for the lack of success which has been experienced by others.

(2) HCS is responsible for administering the Medi-Cal Program. Blue Shield and Blue Cross have contracts to act as fiscal intermediary agents on behalf of the state.

These organizations have a mutual goal and interest in seeing that the Medi-Cal Program is efficiently administered and that abuses by vendors are held to a minimum.

Our investigation reveals, however, that the coordination, cooperation and communication which one would expect to exist between HCS, Blue Cross and Blue Shield does not prevail.

(a) We have already mentioned the inability of an investigator to obtain information from the fiscal agents.

(b) Another example of this lack of communication is seen by the problem of determining which organization will investigate cases. We previously mentioned that Blue Shield has a Utilization Committee which attempts to discover cases of overservicing. There has not been a clear understanding however as to which cases involve fraud and should therefore be referred to HCS.

(c) Problems in the coordination of activities are further manifested by situations where Blue Shield has referred cases to HCS but HCS has no record of receiving the cases. Also, when cases are sent to HCS by Blue Shield recommending either further investigation or suspension of the vendor this is often the last that Blue Shield ever hears of the matter. Recommendations to suspend physicians are made by "peer" committees which exist within county medical societies. Serious frustration on the part of these committees has resulted from the failure of HCS to either take any action or to sustain such recommendations. In regard to cases received from Blue Shield, HCS claims that they are usually not properly reported so that rather than being able to continue investigating cases which are referred, it is necessary for them to start the investigation from scratch. This often results in duplicating work which has already been done by Blue Shield but not properly reported.

(d) Another area of lack of communication or coordination of activities relates to our previous discussion of abuses. We have seen that the activities of certain vendors may tend to overlap

with activities of other vendors. Discovery of overservicing by hospitals or nursing homes, for example, may often give rise upon further inquiry to overservicing by physicians, pharmacists and other vendors. Our investigation disclosed, however, that where abuses have been discovered by one fiscal agent which indicate that other vendors whose claims are reviewed by the other fiscal agent should be investigated there has been a failure to adequately inform either HCS or the fiscal agent of potential investigations which might prove fruitful.

(3) "Investigation Units" exist in the offices of HCS, Blue Shield and the Department of Social Services of Los Angeles County. Although the three units all have basically the same objectives there has been no supervision or coordination of their activities so that often one unit does not know what the other is doing. Thus, one unit might commence an investigation against a vendor who is already under investigation by another unit, or who has been investigated and cleared by another unit. <u>This duplication of investigative efforts constitutes a serious problem with its resultant unnecessary expenditures and inefficient investigations</u>.

(4) <u>A major weakness in the investigative program of HCS has been the lack of adequate personnel</u>.

(a) Ten field investigators are employed by the Utilization Committee of Blue Shield. Their primary area of concern relates to investigating cases of overservicing by physicians which are handled by administrative action.

There are three investigators on the payroll of Los Angeles County, which county accounts for approximately 45% of the money expended under the program.

HCS employs just two investigators to cover the entire state. These investigators' primary responsibility is in the area of criminal fraud.

It therefore seems that the number of investigators decreases in proportion to the importance and geographic scope of the investigative activities.

Each investigator for HCS has approximately 100 cases. Most investigations require interviews with numerous persons and examination of many documents just to determine if a complaint has merit. Therefore, the investigative "staff" of one in southern California and one in northern California is unable to pursue more than a handful of cases at a time.

(b) The lack of an adequate investigative staff has meant that far too few actions have been brought against vendors who have been cheating the program. Failure to bring such actions precludes Medi-Cal from recovering or offsetting monies to which it may be entitled from such vendors and also enables them to continue participating in the program without much fear of detection. Since there is no noticeable evidence of an investigative program -- and hence no threat of criminal prosecution, suspension from Medi-Cal or disciplinary action against a practitioner's license -- the current investigative program offers no deterrent to those vendors who may consider taking advantage of the program.

(c) In discussing the lack of an adequate investigative staff, it should be noted that the basic equipment and staff necessary for the effective performance of an investigator has not been provided by HCS. Lack of portable tape recorders for use in the field when doing interviews and secretarial help to prepare reports and summaries

of interviews are just two illustrations of the handicaps under which investigators must presently work. The investigator for HCS in southern California, for example, does not even have someone to answer his telephone when he is not in his office.

Other examples could be stated which would illustrate the problems involved in discovering and pursuing investigations. The matters mentioned above, however, amply demonstrate the dire need to review the procedures now being used to determine what appropriate steps should be taken to increase the effectiveness of enforcing the program.

IV General Administration of Program

In the course of the investigation information was obtained concerning problems which exist in the general administration of the Medi-Cal Program. Many of Medi-Cal's administrative problems indirectly contribute to the abuses which are occurring under the program.

In relating such problems we are aware that Medi-Cal is only two years old and still experiencing growing pains. Many problems could not have been anticipated (e.g., Medi-Cal must conform to constant changes in regulations established by the federal government) or are inherent in the administration of any program this size. Indeed, efforts have already been made to remedy many of the problems which will be mentioned.

(A) Communication and Coordination

1. Reference has been made to the difficulty which exists in coordinating the activities of HCS and the fiscal agents in regard to investigating vendors who may be abusing the program.

a. There is also a need for greater communication between HCS and the fiscal agents as to the general administration of the program. HCS and the fiscal agents have not established an effective means of communication to enable HCS to keep abreast of problems confronting the intermediaries in the performance of their duties. For example, frequent changes by HCS in the type of information desired from the fiscal agents have often been made without consultation with the fiscal agents as to the feasibility and cost of making such changes.

b. Blue Cross has not performed audits to determine the accuracy of fees being paid to nursing homes and hospitals.

The amount of payment received by nursing homes and

hospitals is determined by a formula which ascertains the "cost of operation" of such institutions. One responsibility of Blue Cross as the fiscal agent for processing claims of nursing homes and hospitals is to perform audits of such institutions to determine if their "cost of operation" justifies the fees they are receiving from Medi-Cal. As previously mentioned, only by doing audits of nursing homes can there be effective discovery of the abuses some homes are engaging in under the program.

Lack of direction from HCS and its failure to formulate policies have contributed significantly to Blue Cross' failure to perform audits until recently. The results of these recent audits reveal that Medi-Cal has been making excessive payments to nursing homes.

As one example, a recent audit by Blue Cross determined that one chain of eight nursing homes has received in excess of $380,000 from Medi-Cal. Other audits which are now in process are disclosing that the majority of institutions audited have also received excessive payments from Medi-Cal.

Audits of hospitals have also recently been commenced by public accounting firms under contract with Blue Cross.

c. The problem of communication also extends into the relationship which HCS has with the counties throughout the state.

(i) There are 58 counties in the State of California. Most of these process Medi-Cal claims for prior authorization. In general there has been a failure on the part of HCS to effectively communicate with these counties for the purpose of discussing problems concerning their duties and the manner in which the laws of Medi-Cal should be applied.

One example of this lack of communication is illustrated by a form which was recently used throughout the state for authorization to admit or retain persons in nursing homes. The form was prepared by HCS without consulting most of the medical consultants who had to determine from the information on the form if the request should be granted. Various county consultants contend that the form should have contained additional information to assist them in making their decisions.

This problem is also seen in the dissemination of a new form which is used in requesting authorization from county consultants to extend the period of time that Medi-Cal beneficiaries can remain in a hospital. This new form was not only devised without the advice of county consultants, but was also distributed to hospitals without prior notification to local consultants.

Another example reflecting lack of communication is illustrated by the fact that for several months consultants for one county were directing correspondence to a division chief at HCS who no longer held his post. County consultants were never notified of the change in the division chief.

(ii) <u>"Communication" between HCS and the counties is also weak in regard to the amount of discretion and responsibility county consultants can exercise on matters not specifically covered by any law or regulation</u>. Needless to say, a multitude of problems arise in various counties for which there is no specific answer provided in any law or regulation governing the program. In such instances, the consultants have a choice of either acting upon their own discretion or requesting direction from HCS. The failure of HCS to respond promptly to requests for advice often results in no action

at all being taken by the counties. The failure to clearly advise the counties as to areas of discretionary responsibility has resulted in counties taking inconsistent positions on matters where there should be uniformity.

(iii) HCS has also issued directives which were inconsistent with existing laws and regulations governing the Medi-Cal Program. The current time lag in correcting such inconsistencies -- often weeks -- would be eliminated by more effective lines of communication.

(B) Evasion of Regulations

Certain "loopholes" exist in the laws and regulations governing Medi-Cal which enable vendors to engage in activities which are contrary to the intent and language of the law.

1. Through a simple subterfuge, physicians who are suspended from the program may continue to receive Medi-Cal payments.

Persons participating as vendors in the Medi-Cal Program possess a vendor number. Usually this number is the same as the professional license number possessed by the vendor. When the vendor is a physician, however, and practices as a member of a group or clinic a vendor number is also assigned to the group or clinic.

As a result, physicians who have been suspended from the program for overservicing or fraud are able to continue treating Medi-Cal patients and to receive payment for their services by submitting their claims under their group or clinic vendor number. This results in the physician being able to evade the purpose of the suspension which is to remove him as a participant in the Medi-Cal Program.

2. The regulations also provide that a physical therapist shall not receive payment for rendering more than six treatments to a patient without having obtained a new prescription from a physician authorizing further treatments. Home health agencies, another type of vendor under the program, are also allowed to provide physical therapy to Medi-Cal patients.

Unlike the individual physical therapist, no limitation has been placed on the amount of payments which can be made to a home health agency for providing physical therapy. As a result, it is common for physical therapists to have an arrangement with

home health agencies whereby the latter will submit claims for services rendered by the physical therapists as though the service was rendered by the home health agency itself. In effect the home health agency is merely acting as a billing service for the therapist and receives a fee from the therapist for doing so. Under this arrangement with home health agencies the individual therapists are able to evade the limitation which the Medi-Cal Regulations impose upon them.

(C) Determining "Cost" of Drugs

We have seen that some pharmacies inflate their fees by overstating the cost of the drugs they dispense.

HCS publishes a drug formulary which basically provides that "cost" is intended to be the acquisition cost of the drug. (The formulary defines "cost" as being the lower of the maximum allowable wholesale cost or the actual cost to the pharmacist. The former price refers to a few drugs in the formulary on which there is placed a maximum allowable wholesale cost.)

A new drug formulary has recently been published. "Cost" has again been defined in the same manner. However, appearing under the caption "Billing Instructions" in the new formulary is a section which provides, in part, that the wholesale cost for the standard package of the drug dispensed shall be used in determining the cost of the drug to the pharmacy. A "standard package" is defined as 100's, pints, or pounds or the available size that is closest to said packages.

In providing that "cost" should be figured at the wholesale cost of a "standard package" this section ignores the acquisition cost of the drug. Hence, it gives the pharmacy the advantage of

obtaining drugs at a cheaper price by purchasing in large quantities without passing this saving along to Medi-Cal. The effect of this new Medi-Cal instruction is to allow reimbursement to the pharmacy for more than its actual cost in purchasing the drug.

In the past several years a great increase has occurred in the cost of drugs under the welfare program. In 1967 the number of welfare prescriptions filled on a nationwide basis was 26.4% greater than the year before. In California the increase in welfare prescriptions over the same period of time was 37.4%. California also led the nation in both the number of welfare prescriptions filled in 1967 and the amount of dollar volume paid out for prescriptions in that year.

The number of welfare prescriptions and their cost for the current fiscal year have both been estimated as being higher than in the past year. It is now anticipated that as a result of the billing instruction in the new drug formulary the cost of drugs will be even greater than predicted.

Although previously mentioned, it is again significant to note that under the new welfare program in California the amount of money reimbursed to pharmacies will be greater than the reimbursement provided under private negotiated contracts.

(D) Purchase of Appliances

Appliances such as wheelchairs, crutches and beds are purchased by both the state for persons eligible for Medi-Cal and by counties for persons who are on welfare but not under the Medi-Cal Program.

1. In Los Angeles County alone Medi-Cal purchases over $250,000 worth of appliances a year. However, whereas Los Angeles

County has entered into contracts with suppliers of such appliances to purchase them at a discount the state has no such agreements and purchases identical appliances at a full retail price. The effect is that the Medi-Cal is paying more money (often as much as twenty percent more) than the county for identical medical appliances.

2. When Medi-Cal does purchase an appliance, the patient retains title to it. This means that when there is no longer any need for the appliance, because of death or otherwise, the patient or his family retains possession of the appliance.

Prior to Medi-Cal, Los Angeles County developed a procedure whereby appliances could be reobtained, serviced and stored so as to be available for future use by another welfare patient. No procedure for Medi-Cal to reobtain medical appliances -- after it gives them to patients -- exists under the current program.

(E) Beneficiaries under the Medi-Cal Program who possess certain assets are supposed to pay a portion of the cost of the services they receive.

1. The counties have the responsibility of ascertaining the liability of the patient. There has been a general failure by the counties in assuring that the financial liability of patients for Medi-Cal treatment is being paid.

If the patient's liability is not fulfilled, Medi-Cal ends up paying the vendor money which should have been paid by the patient. One county which is concentrating its efforts in this area has recovered from Medi-Cal patients approximately $20,000 in a period of one year.

2. The state also has a right of subrogation where there may be third party liability to a Medi-Cal patient. Failure to

ascertain cases where subrogation might exist and to pursue such cases is also depriving Medi-Cal of a potential recovery of money.

(F) The failure by the counties and HCS to maintain current records of beneficiary eligibility has also been a source of many problems in administering the program.

1. One problem of constant irritation has been the making of duplicate payments to vendors. This often occurs where an initial claim is rejected because the patient is not found to be eligible for benefits. Upon further inquiry, however, the patient is deemed eligible and a second claim is submitted. This problem with eligibility records has often resulted in payments being made upon both claims.

2. The failure by the counties and HCS to maintain current records on eligibility has also caused the rejection of claims which should have been paid and the payment of claims which should have been rejected. By not keeping records current inquiries as to eligibility have also resulted in undue delay in rendering services and paying vendors.

(G) Processing Claims

Mention has been made that the fiscal agents are responsible for processing claims of vendors. A closer look at their activities is necessary in considering the overall administration of the Medi-Cal Program.

Blue Shield receives 70,000 claims a day to process. These claims are initially reviewed for completeness of form and legibility. They are then examined on an individual claim basis by people trained to determine if the vendor has billed the proper amount for the services and if the services seem reasonable. If the claims seem proper they are forwarded to be microfilmed and to be paid.

Each claim is reviewed for the purpose of preparing it for data processing. This function actually requires some employees to cross out information requested on the forms provided by the state, but which is not needed for the processing of the claim. (E.g., telephone number of vendor.) Other employees have the task of printing names of vendors which are not legible on the claims submitted.

Blue Cross processes some 5,000 claims a day from institutional vendors. They, too, use trained personnel who review claims primarily to determine if the services and amount of claim is proper. These claims are also processed to prepare them for data processing.

Both fiscal agents utilize computers to a great extent. Among other things, the computers are supposed to be used for the purpose of determining who has been paid, amounts which have been paid, and kicking out requests for duplicate payment. The effectiveness of any computer is dependent upon how it is programmed and the accuracy of information it is given.

1. <u>There have been numerous instances where vendors have received double and triple payment for services they have rendered</u>.

Preliminary investigation has disclosed that one hospital, for example, has received duplicate payments involving some 59 different patients amounting to $17,000 in overpayments.

a. Various reasons exist for such duplicate payments. In the case of the hospital it was found that employees of the fiscal agent insert a diagnostic code on the claim received from the hospital. The code is determined by the diagnosis set forth on the claim. If a duplicate claim is submitted a different employee might interpret the same diagnosis in such a way so as to insert a different code number on the claim. Due to the difference in code numbers the

computer will not detect the duplicate claim and payment will be made upon both claims.

b. Another means in which duplicate payments can occur is where a vendor initially submits a claim for $1,000 which shows that the patient's liability for such services is $100. The claim would thus request a net payment to the vendor of $900. If it was subsequently determined that the patient's liability should have been $200 a duplicate claim might be submitted by the vendor requesting $800. Due to the difference in the net amount claimed the computer would once again be unable to detect the duplicate claim and again it is probable that payments of both $800 and $900 would be made to the vendor.

2. There also have been cases where the computers have not properly recorded where vendors have or have not been paid. This type of error often results in inquiries being made by the vendors resulting in additional time and expense in ascertaining if payment has been made.

The inability of the fiscal agents to accurately advise investigators and consultants who request information as to whether vendors have been paid creates further delay and interference in the pursuit of investigations. Investigation disclosed, for example, that upon inquiry as to whether specific vendors have been paid the fiscal agent replied in the negative although such vendors had in fact received payment.

3. The current system of processing claims has not only resulted in making duplicate payments to vendors who have rendered services to patients, but errors in the program have also caused checks to be sent to persons who have never provided services to

Medi-Cal patients.

It is difficult to estimate the amount of money which Medi-Cal has mistakenly paid out as a result of the errors we have mentioned. At the outset of the report we noted that as of June 30, 1967, one and a half million dollars in overpayments were voluntarily refunded by vendors. HCS estimates that another one million dollars in overpayments are still outstanding. Unless the vendor is honest and voluntarily notifies the fiscal agents of such duplicate payments it is unlikely that they would be discovered under the current auditing procedures.

Both fiscal agents have expressed the desire and need for better computer operations which would assist them in the performance of their duties in processing claims for payment.

RECOMMENDATIONS

The responsibility imposed upon HCS to administer the Medi-Cal Program is not one to be envied. Massive problems have confronted HCS from the initial day the program began operating and many of them still exist today.

Since the operation of the Medi-Cal Program is under constant review by both HCS and the California Legislature we offer herein suggestions concerning certain areas in the program which may be of some benefit to those agencies which are looking for ways to improve the program.

Many of the matters mentioned in this report have been discussed with HCS which has already begun to take steps to remedy some of the weaknesses found in the program.

1. Establish an Effective Investigating Unit

a) One problem which has been mentioned in regard to the enforcement of the program has been the difficulty in discovering vendors who have taken advantage of the program. Similar difficulty exists in finding those recipients of Medi-Cal who also take advantage of the program.

We have noted that under the current system investigators are employed by HCS, Los Angeles County and the fiscal agents. Failure to coordinate their activities has resulted not only in duplication of work and needless expenditure of money, but has produced far too few cases against persons abusing the program.

HCS investigations have produced few proceedings against vendors. This lack of suspensions and criminal or other disciplinary actions has been caused in great part by the inordinate amount of time which expires between the commencement and the conclusion of

investigations. Because of the time lag evidence becomes stale and, in some cases, the witnesses have died. The latter, of course, is a particular problem in the field of medical investigations.

It is therefore recommended that a single investigative unit be established, consisting of at least ten men, under the supervision of one person who would have the responsibility of assigning cases and coordinating investigative activities.

The investigators should be experienced or trained to efficiently perform investigations into the various types of abuses mentioned in this report. Since Los Angeles County receives approximately forty-five percent of the money spent in the welfare program the majority of investigators should be located in the Los Angeles area.

The recommendation of a single investigative unit is not intended to preclude consideration of a proposed arrangement whereby the fiscal agents would have their own investigators.

b) The investigative staff should be provided with adequate equipment and secretarial help to assist them to perform their duties in an efficient manner.

c) This report has discussed the various means by which vendors have been taking advantage of the program. It is recommended that with use of this knowledge a manual be prepared to set forth basic procedures which should be followed by investigators when doing audits and investigations of specific types of vendors.

d) Investigations now occur as the result of complaints which may be received. It is suggested that consideration be given to having investigators perform routine audits and investigations without the necessity of receiving a complaint. Such routine

investigations would be especially effective in discovering abuses among such vendors as pharmacies and nursing homes and in acting as a deterrent to those who might otherwise consider abusing the program.

e) The inability of investigators to obtain information from the fiscal agents has hampered effective investigation. Procedures should therefore be established whereby investigators can request and obtain within a reasonable period of time information which is needed for investigations.

f) Both fiscal agents when processing claims attempt to discover providers who may be engaging in fraud or providing excessive services.

Effective liaison should be established between the investigative unit and the fiscal agents so that they may be apprised of the activities of each other.

2. Improve Procedures to Expedite Suspension Proceedings

If our recommendations for investigations are followed, there should be a vast improvement in the ability of the investigators to expedite cases and, where appropriate, to recommend disciplinary proceedings. While recommendations for criminal or disciplinary action would be referred to agencies other than HCS, in most instances the suspension of the vendor from the program would also be appropriate. This emphasizes the need for improving HCS suspension proceedings.

In the past, HCS' method in acting on suspensions from the program has proven unsatisfactory from the standpoint of both procedure and results.

It is therefore recommended that HCS take steps to improve the manner in which it handles proceedings to determine if a vendor should be suspended. Two possible sources to which HCS may look

for advice in this matter are the Attorney General's Office and the Office of Administrative Procedure since both these offices have extensive experience in the processing of administrative hearings.

3. Publicize Existence and Actions of Investigative Unit

It is recommended that the existence of the investigative unit be made known to the public and to persons providing and receiving benefits under the program.

This would encourage information and complaints from the public and would also deter abuses.

The establishment of an effective unit should also result in an increase in the number of criminal actions, suspensions, and disciplinary actions taken against persons participating in the program. Here again, it is recommended that such actions be publicized as a deterrant to abuses.

4. Establish Liaison with Professional Licensing Boards

Most of the persons providing services under Medi-Cal, such as physicians, dentists and optometrists are licensed by a professional board within the Department of Professional and Vocational Standards. Many of the abusive activities engaged in by vendors under the welfare program would also constitute a violation of the regulations established by their licensing boards.

Since it is the desire of both HCS and such licensing boards to discover and take appropriate action against such vendors, it is recommended that HCS establish an effective liaison with the relevant professional boards. By doing so, HCS not only will bring to the attention of such boards the activities of their licentiates which may warrant disciplinary action, but HCS may also be able to obtain additional investigative help through use of the staff of

investigators employed by such boards.

5. Improve Communication Between Organizations Participating in the Administration of the Program

This report has revealed that the lack of communication between HCS, the fiscal agents and the counties has been a major impediment to the effective administration of the program.

It is therefore recommended that HCS should take appropriate steps to improve the communication and cooperation between these agencies.

One suggestion would be to hold periodic meetings with the professional county consultants and the fiscal agents to provide the opportunity to exchange views on improving program administration. Professional consultants, for example, from their review of thousands of claims might be a good source from which to obtain information to improve the program to assure the providing of necessary health services. Such meetings would also clarify such matters as when discretion is to be exercised by counties when processing claims. Meetings with the fiscal agents could be used to keep HCS abreast of the problems in processing claims and advised of new electronic data processing techniques to meet present and anticipated problems.

6. New Regulations

Consideration should be given to enacting new regulations which would implement the enforcement of the program.

a) Improved communication with the counties and fiscal agents might prove to be one source of determining additional regulations which may be appropriate.

b) At the present time vendors are not required to maintain

any specific records or documents in regard to services they have provided. For example, nursing homes are not required to maintain records which would show the various services rendered to their patients. We have seen from this report that a major area of fraudulent billing concerns services provided to persons in nursing homes.

It is therefore suggested that consideration be given to the enactment of a regulation which would specify the types of records that must be maintained by vendors and which requires them to retain such records for a reasonable period of time. One possible effect of such a regulation might be to expedite investigations by enabling investigators to examine documents in the possession of vendors thereby removing the delay now encountered when records must be obtained from the fiscal agents.

c) Mention has been made of at least two "loopholes" in the program which allows physical therepists to bill through nursing homes and suspended physicians to bill through a group practice to circumvent existing regulations.

Regulations should be enacted to prevent such circumvention.

7. Review Procedure of Processing Claims

Blue Shield employes some 350 persons to process 70,000 claims a day. Blue Cross employs approximately 70 persons to process 5,000 claims a day.

The procedures used by these fiscal agents should be periodically reviewed to see if their system of processing claims can be expedited and the cost lowered.

a) In light of the large number of claims processed each day, the elimination of any one unnecessary step might result in a significant savings of money.

As an example, claim forms provided by HCS request information which is not needed in the processing of claims. In fact, persons reviewing claims actually cross out such information to avoid errors in preparation of data processing. Other persons who review claims do so for the limited purpose of printing the name of the vendor on those claims where the name is not legible.

The expense of providing new forms which only contain required information or the identification of the vendor; or the providing of preprinted identification cards to vendors and recipients of benefits, might be one means to expedite and lower the cost of processing claims.

b) Reference was made in the report to the fact that the fiscal agents microfilm the claims they process. The large number of claims processed may well make it necessary to do so since it enables thousands of records to be stored on microfilm in a single file drawer.

Since the use of microfilm however is one factor in the delay in providing information to investigators, efforts should be made to establish a procedure whereby information can be made more readily available to investigators.

8. Improve Use of Computers

Computers are presently used by both fiscal agents in the reviewing and processing of claims. Efforts should be made to improve control procedures and the programming of computers to assist them in their handling of claims.

Improved procedures in the computer program should eliminate errors such as making payments to persons who do not participate in the program and in making duplicate payments.

Since Medi-Cal pays a fixed fee to many vendors for specific procedures and services which are usually listed by code number on claim forms, consideration should be given to the feasibility of programming computers to make use of this information. By doing so, such errors as excessive payments and payments for services not authorized should be eliminated. The success of such programming might also reduce the need to employ persons who now manually perform these tasks.

Another area in which improved techniques of the computer system might be of value is in providing information to investigators and to vendors who request information on the status of claims. The inability to accurately determine who has been paid is one cause of the needless expenditure of money under the program.

It is important to mention that, prior to considering methods to improve the use of computers, HCS and the fiscal agents should attempt to anticipate the type of information and statistics which would be of value in the future to both the administration and the legislature as they seek to improve the Medi-Cal Program.

9. Review of Claims on a Local Basis

Prior to Medi-Cal the county welfare departments had the responsibility of receiving, reviewing and paying claims of persons providing services under the welfare program. That responsibility has now been shifted to the fiscal agents which process claims from vendors all over the state, although professional consultants employed by the counties still pass upon requests for prior authorization.

In the opinion of most persons interviewed, the current method of review has greatly diminished the ability of both the

county consultants and the fiscal agents to discover vendors abusing the program and has reduced the amount of money saved by the discovery of such abuses.

It is therefore recommended that consideration be given to returning to a system where claims are reviewed on a local basis rather than out of the one office of Blue Shield and the two offices of Blue Cross. Indeed, to some extent this type of review is being employed under the current system.

Blue Shield, for example, subcontracts with various county medical foundations whereby said foundations perform the task of receiving and reviewing claims of physicians in their county. There is also a pilot project going on in San Joaquin County where the county medical foundation is performing the task of receiving and reviewing claims submitted by most vendors. Evaluation of this project should be of considerable help in determining the feasibility of again having local review.

One advantage of a local review is that it is usually performed by persons who are more familiar with the practice in a given area and with vendors whose reputation might justify their claims being closely scrutinized.

Another advantage is that local review allows for maintenance of better records. For example, San Joaquin County Medical Foundation in the pilot project has been able to maintain a patient folder upon which it records all services which the patient receives from any type of vendor. This has enabled the foundation to discover situations where vendors, or the patient himself, has been taking advantage of the program. The foundation is currently working on a

method of establishing a profile on vendors participating in the program as another means of discovering abuses being engaged in by vendors. Also, the foundation has been able to program computers to provide greater information than that which is now available in the processing of claims by Blue Shield and Blue Cross on a statewide basis. This too has been a means of enabling greater detection of abuses under the program.

While a return to reviewing claims on a local basis might present problems such as central control of payment of checks and maintenance of statistics, the concept of local review appears to merit further attention.

Another interesting experiment in the pilot project in San Joaquin is that the county foundation is processing claims of physicians on a "prepaid" basis. A fixed amount of money has been given to the foundation to cover the services provided by physicians in the county.

If the funds provided are not adequate the loss is incurred by the member physicians in the foundation. If successful, use of a prepaid system should be studied and evaluated to see if it would be appropriate in other areas in the state.

10. Post-examination of Claims

Reference was briefly made in the report to the fact that the Utilization Committee of Blue Shield recently began checking claims by doing a "post-examination" of claims.

Careful evaluation of the success in discovering abuses should be given to this method of examining claims. If proven successful, consideration should be given to establishing some type of post-examination for other types of vendors.

Several advantages appear to be offered under this system.

First, a review of claims by this method is done on a "group basis" which we have seen is preferable to the examination of claims on an "individual claim" basis.

Secondly, by taking advantage of information which can be obtained from computers it enables those who review claims to take the initiative in checking on vendors who engage in services that are considered likely to be abusing the program. By use of computers, for example, it is possible to establish profiles of vendors who receive the greatest reimbursement for specific procedures.

If successful as a method of discovering abuses the use of post-examination of claims might achieve additional savings by eliminating the need and cost of hiring persons who now perform duties which would be unnecessary in the processing of claims.

Finally, the use of a post-examination would probably be successful in regaining money from vendors who have abused the program. Since vendors who do abuse the program usually perform services to which they are legitimately entitled to receive payment, it would be possible to withhold money due the vendor for legitimate claims as an offset for the money which he wrongfully obtained.

One example of the success resulting from a post audit review of claims is illustrated by an investigation made into the activities of twenty physicians who performed an unusual number of surgical operations for umbilical hernias in children under five. Of the cases so far reviewed, the determination has been made that the operations performed by many of these physicians were in fact unnecessary.

11. Controlling the Cost of Drugs

We have discussed at length the potential increase in costs which may accompany the new method under which pharmacies have been instructed to ascertain their "cost" of drugs for the purpose of billing the Medi-Cal Program.

If the intent of the administration is to reimburse pharmacies for the true cost of drugs they dispense and then to pay them a fixed professional fee for their services, the billing instructions in the new drug formulary does not achieve this goal. If pharmacies are to be paid in a manner which fixes their cost on the purchase of a minimum quantity of drugs it is recommended that this method of reimbursement be carefully evaluated to determine its effect on the anticipated cost of the drug program.

The new drug formulary also deletes a number of drugs upon which there was previously placed a maximum cost which could be charged to the welfare program. If the effect of deleting these drugs results in a significant increase in the cost to Medi-Cal to provide such drugs, consideration should be given not only to reinstating a maximum cost on these drugs but also to the merit of imposing similar maximum costs on other drugs. Imposing a maximum cost on drugs apparently has not had the effect of preventing such drugs from being made available to patients in the program so that such action does not prevent patients from receiving proper care.

In connection with the cost of drugs, suggestions have been made that a fair price could be established for all drugs in the formulary thereby establishing a definite fee schedule for drugs.

As in the case of any other specific service being paid based on a fee schedule, improved computer programming of such

information could expedite the payment of such claims and eliminate the errors which have been found in the amount of money being paid and even in the payment of drugs and other medical supplies which are not authorized under the program.

Another means of controlling the drug cost of the program which has been suggested is to establish "Medi-Cal Pharmacies" throughout the state. This would require patients to go to one of the numerou pharmacies which would contract with the state to service persons in the program.

12. Scope of Benefits

It is the opinion of many persons directly involved in administering the Medi-Cal Program that Medi-Cal patients are receiving health care services which are far greater than services which a non-welfare patient would either anticipate or demand.

The opportunity to provide and receive such services has created a tempting area of abuse by both vendors and recipients of benefits.

It is therefore recommended that consideration be given to the question of whether changes could be made to assure persons on welfare of proper medical treatment without providing the opportunity to abuse the program.

To illustrate this problem, we mentioned in the report that the investigation disclosed that thousands of persons are now residing in nursing homes although their physical conditions do not warrant such extensive care. One major reason for this situation results from Medi-Cal's failure to provide benefits to persons in facilities other than nursing homes (e.g., board and care homes, rest homes, etc.).

Family pressure upon physicians to keep persons in nursing homes since they would not get reimbursed if in other types of facilities is just one reason why so many persons are found in nursing homes although their physical conditions do not merit such care.

If reduced Medi-Cal payments were made to facilities providing less extensive care than nursing homes, the end result might be to effectuate a savings in the total Medi-Cal Program. Furthermore, a program which would remove thousands of persons from nursing homes who do not need such care would also create vacancies for persons who do require such care but are unable to receive it due to lack of space in the homes.

13. Third Party Liability

Although provisions exist in the law for Medi-Cal to recover its expenditures, if there is third party liability involved, the program has been very lax in pursuing this avenue to reduce the cost of the program.

It is therefore recommended that procedures be established to allow Medi-Cal to avail itself of this source of revenue.

Similarly, the methods now used to determine if the recipients of benefits are paying their share of liability under the program should be reviewed since the failure to do so needlessly increases the cost of the program.

14. Purchase of Appliances

Consideration should be given to determining if the state could contract with vendors of appliances (e.g., wheelchairs, crutches, etc.) whereby there is an agreement to purchase such appliances at a discount. Also, study should be given to the question of whether a savings would result if a procedure was

established whereby the state or the vendor of the appliance could reobtain, service and store the appliance from patients who no longer required them, which appliances could then be used for other patients.

These matters should be reviewed to determine not only if they are feasible from a money savings point of view but if they can be accomplished in compliance with federal laws under which Medi-Cal operates.

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CONCLUSION

The recommendations set forth herein are not intended to exhaust all problem areas in the Medi-Cal Program which require attention.

These recommendations are intended to correct the weaknesses in the administration of the program which contribute especially to cheating by persons participating in the program.

The abuses and weaknesses pointed out in the report are serious in nature and do merit further attention by the appropriate bodies which can take steps to improve the administration of the program and achieve immense savings of money without diminishing the quality of the services being offered to persons under the program.

As you requested, this report will be provided to law enforcement agencies to improve surveillance of outright criminal activity in the Medi-Cal Program.

Herbert Davis

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