MEDICARE AND MEDICAID

1947-8

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

JULY 1 AND 2, 1969

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
32-106 O WASHINGTON : 1969

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $1.75

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

CLINTON P. ANDERSON, New Mexico
ALBERT GORE, Tennessee
HERMAN E. TALMADGE, Georgia
EUGENE J. McCARTHY, Minnesota
VANCE HARTKE, Indiana
J. W. FULBRIGHT, Arkansas
ABRAHAM RIBICOFF, Connecticut
FRED R. HARRIS, Oklahoma
HARRY F. BYRD, Jr., Virginia

JOHN J. WILLIAMS, Delaware
WALLACE F. BENNETT, Utah
CARL T. CURTIS, Nebraska
EVERETT McKINLEY DIRKSEN, Illinois
JACK MILLER, Iowa
LEN B. JORDAN, Idaho
PAUL J. FANNIN, Arizona

TOM VAIL, *Chief Counsel*
EVELYN R. THOMPSON, *Assistant Chief Clerk*

CONTENTS

Witnesses

Additional Information

Appendix A

Appendix B

Appendix C

Appendix D

MEDICARE AND MEDICAID

TUESDAY, JULY 1, 1969

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Gore, Talmadge, Hartke, Harris, Byrd, Jr., Williams, Bennett, Curtis, Dirksen, Jordan, and Fannin.

OPENING STATEMENT OF THE CHAIRMAN

The CHAIRMAN. This hearing will come to order.

This morning, the Committee on Finance begins the first of a series of hearings on the costly problems confronting us in the medicare and medicaid programs.

Both these programs were soundly conceived when they were enacted. They've done a lot of good for a lot of people and can continue to serve the national interest in the future. We want the medicaid program to provide help to people who need it and we want the medicare program to look after the medical needs of our senior citizens. We want that care to be high quality. But, we think it should be provided on a basis that is efficient and economical, not on a basis which is wasteful and extravagant.

The Committee on Finance has from the beginning of those programs followed their progress closely. Unfortunately, in many instances, data has not been available, until the last 6 months or so, which could provide the basis for a comprehensive exercise of our legislative oversight responsibility.

However, during the past year we have progressively stepped up our scrutiny of the medicare and medicaid programs. Today, we are quite capable of identifying and pinpointing major areas of concern—including widespread abuse, and fraud, as well as lax administration. It almost appears as if everyone involved in medicare wants to make that extra buck at the expense of the taxpayer and the millions of older people in medicare.

It seems to this Senator, and I know that other Senators on the committee share this view, that it is past time for the committee to determine whether these runaway programs can be brought under control. Firm reins are needed to keep medicare and medical in check.

Our committee and its staff is making what I believe is the first real in-depth study of payments to doctors under medicare and medicaid. Let me illustrate the kind of things which have developed—and these are only a few examples of the situations we know about:

(1) A general practitioner who billed medicare $58,000 in 1968 for house calls made to 49 patients. Mind you, he only had 49 medicare patients. This works out to a visit every third day for every one of his 49 patients for an entire year, or to put it another way, it means a

visit twice a week and every second Sunday at $9 a visit. Who says you can't get a doctor to make a house call anymore?

(2) Another physician engaged in what we call gang visits to nursing home patients. In 1968, 54 patients received the benefit of 4,560 visits from that doctor—an average of over 80 visits each. The same physician was paid by the program a total of $42,000 for 8,275 injections which he administered to 149 patients. This works out to be about 60 injections per patient per year at about $5 per injection.

I am pleased that we will have an opportunity today and tomorrow, to discuss all of these matters with representatives of the administration. As a matter of fact, it was just about 3 years ago that administration officials, including Social Security Commissioner Ball, whom I am happy to see here today, appeared before this committee to discuss their proposed reimbursement formula for medicare. At that time, the committee was quite critical of a number of very generous provisions in the formula—including a 2-percent bonus to hospitals—above their actual reimbursable costs, which some people argued was not authorized by law—I mean the 2 percent being not authorized. I know the committee is pleased to note that 3 years after that hearing—as a matter of fact, effective today—the 2-percent bonus has been taken out of medicare and medicaid the same way it was put in—by administrative action. Federal, State, and local taxpayers will save over $100 million in fiscal 1970 as a result of this action alone. I anticipate that as these current hearings progress, we will find other areas which may yield savings of even greater magnitude than the 2-percent bonus.

One feature of medicare and medicaid that particularly concerns me—and I know it also concerns the ranking minority member of the committee, Senator Williams—is the "Swiss bank account" system of reporting the payments made to doctors and hospitals under the program. As of today, not even the Federal tax collector has been able to crack that code. With possibly as many as 10,000 doctors, dentists, and other health practitioners in this country reaping more than $25,000 a year from these programs, it is a sad commentary that the Internal Revenue Service has no record of any of these payments and is unable to tell us whether these huge sums are being reported for tax purposes.

Senator GORE. Mr. Chairman, why is it that the Internal Revenue Service can't obtain this information?

The CHAIRMAN. We will get to that, Senator.

Senator GORE. I do not want to interrupt, but I think this is a matter of importance. You will tell us why?

The CHAIRMAN. Yes, we will find out from our staff and from these witnesses, Senator.

Another problem is that some physicians are fragmenting their bills and making separate charges for things that once were included within what they received in their regular fees. Lab fees and psychiatric counseling are two items that come to mind.

Now, before I recognize the Under Secretary, I want to take just a moment to commend the Senior Senator from Delaware, the ranking minority member of this committee, Senator Williams, for the diligence with which he has pursued this medicare-medicaid matter. In addition, let me recognize the important role the Senior Senator from New Mexico has played. Senator Anderson has consistently importuned the committee to more closely scrutinize these programs so

that they could be the model programs he envisioned, when he played the role of "father-of-medicare." In fact, it was at Senator Williams' and Senator Anderson's initiative that the staff was directed to commence this inquiry.

Senator Ribicoff wanted very much to be here this morning. He has repeatedly expressed his concern to the committee over the problems in medicare and medicaid and has been briefed on what we are finding in the programs. Unfortunately, a minor ailment prevents him from being here, but I know that he will fully participate in the hearings which will follow these 2 days.

At this point, I think it would be well for our staff to describe briefly the series of tables and charts which they have made, outlining their preliminary findings. While they are doing that, may I suggest, Mr. Secretary, that you look over your statement and plan to summarize it, or at least Mr. Ball might summarize. We will read all this, but in order that each Senator might have the opportunity to ask each question that comes to mind this morning—and they have all been briefed on the areas we plan to explore—we have asked them to limit themselves initially to 10 minutes each. They know about most of what you are going to discuss here. They will read your statements while other Senators are asking questions.

Senator BENNETT. Mr. Chairman, I would not want you to be accused of doing what you are accusing the doctors of doing. Your written statement says that Senator Ribicoff has a minor ailment. You said major. I hope you did not expand it.

The CHAIRMAN. I will let the printed speech speak for itself.

We will insert at this point in the record our staff's committee press release announcing the start of these hearings, and data relating to the medicaid-medicare study.

[Press release from the Committee on Finance, U.S. Senate, June 26, 1969]

FINANCE COMMITTEE HEARINGS ON MEDICARE AND MEDICAID

Senator Russell B. Long (D., La.), Chairman of the Committee on Finance, announced today that as part of its comprehensive review of the operations and status of the Medicare and Medicaid programs the Committee will hold initial hearings on Tuesday and Wednesday, July 1 and 2. The hearings will be held in Room 2221 New Senate Office Building and will be open to the public.

These first hearings will involve an examination of the programs with Department of Health, Education, and Welfare officials. He noted that among those who would testify are: H.E.W. Under Secretary John Veneman. The Social Security Administration will be represented by Commissioner Robert M. Ball, Deputy Commissioner Arthur E. Hess, Thomas Tierney, Director, Bureau of Health Insurance, and Chief Actuary. In addition, Dr. Francis M. Land, Commissioner of the Medical Services Administration will also testify.

Senator Long praised the initiative taken by the Committee's ranking Republican member, John J. Williams (R.,-Del.). He said that Senator Williams "has rendered invaluable service thus far in exposing fraud, abuse, and maladministration in two multibillion dollar programs. I expect that he will play an important part in our forthcoming hearings." The Chairman indicated that the Committee would schedule additional hearings at a later date during which providers of health care, fiscal agents and other interested individuals and organizations will testify. Senator Long further advised that the report on Medicare and Medicaid which it directed its staff to undertake earlier this year would be submitted to the Committee within the next few weeks.

He said: "We want the medicaid program to provide help to people who need it and we want the medicare program to look after the medical needs of our senior citizens. We want that care to be high quality. But, we think it should be provided on the basis that is efficient and economical, not on a basis which is wasteful and extravagant."

The Chairman suggested that persons desiring to participate in future phases of the Committee's hearings into the Medicare and Medicaid programs contact Tom Vail, Chief Counsel, Committee on Finance, Room 2227 New Senate Office Building, Washington, D.C.

EXPLANATION OF CHART 1

Medical Assistance: Vendor Payments for Medical Care

It was in 1950 that the Congress first authorized "vendor payments" for medical care—payments from the welfare agency directly to physicians, health care institutions, and other providers of medical services. Federal sharing was liberalized in subsequent amendments, and by 1960 four-fifths of the States made provision for medical vendor payments. In 1951, vendor payments for medical care totaled slightly more than $100 million; by the end of the decade, they had increased to about one-half billion dollars. More than half of the total was spent under Old Age Assistance.

A new category of assistance recipient was established by the Congress in 1960 in the Kerr-Mills program: the "medically needy" aged, whose incomes were high enough that they did not need cash assistance payments, but who needed help in meeting the costs of medical care. Between 1960 and 1965, total vendor payments more than doubled, from about one-half billion dollars to $1.3 billion. Increases in vendor payments under Old-Age Assistance and the new Medical Assistance for the Aged program accounted for three-quarters of the increase.

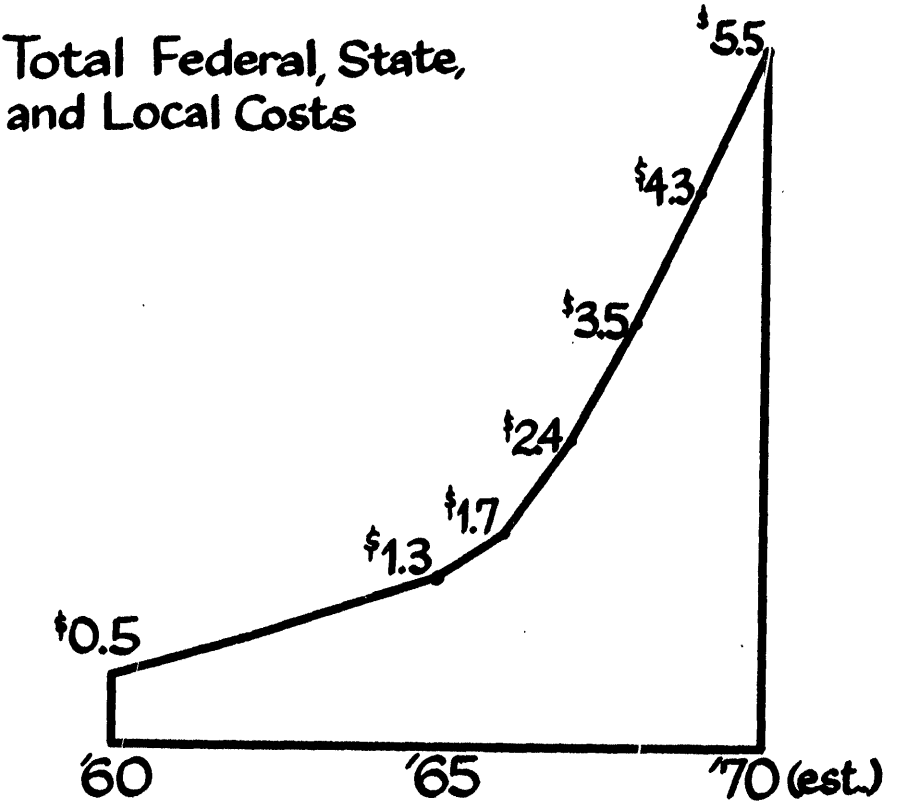
In 1965, a new medical assistance (Medicaid) program was enacted as a part of the Social Security Amendments of 1965 (which also included Medicare). The Medicaid program had these features: (1) it substituted a single program of medical assistance for the vendor payments under the categorical cash assistance and Medical Assistance for the Aged programs, with a requirement that beginning in January 1970 Federal sharing in vendor payments would only be provided under the Medicaid program; (2) it offered all States a higher rate of Federal matching for vendor payments for medical care; (3) it required each State to cover all persons receiving or eligible to receive cash assistance; (4) it permitted States to include medically needy blind, disabled, and dependent children and their families (as well as the medically needy aged) at the option of the State; and (5) it required that States include inpatient and outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physicians' services; it permitted the States to include other forms of health care at their option.

Expenditures under the Medicaid program have increased much more rapidly than anyone had anticipated. Between 1965 and 1970, total Federal, State, and local costs will have risen from $1.3 to $5.5 billion.

CHART 1

Vendor Payments for Medical Care Have Risen Sharply Since Medicaid Was Enacted

(dollars in billions)



EXPLANATION OF CHART 2

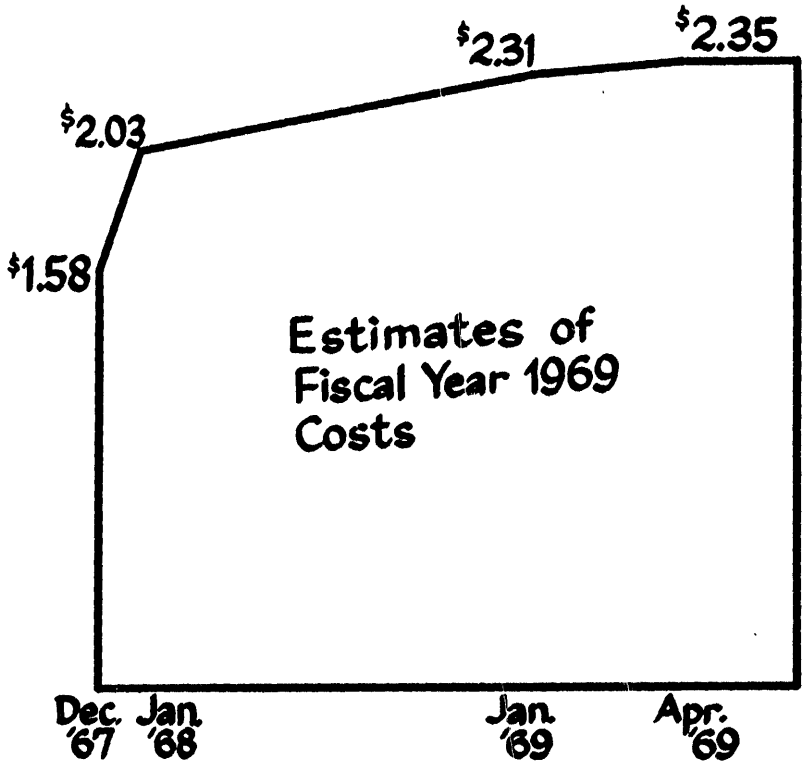
Revision in Estimates of Fiscal Year 1969 Medicaid Costs

The sharp rise in medical vendor payment costs and the difficulty of estimating the amounts required is shown dramatically in the revisions made in the estimates for fiscal year 1969. In December 1967, the Congress was told that fiscal year 1969 estimates would total $1.58 billion in Federal funds. One month later this estimate was revised upward by $450 million. In the budget submitted to the Congress this January, the estimate was increased by another $200 million, and in the revised budget submitted 3 months later another $40 million was added.

The current estimate of $2.5 billion is almost 50 percent greater than the estimate made 19 months ago.

CHART 2

Current Estimates of Federal Medicaid Costs in Fiscal Year 1969 are Almost 50% Higher Than Estimates Made 19 Months Ago (dollars in billions)



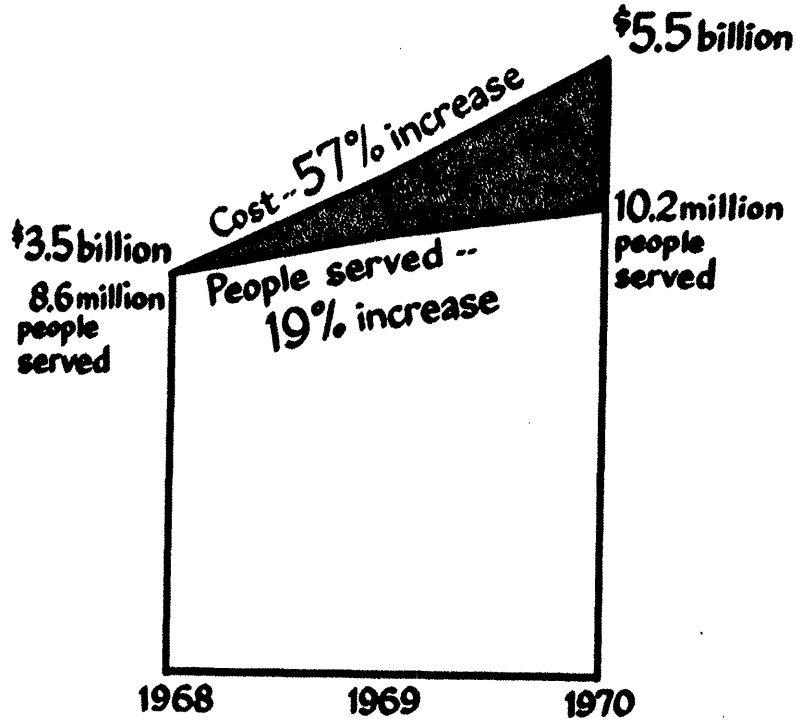
EXPLANATION OF CHART 3

Increased Medicaid Costs Outstrip Increases in Numbers of People Served

Though Medicaid costs are increasing rapidly, much of the increas is eaten up by the inflation in medical care costs. The 1970 budge estimates that the total Federal, State, and local cost of medica vendor payments will rise from $3.5 billion in 1968 to $5.5 billion i 1970—a 57-percent cost increase. During the same period, however the number of people served is estimated in the budget to increas from 8.6 to 10.2 million—a 19-percent increase, only one-third of th increase in cost.

CHART 3

Medicaid Cost Increases Between 1968 and 1970 are Estimated to be 3 times as great as the Increase in the number of people served



EXPLANATION OF CHART 4

Medical Vendor Payments as a Portion of Total Welfare Costs

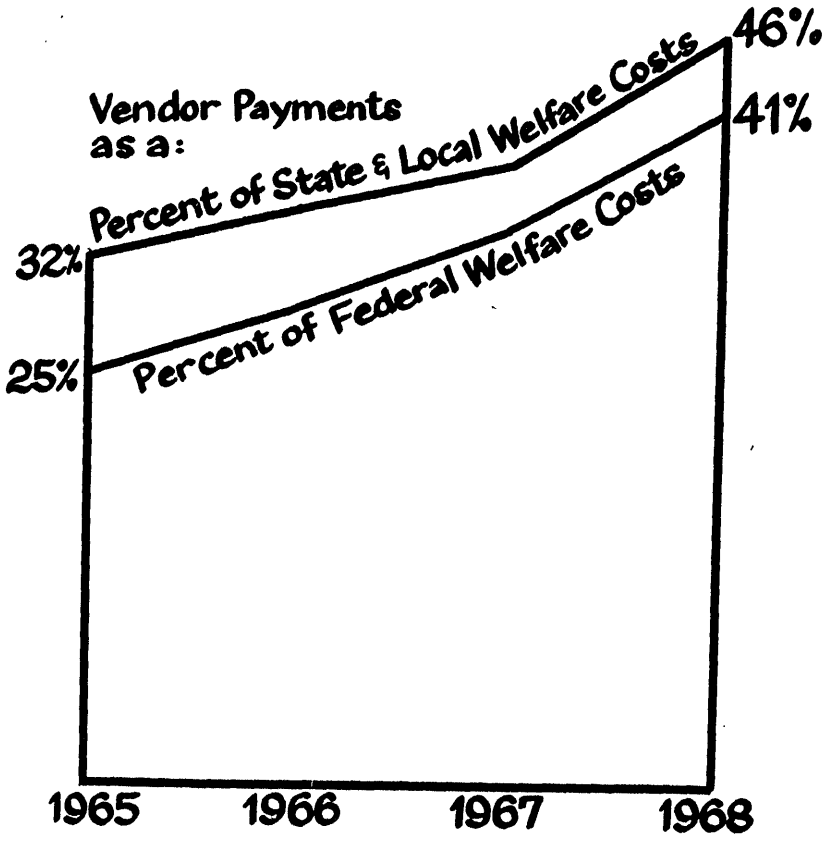
Increasing Medicaid costs have had a particularly severe fiscal impact on the States. Welfare costs typically constitute one of the largest items in the State budget, and vendor payments for medical care have represented an increasing share of welfare costs. In fiscal year 1965, just before Medicaid's enactment, medical assistance represented 25 percent of total Federal, State, and local welfare costs (excluding administrative costs). Over a 4-year period, this percentage has risen to 41 percent. Looking at State and local funds only, medical vendor payments have risen over the 4-year period from less than one-third to almost one-half of welfare expenditures (excluding costs of administration). In absolute dollar terms, the rise has been precipitous: from $764 million in State and local funds for medical vendor payments in fiscal year 1965 to $1,896 million in fiscal year 1968—a 150 percent increase within 4 years.

A questionnaire was sent by the staff to each Governor asking whether current Medicaid estimates were greater than earlier projected costs for the same years. About half of the States whose Medicaid programs were initiated in 1966 or 1967 responded that Medicaid costs are exceeding earlier projections. In a few States the costs are not exceeding earlier estimates only because the program has been cut back to fit within appropriation ceilings.

The questionnaire also asked whether Medicaid cost increases had forced the State to increase taxes, reduce other State programs, or take other action. One-third of the States initiating a Medicaid program in 1966 or 1967 have raised State taxes at least in part due to Medicaid costs; a number of Governors state that the tax increases in their States could be directly linked to greater-than-anticipated Medicaid costs. Several Governors attributed either cutbacks in other State programs or curtailment of growth in other programs directly to increased Medicaid costs.

CHART 4

Medical Vendor Payments Have Grown as a Portion of Total Welfare Costs



EXPLANATION OF CHART 5

Actuarial Estimates of 1970 and 1990 Hospital Insurance Benefits

The Medicare law enacted in 1965 included benefits under two parts: (1) Part A, Hospital Insurance, provided hospital benefits and extended care and home health benefits after hospitalization; and (2) Part B, Supplementary Medical Insurance, paid part of the cost of doctors' services, diagnostic services (such as X-ray and laboratory tests), and home health services (even without prior hospitalization). The Hospital Insurance program was to be financed through an employer-employee tax like the social security cash benefit programs. Almost all of the cost of the program was attributed to hospital benefits. In 1965, when the Medicare program was enacted, the actuarial cost estimates were based on current data on utilization of hospital care and hospital costs. Based on these data, the program was estimated to cost $2.9 billion in 1970 and $8.8 billion in 1990.

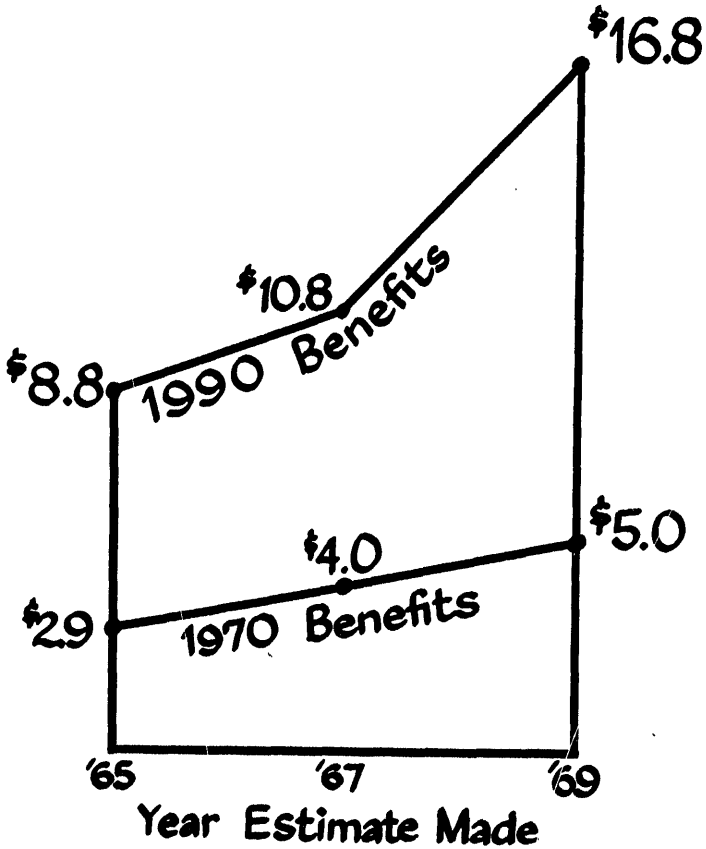
Preliminary experience led to a thorough reevaluation of the earlier actuarial estimates in 1967. At that time, cost estimates were increased by about 25 percent; 1970 costs were increased to $4 billion, while estimates of 1990 costs were increased to $10.8 billion.

Again in early 1969, the actuarial cost estimates were reevaluated, and new estimates were incorporated in the 1969 report of the Hospital Insurance Trust Fund trustees. For the first time, actuarial assumptions were more firmly based on actual program experience. The increases in projected program costs were dramatic; 1970 benefit payments are now estimated at $5 billion, and 1990 benefit payments are now projected at $16.8 billion—in both cases, almost twice the original estimates made in 1965.

CHART 5

Hospital Insurance Benefit Estimates Have Been Almost Doubled in 4 Years

(dollars in billions)



32-108 O - 69 - 2

EXPLANATION OF CHART 6

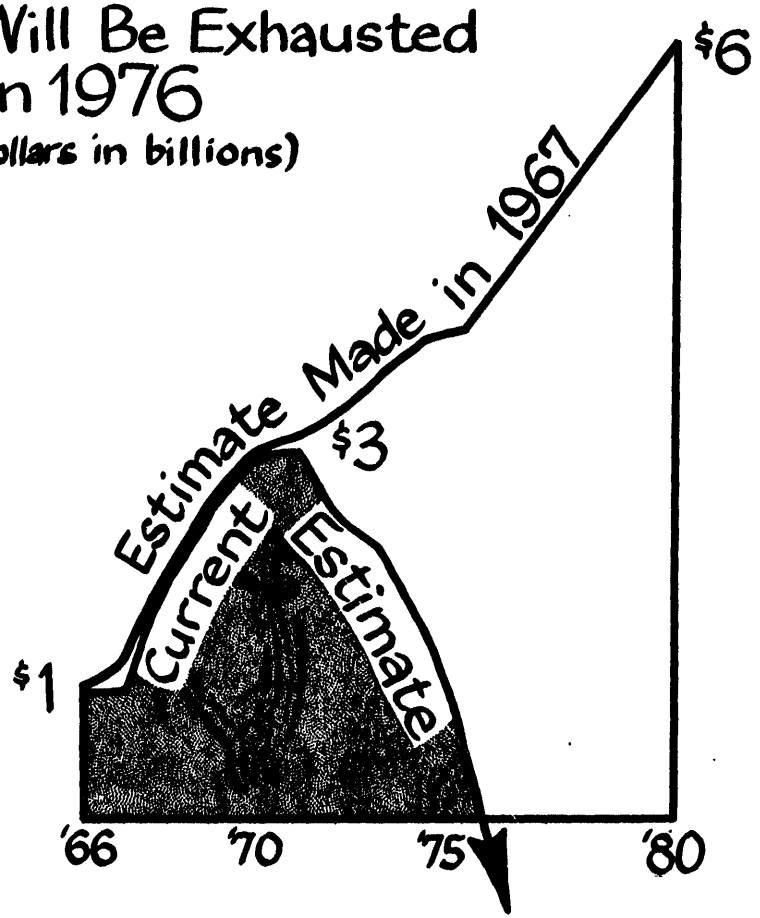
Hospital Insurance Trust Fund Due To Be Exhausted in 1976

In 1967 the Congress increased Hospital Insurance taxes by about 25 percent to shore up the program's financing. Without this increase, the Social Security Chief Actuary had estimated that the Hospital Insurance Trust Fund would have been exhausted in 1970. The Hospital Insurance tax increase was meant to restore the actuarial soundness of the Hospital Insurance program—that is, to insure that tax income would more than equal benefit payments over the next 25 years. But the current projections of the progress of the Hospital Insurance Trust Fund included in the 1969 Trustees' Report show that unless taxes are increased or benefits reduced, the Trust Fund will be exhausted in 1976.

CHART 6

Unless Taxes Are Raised or Benefits Reduced, the Hospital Insurance Trust Fund Will Be Exhausted in 1976

(dollars in billions)



EXPLANATION OF CHART 7

Restoring Actuarial Soundness of Hospital Insurance Program

With the actuarial projection that the hospital insurance trust fund will be exhausted in 1976, there are three ways of restoring the actuarial soundness of the Hospital Insurance program:

(1) Hospital Insurance taxes can be increased by 20 percent;

(2) The hospital deductible of $44 (about equal to 1 day of hospitalization) can be increased to $175 (about 4 days of hospitalization); or

(3) Cost controls can be put into effect.

Of course, it would be possible to combine these alternatives.

CHART 7

Alternative Ways of Restoring Actuarial Soundness of Hospital Insurance Program:

- Increase Hospital Insurance Taxes 20%

or

- Increase deductible from $44 to $175

or

- Control Costs

EXPLANATION OF CHART 8

Estimates of 1970 Hospital Costs Per Beneficiary

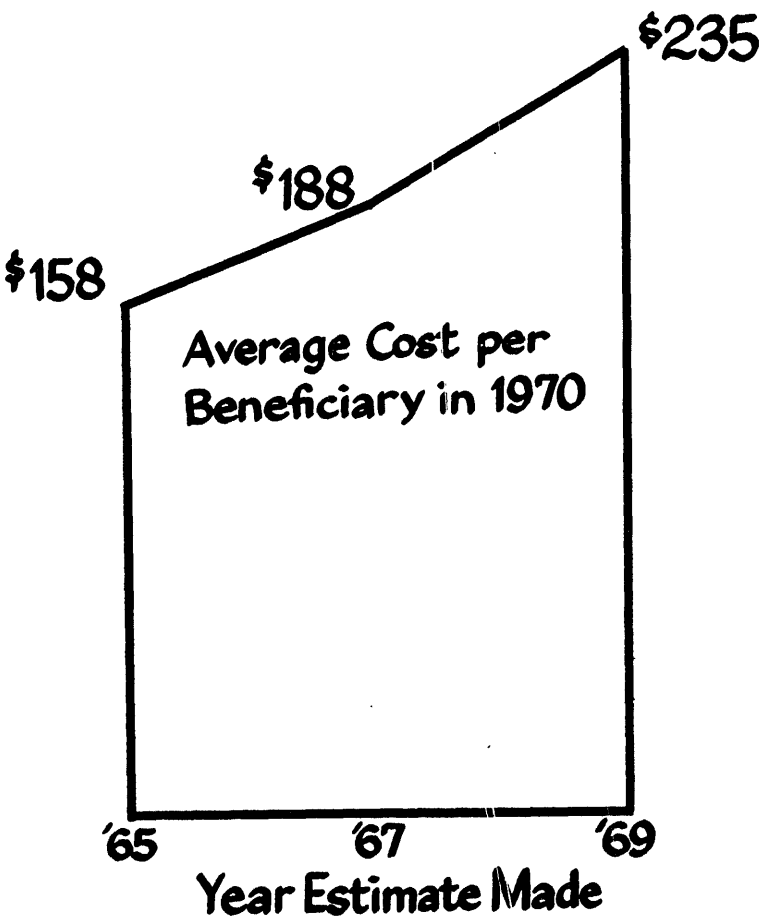
Under the 1965 actuarial estimates made when Medicare was enacted, it was assumed that average daily hospital costs would reach $50 by 1970. It was also assumed on the average, hospital insurance beneficiaries would spend 3.16 days in the hospital per year. The product of these two numbers, $158, represented the estimate of the annual hospital cost per beneficiary in 1970 (equivalent to the total hospital benefits divided by the number of persons enrolled in the hospital insurance program). Both of these assumptions were based on a careful analysis of experience with rising hospital costs and hospital utilization by persons over 65 during the previous decade. In fact, the assumptions were deliberately given a conservative bias by choosing a somewhat higher utilization than was warranted by experience at that time.

By 1967 it had become clear that hospital costs were increasing far more rapidly than had been projected. The revised actuarial estimates now assumed that 1970 average daily hospital costs would be more than $59. The same utilization rate (3.16 days of hospitalization per beneficiary per year) was assumed, and thus it was estimated that in 1970 the hospital cost per beneficiary would be $188.

By 1969, the first year's experience showed that hospital utilization had exceeded the earlier assumption by 20 percent. In the new actuarial estimates, it was assumed that the actual 1967 utilization rate of 3.8 days of hospitalization per beneficiary per year would continue in the future. The 1970 average daily hospital costs are now estimated at $62 for an average cost per beneficiary in 1970 of $235—almost a 50-percent increase above the estimate made in 1965.

CHART 8

Estimates of 1970 Hospital Costs per Beneficiary Have Been Increased Sharply



EXPLANATION OF CHART 9

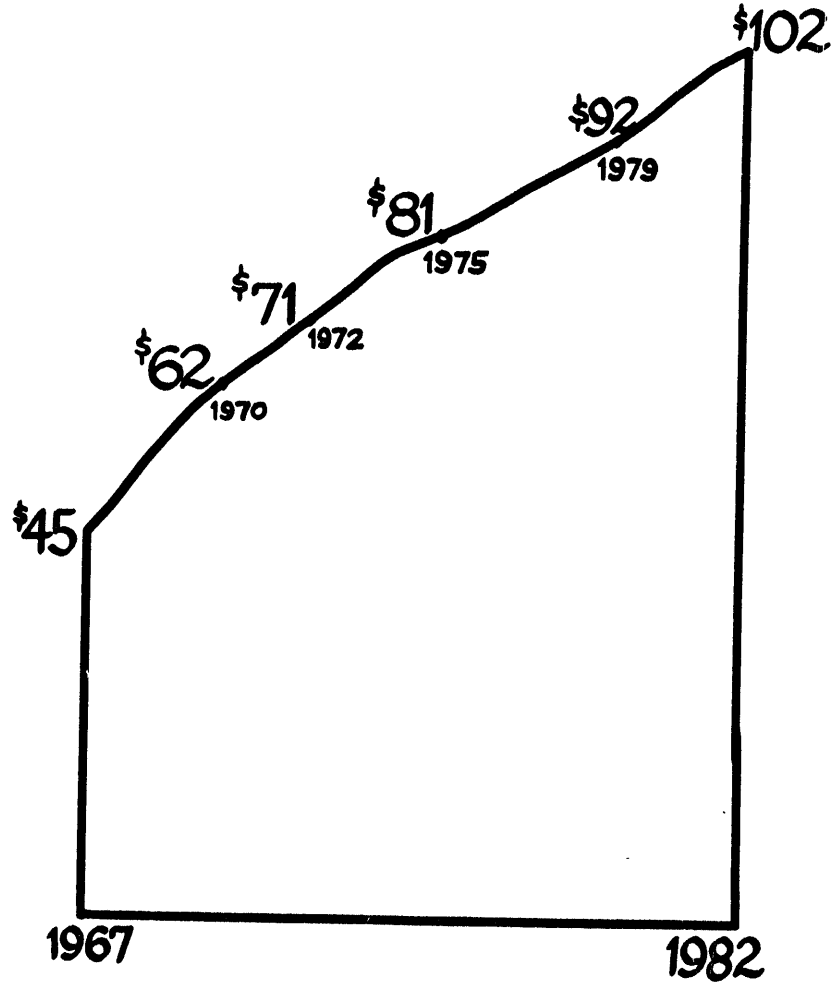
Projected Daily Hospital Rates

Under the 1969 actuarial projections it is assumed that the 1967 average daily hospital cost of about $45 increased 13 percent in 1968 and will increase by 12 percent in 1969, 9 percent in 1970, and by declining amounts after that until a stable annual increase of 3.5 percent is reached in 1975.

Under these estimates the average daily hospital rate will be about $62 in 1970, $71 in 1972, $81 in 1975, $92 in 1979, and $102 by 1982.

CHART 9

Estimated Daily Hospital Rates, 1967-1982



EXPLANATION OF CHART 10

Extended Care Benefits in 1967

The original actuarial estimates made in 1965 when Medicare was enacted assumed that on the average, each person enrolled in the hospital insurance program would spend one-sixth of a day in an extended care facility in 1967. Based on then recent experience, it was assumed that the average daily cost in an extended care facility would be $11.26. The product of these two numbers, $1.80, represented the estimate of the extended care benefit cost per beneficiary in 1967 (the equivalent of total extended care benefits under the program divided by the number of persons enrolled in the program).

Actual experience in 1967 showed that the cost per beneficiary per year was $18—10 times the earlier estimate. The actual average daily cost was $18.16, and the utilization rate was 1 day per beneficiary per year.

CHART 10

Extended Care Benefits in 1967 Cost 10 Times the Original Estimate

1967 estimate made in 1965:

$11 daily cost
× 0.16 days per beneficiary
$1.80 per beneficiary per year

Actual 1967:

$18 daily cost
× 1 day per beneficiary
$18 per beneficiary per year

EXPLANATION OF CHART 11

Supplementary Medical Insurance Deficit on an Accrual Basis

The financing of the supplementary medical insurance program is essentially different from that for the cash benefit and hospital insurance programs in several fundamental respects. First, the premium rate for any period is required by law to be set at such an amount that income from premiums and Government matching contributions accrued in the period is estimated to be sufficient to cover the benefit payments and processing costs related to all services furnished during that period. In this way, those enrolled in the program during any period for which a particular premium rate is applicable will, as a group, pay for half the cost of the services that they as a group receive during that period. Thus costs are measured on an accrued (incurred) basis when the services are provided, rather than on a cash basis, when the services are paid for.

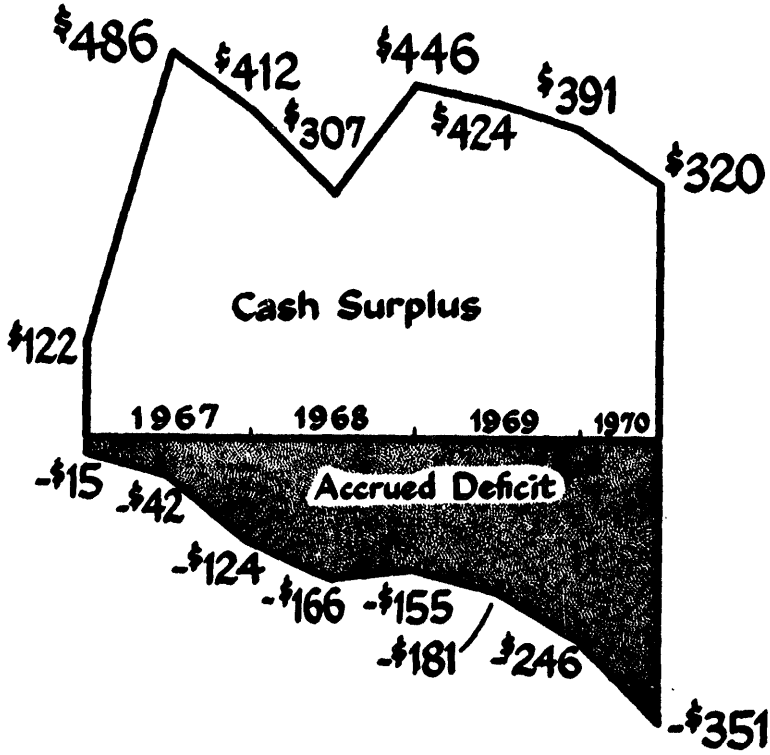
Second, the financing of the program is set only for short periods into the future, so that there is no need for long-term projections of the experience of the program. (The premium rate for each fiscal year period is promulgated before the January 1 that precedes the beginning of such fiscal year.) Further, there is no natural accumulation of an excess of income over disbursements as the covered population matures. The natural lag in the payment of benefits results in a cash surplus which provides some margin to insure enough assets on hand at any time to pay benefits should the premium prove inadequate by a small margin.

Since there is a delay in the submission and payment of bills, the supplementary medical insurance trust fund has shown a positive cash balance since the beginning of the program. However, this cash balance is expected to decline by more than $100 million during fiscal year 1970, when the $4 monthly premium is in effect.

The law, however, requires that monthly premiums be based on the estimated accrued costs. On this basis, the supplementary medical insurance program has shown a growing deficit from its inception, a deficit which is expected to grow during the current fiscal year. The deficit is expected to almost double between June 30, 1969 (—$181 million) and June 30, 1970 (—$351 million), because the $4 monthly premium for fiscal year 1970 is expected to be about 10 percent too low.

CHART 11

Supplementary Medical Insurance Has a Cash Surplus, but a Growing Deficit on an Accrual Basis (dollars in millions)



EXPLANATION OF CHART 12

Restoring Actuarial Soundness of Supplementary Medical Insurance Program

With the actuarial projection that the accrued deficit in the Supplementary Medical Insurance Trust Fund will almost double in the current fiscal year, there are three ways of restoring the actuarial soundness of the Supplementary Medical Insurance program:

(1) The monthly premium can be increased from $4 to $4.40;
(2) The deductible of $50 can be increased to $80; or
(3) Cost controls can be put into effect.

Of course, it would be possible to combine these alternatives.

CHART 12

Alternative Ways of Restoring Actuarial Soundness of Supplementary Medical Insurance Program:

- Increase monthly premium from $4.00 to $4.40

or

- Increase deductible from $50 to $80

or

- Control Costs

EXPLANATION OF CHART 13

Increases in Physician Fees

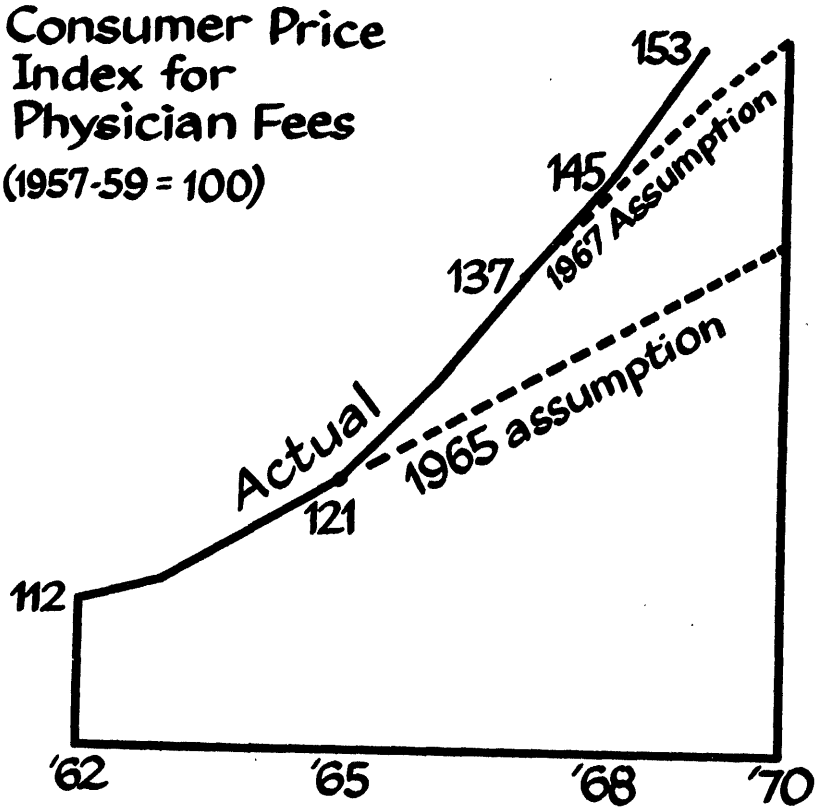
Between 1956 and 1965, physician fees had risen an average of 3 percent annually. The 1965 actuarial estimates assumed a continuation of this rate of increase.

However, physician fees between June 1965 and June 1967 actually rose at an annual rate of 6.5 percent per year (compared to the 3-percent average rate of the previous 10 years). In setting the supplementary medical insurance premium which was to go into effect in April 1968, it was assumed that physician fees would rise at the rate of 5 percent per year between July 1967 and July 1969, and by 3 percent per year thereafter.

Between June 1967 and June 1968, physician fees rose 5.5 percent (compared with the 5-percent increase previously estimated). The late 1968 actuarial estimate assumed that physician fees would increase 5 percent in 1969, 4.5 percent in 1970, and 3.5 percent in 1971. Despite the actuarial estimates which indicated the need for a 10-percent increase in the monthly premiums, it was decided not to increase the $4 monthly supplementary medical insurance premium on the assumption that either (1) there would be no increase in either physician fees or utilization of services between July 1969 and June 1970, or (2) reimbursement would much more often than in the past be based on less than the full charge. Between December 1968, the month of the promulgation of the $4 premium rate, and April 1969 physician fees rose 2.8 percent.

CHART 13

Physician Fees Have Increased More Rapidly Than The Estimates Assumed



32-108 O - 69 - 3

EXPLANATION OF CHART 14

Intermediary and Carrier Costs

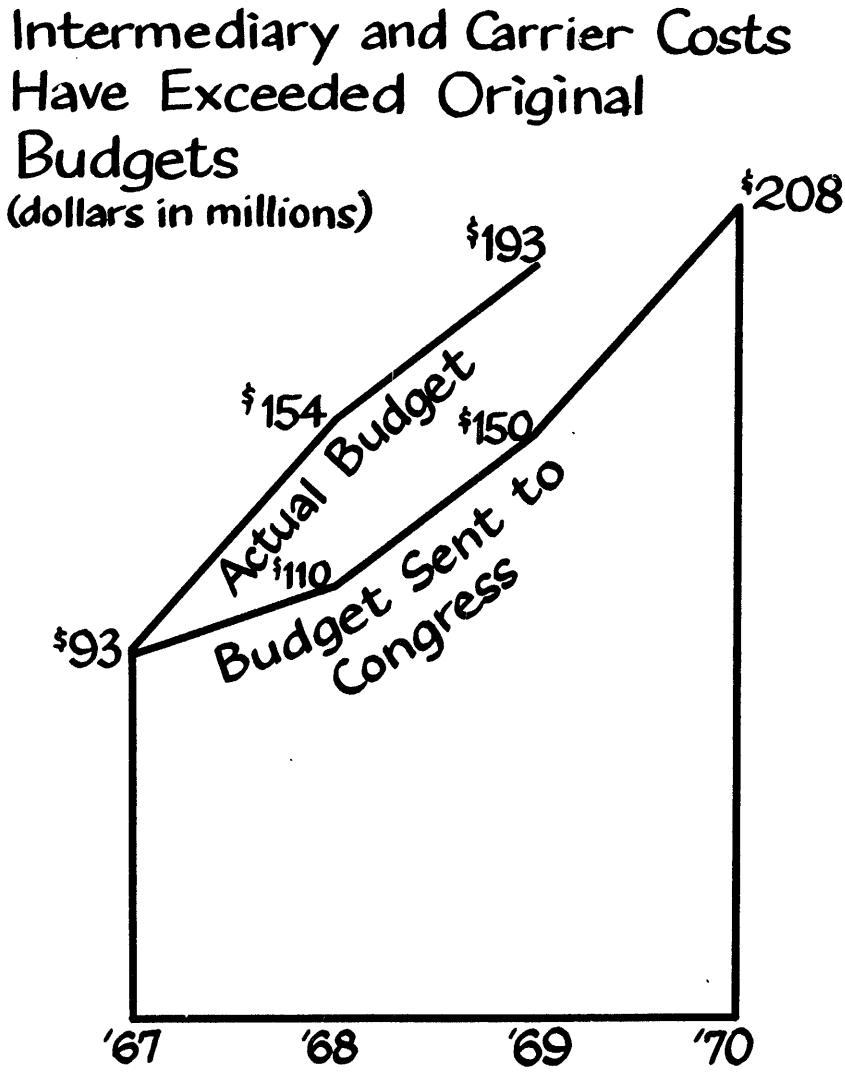
Though only a small portion of the total cost of the Medicare program, administrative costs have been subject to the same problem of unanticipated increases as have the benefit payments.

The President's budget for fiscal year 1968, for example, anticipated a need of $44 million for part A intermediaries (insurance companies and Blue Cross plans that handle Hospital Insurance claims) and $66.2 million for part B carriers (insurance companies and Blue Shield plans that handle Supplementary Medical Insurance claims), a total of $110.2 million. These funds soon proved insufficient; a special $25 million contingency fund was also exhausted; and a supplemental appropriation was sought. The actual fiscal year 1968 budget was $55.3 million for part A intermediaries (26 percent more than the original estimate) and $88.2 million for part B carriers (48 percent more than the original estimate), a total of $153.5 million.

In fiscal year 1969, the story has been much the same. The original President's budget included $60.8 million for part A intermediaries and $89 million for part B carriers, a total of $149.8 million. As in fiscal year 1968, use of a special $25 million contingency fund was necessary. But this was not enough. A $16.5 million supplemental appropriation was sought by the President; the Senate added another $4.7 million to this amount because the Department of Health, Education, and Welfare determined that this additional amount was needed. The current estimate of need is $76.5 million for part A intermediaries (26 percent more than the original estimate) and $116.7 million for part B carriers (31 percent more than the original estimate), a total of $193.3 million.

The current 1970 budget estimates a need for $208 million for intermediary and carrier costs.

CHART 14


Intermediary and Carrier Costs Have Exceeded Original Budgets
(dollars in millions)
$208
$193
$154
$150
Actual Budget
$110
Budget Sent to Congress
$93
'67
'68
'69
'70

EXPLANATION OF CHART 15

Preliminary Findings: Medicaid

The January budget estimated Federal Medicaid costs in fiscal 1970 at $3.07 billion.

A revised estimate issued in April by the new administration shows a downward revision of $505 million. The reduction is estimated to occur as a result of elimination of the 2 percent bonus above costs paid to hospitals; a reduction of $120 million in Federal matching for care of the mentally ill; and limitation of payments to physicians to the lowest Blue Shield schedule in each geographic area. (It is our understanding that the administration has departed from its earlier position on the last item—limiting Medicaid payments to physicians.)

Some $238 million of the estimated reduction is attributable to downward revisions in State estimates of fiscal 1970 Medicaid spending. But one-half of this $238 million is nothing more than a bookkeeping change—a shift of skilled nursing home costs under Medicaid to intermediate care facility costs under Old-Age Assistance. Additionally, $120 million of the estimated reduction assumes a change in law with respect to the mentally-ill aged. Necessary implementing legislation has not been requested and in view of the legislative history of Federal matching for the mentally ill, congressional approval of such a proposal may be difficult to secure.

Medicare has served to increase the cost of hospital, physicians' and nursing home care of Medicaid. By HEW regulation, States must pay hospitals on the same formula as Medicare. The State of Connecticut has refused to follow that regulation, maintaining that to do so would cost it an additional $4 to $5 million a year.

Payment for physicians' services on the basis of "customary and prevailing charges" under Medicare has led to pressure by physicians for similar treatment under Medicaid. That pressure has been increased by published statements of the principal HEW Medicaid official that the Medicare method is the only "logical" way to pay for doctors' care under Medicaid.

A number of States have yielded to demands that they reimburse skilled nursing homes on the more generous basis under which extended care facilities are paid under Medicare.

Overutilization of care and services under Medicaid results from widespread abuse by recipients and providers of services coupled with a lack of effective control mechanisms.

Medicaid is both victim and cause of the superinflation in the medical care field through the increased demand on scarce resources which it has generated.

Federal officials have been lax in not seeing to it that States establish and employ effective controls on utilization and costs, and States have been unwilling to assume the responsibility on their own. The Federal Medicaid administrators have not provided States with the expert assistance necessary to establish and implement proper controls. Also, they have not developed mechanisms for coordination and communication among the States about methods of identifying and solving Medicaid problems.

CHART 15

Principal Preliminary Findings

- Medicaid
  - 1970 estimates of program costs too low
  - Reasons for high costs:
    - Impact of Medicare
    - Overutilization
    - General Inflation
    - Administrative laxity

EXPLANATION OF CHART 16

Preliminary Findings: Physician Reimbursement

The provisions of the statute and the clear congressional intent that Medicare carriers should not pay physicians more than they would ordinarily pay for their own subscribers has not been followed. Congress said that in paying physicians "consideration" should be given to customary and prevailing fees. Blue Shield had testified in 1965 that they regularly surveyed prevailing and customary physician fees, and that their fee schedules were very close and getting closer to prevailing fees. In actual practice the Medicare regulations require that payment should be made *solely* on the basis of customary and prevailing fees and that private insurance schedules should not have any influence on what Medicare paid. As a consequence, Medicare generally makes payments for the aged which are substantially higher than those paid under Blue Shield's most widely held contracts for the working population, and thus physicians' incomes have been inflated.

The need to maintain detailed data with respect to customary charges for each physician and for prevailing fees in each locality has led to weak administrative practices, unwarranted delays in payments to physicians and beneficiaries, and high administrative costs. There is a good deal of evidence that Medicare's pattern of inflated payments has also served to increase physicians' charges to the general public because a doctor is not permitted to charge more under Medicare (at least theoretically) than he does for his other patients.

Medicare is making payments for services by supervisory physicians in teaching hospitals—payments which were not generally made before Medicare.

These services, in fact, are not provided by those physicians but by residents and interns. Payment for these "services" may be costing as much as $100 million a year to Medicare. There is a question whether Medicare beneficiaries have a legal obligation to pay for such services. (Medicare payments are expressly prohibited by law in the absence of a legal obligation to pay.) Moreover, since the salaries of the interns and residents who actually provide the care are paid for under the hospital insurance program, Medicare may be paying for the same services twice.

There is substantial evidence that many physicians are engaging in the practice known as "gang visits" to nursing home and hospital patients. Under this practice a physician may see as many as 30, 40, and 50 patients in a day in the same facility—regardless of whether the visit is medically necessary or whether any service is actually furnished. The physician in many cases charges his full fee for each patient, billing Medicare for as much as $300 or $400 for one sweep through a nursing home.

There is evidence that physicians are now billing separately for services which were previously routinely included in a charge for an office visit or a surgical fee. For example, routine laboratory tests which were part of the office visit charge are now billed in addition to the fee for the visit. In some cases a surgeon now charges separately for preoperative and postoperative visits, services which used to be part of his surgical fee. This kind of price increase does not show up in the consumer price index figures set out in an earlier chart.

Conflict of interest situations occur with apparent widespread physician investment in nursing homes and proprietary hospitals. The physicians in these situations have an economic incentive to order as many services as possible and to extend the duration of stay for those of his patients whom he places in a medical facility in which he has an investment. It appears that many general practitioners are providing services—such as psychiatric counseling, injections, and laboratory work—to an extent unrelated to medical needs and solely for the purpose of maximizing their Medicare billings.

CHART 16

Principal Preliminary Findings

- Physician reimbursement
  - Congressional intent not followed
  - Lax carrier performance
  - As a result:
    - Payments much higher than Blue Shield's
    - Inflated physician incomes
    - Costly and complex administration
    - Inflated costs for total population
  - Unprecedented payments to supervisory physicians
  - Abuses:
    - "Gang visits"
    - Visits not necessary
    - Fragmentation in billing
    - Conflict of interest situations
    - Unnecessary services

EXPLANATION OF CHART 17

Preliminary Findings: Carrier and Intermediary Performance, Hospitals, Extended Care Facilities

With relatively few exceptions carriers and intermediaries have not been administering Medicare with the tight control necessary to the "efficient and economical" performance required by the law. Only a small proportion of the carriers now have in effect an adequate system for detecting and handling cases of abuse and overutilization.

Situations have occurred wherein a provider of health services transferred its insurance business to the government intermediary it had selected. Presumably, the intermediary would be reluctant to take action as the government's agent which would jeopardize its private business—a clear case of conflict of interest. In another case, the principal Medicare administrator of an insurance company served on the board of directors of a nursing home chain in New England (reportedly, the official recently resigned from that board).

Reports have been received of various intermediaries soliciting hospital and nursing homes for which they wish to act as intermediary, through implicit assurance that if selected they would treat the hospital or nursing home more generously with Medicare's money than the present intermediary. This situation leads to competition in spending Medicare money rather than conserving it.

In general, claims control procedures are ineffective. When asked for simple basic data about the physicians' services which Medicare paid for, one carrier advised that it would take 9 weeks and thousands of additional dollars to develop this simple information—information which they should have been routinely developing as a basic claims control. Another did not keep records on the total Medicare payments it made to individual physicians nor did it know how many different Medicare patients had been rendered service by the various doctors it paid.

Utilization review in hospitals is largely ineffective. Evidence of this may be seen in the tremendous jump in hospital utilization by Medicare beneficiaries. As the president of one State medical society put it: "Hospital utilization review works well in an area where there is a shortage of hospital beds. In other areas, however, where there is no shortage, utilization review is no more than token." A study in one State showed that only one-half of the hospitals had a utilization review plan which met the statutory requirement for sample review of admissions.

The costs of hospital benefits during Medicare's first year of operation are not fully known because only 22 percent of hospitals have completed settlement with the Government. This lag of several years in settling accounts with hospitals makes Medicare estimating and accounting very difficult.

Utilization review in extended care facilities is generally either nonexistent or is a meaningless formality. In one State *not one* of the extended care facilities met this statutory requirement.

Another cause for concern is the alarming growth in chain operations in the nursing home field. Some of these chains actively solicit physician purchase of stock to assure a high occupancy rate. Other chains purchase stock of hospital supply and pharmaceutical supply houses. This leads to arrangements with respect to intercompany sales at what may very well be higher prices than would otherwise be paid—a form of captive market used to milk the Medicare trust funds.

Only a small percentage of nursing homes have finally settled with the Government for their first year under the program.

Unnecessary services are being provided on a widespread basis in nursing homes. Twenty Medicare patients were lined up in a nursing home hallway in their wheel chairs and given a single exercise by a physical therapy aide for a period of 5 minutes. Medicare was charged $9 for each of those patients for that service.

The majority of the extended care facilities participating in the program do not fully meet the standards set in the law and regulations.

CHART 17

Principal Preliminary Findings

- Carrier and Intermediary performance
  - Widespread lax administration
  - Conflict of interest situations
  - Intermediary solicitation of business
  - Poor claims control procedures
- Hospitals
  - Utilization review largely ineffective
  - Only 22% of 1st period accounts (1966-67) settled
  - Rapidly increasing costs
- Extended Care Facilities
  - Utilization review virtually nonexistent
  - Chain operations growing
  - Very few 1st period accounts (1967) settled
  - Unnecessary services
  - Participation of unqualified facilities

EXPLANATION OF CHART 18

Preliminary Findings: Reimbursement of Institutions, Federal Administration

Medicare has paid a 2 percent bonus to hospitals (1½ percent for proprietary facilities) above their actual costs. The committee has strongly criticized this cost-plus method of reimbursement since May, 1966. This method of reimbursement can only serve as a further incentive to inflate costs—the more costs can be increased, the greater the bonus. (The new Administration has recognized the validity of the Committee criticism and has announced that it would terminate payments of the bonus effective today, July 1, 1969.)

The Medicare reimbursement formula has other deficiencies. In most cases it pays a disproportionate share of unoccupied bed costs in a facility: it permits inflated depreciation allowances on inflated cost bases. Its reimbursement of covered costs without limitation is a built-in incentive for inefficiency and inflation.

Evidence exists that "kick back" arrangements between suppliers—such as pharmacies and physical therapists—and nursing homes may be widespread.

The administration of Medicare is inadequate and ineffective from the standpoint of insistence upon proper cost controls and utilization review. There is a high degree of tolerance for carriers and intermediaries who cannot reasonably be considered as "efficient and economical" as required by law. There is a lack of current program information with respect to costs and utilization which hampers both effective administration and estimating.

In their eagerness to get as much health care as possible to the greatest number of people, secondary concern seems to have been given to the quality of the care and the control of costs. The resulting severe actuarial deficiencies which have occurred in Medicare are then glossed over with statements that Congress need merely increase the Social Security tax, or wage base and the costs can be paid.

CHART 18

Principal Preliminary Findings

- Reimbursement of institutions
  - Formula provides 2% bonus
  - Pays for unoccupied beds
  - Supplier kickback arrangements
  - Inflated depreciation allowances
  - Incentive for inefficiency
- Federal Administration
  - Inadequate and ineffective controls
  - Tolerance of inefficient carriers and intermediaries
  - Lack of current program information
  - Cost of program apparently of secondary concern

EXPLANATION OF CHART 19

Preliminary Findings: Lack of Coordination, Medicare-Medicaid, Federal Tax Collector

There is a surprising lack of coordination between Medicare and Medicaid despite the fact that both programs are concerned with paying for health care. In fact, in hundreds of thousands of cases the two programs pay the same providers of services with respect to the same patients. The result at the Federal level is duplication of effort and an inability of one program to take advantage of whatever expertise and skills the other may have developed. There is no uniform system of coordinating information on possible fraud cases between the two programs.

At the State level, for example, Medicare may have information concerning abuses by a physician who also treats Medicaid patients. Medicaid officials in that State, however, do not have access to the details of the Medicare abuse.

Medicare carriers have been permitted to use a variety of so-called identification systems with respect to the physicians to whom they make payments. These systems use a wide variety of numbers—sometimes more than one number for the same physician. They have been characterized as comparable to Swiss bank accounts, since the effect is to make it very difficult to trace the Federal payment. Medicaid and Medicare paid some $2 billion to physicians in the past year. Unlike other payments to individuals, these are not reported to the Internal Revenue Service. The tax collector wants that information.

CHART 19

Principal Preliminary Findings

- Lack of coordination with other Government agencies
  - Medicare - Medicaid
    - Federal level
    - State level
  - Federal Tax Collector
    - $2 billion unreported
    - "Swiss bank account" numbers

The CHAIRMAN. The staff might be somewhat new at the chart-making business. Some of the charts are a little bit rough, but they do indicate the problems and they pretty well indicate what our staff has been doing in this area and I think they can serve as a basis for this hearing, and perhaps a few suggestions.

STATEMENT OF MICHAEL STERN, PROFESSIONAL STAFF MEMBER

Mr. STERN. Mr. Chairman, the first part of this presentation deals with the fiscal dimensions of medicaid and medicare. The first chart shows vendor payments for medical care.

Before 1950, the only kind of payments made under public assistance were made directly to beneficiaries. In 1950, for the first time, the law was changed to permit payments to be made directly to vendors of medical care—that is, doctors, dentists, hospitals, and other providers of medical care. Beginning with 1951, these payments gradually rose from about $100 million to half a billion dollars. In 1960, something new was added. Under the Kerr-Mills program, payment could be made for the first time on behalf of aged persons who were medically needy; that is, persons who were not eligible for old-age assistance, but who needed help to meet the cost of medical care.

Vendor payments for medical care rose from a half billion dollars in 1960 to about $1.3 billion in 1965, largely due to expansion of medical assistance for the aged under the Kerr-Mills program.

In 1965, the concept of "medically needy" was extended beyond the aged to include other needy individuals under the medicaid program. Since 1965, vendor payments for medical care rose from $1.3 billion to a projected $5.5 billion in 1970. A large part of this growth is due to the inclusion of "medically needy" persons under medical assistance—persons not eligible to receive cash assistance.

With this tremendous growth in expenditures under the program, we find that medicaid has contributed to the very inflation in medical care costs of which it has been a victim.

Senator GORE. Can we ask the staff member a question now and then?

The CHAIRMAN. I would prefer that we let them make their presentation; then we will discuss this matter with Commissioner Ball and if you want to, you can question the staff at that time, Senator Gore.

Mr. STERN. Chart 2 illustrates some of the difficulties that have been experienced in trying to estimate medicaid costs. This chart shows Federal costs only for fiscal year 1969. In December 1967, these costs were estimated as being about $1.6 billion and in the budget that came out about a month later, the revised estimate was over $2 billion. That estimate in turn has been revised upward twice, and the current estimate is $2.35 billion, which is about half again as much as the original estimate.

One of the unfortunate things is that this additional money is not buying as much as it used to. As chart 3 shows, between 1968 and 1970, the budget estimates that the total Federal, State, and local cost of medicaid will rise from $3.5 to $5.5 billion. However, the number of people served will only go up from 8.6 million to 10.2 million. The cost increase of 57 percent is about three times the increase in the number of people served during the 2-year period.

Medicaid has become an increasingly significant proportion of Welfare costs at the State and local level as well as at the Federal level. Chart 4 shows that in 1965, the year before the medicaid program was enacted, medical vendor payments represented one-quarter of Federal welfare costs and 32 percent of State and local welfare costs. By 1968, those percentages had increased to 41 percent and 46 percent respectively—in other words, medical vendor payments now represent almost half of State and local welfare costs. Increases in State expenditures for medical vendor payments have strained State financial resources severely. The committee staff has sent a questionnaire to each Governor. About a third of the States which initiated medicaid programs in 1966 or 1967 have either had to raise taxes, at least partly because of the rises in medicaid costs, and in some cases, the Governors say they have had to cut back other programs, such as education programs, because of the increased medicaid costs.

Medicare has two parts. Part A, hospital insurance, pays part of the cost of hospitalization or alternatives to hospitalization, and is financed through a payroll tax. Part B, supplementary medical insurance, pays mostly for physicians' services.

Chart 5 shows how the actuarial estimates of the cost of the hospital insurance program have increased. In 1965, when the program was first enacted, it was estimated by the actuaries that the benefits would total $2.9 billion in 1970 and $8.8 billion in 1990. But as program data became available, the estimates of cost were revised upward to the extent that in the most recent actuarial estimate, the 1970 costs are projected at $5 billion and the 1990 costs at $16.8 billion. This is not the fault of the actuaries; the original actuarial estimates in 1965 were based on a close study of the experience available at that time.

In 1967, when the Congress was considering social security amendments, the actuary projected that the Hospital Insurance Trust Fund would be exhausted by 1970 unless taxes were increased. They were increased by the Congress, and the actuary projected that the Hospital Insurance Trust Fund would grow over a 25-year period. This year, however, the actuary has revised the estimates, and as shown on chart 6, he now projects that the trust fund will be exhausted in 1976 unless taxes are increased again or benefits cut back.

Chart 7 shows alternative ways of restoring the actuarial soundness of the hospital insurance program. The hospital insurance taxes could be increased by 20 percent; or the deductible, which is now $44—roughly equivalent to 1 hospital day—could be increased to $175, roughly equivalent to 4 hospital days; or the cost could be controlled. Of course, these alternatives could be combined.

The average hospital costs per beneficiary are based on two factors: the extent to which facilities are utilized and the cost per hospital day. Both of these have been substantially increased as new estimates have been made, and the results are shown in chart 8. In 1965, it was assumed that on the average, a medicare beneficiary would spend 3.16 days in a hospital in 1970 and that in that year, the average hospital daily cost would be about $50. Multiplying these two factors results in an average hospital cost per beneficiary of $158 in 1970. Under the latest estimate, it is assumed that the ultization rate will be 3.8 hospital days per year per beneficiary—20 percent higher

than the original estimate—based on actual experience in 1967. It is also now assumed that the average hospital daily cost in 1970 will be $62 a day. Thus it is now estimated that average hospital costs will total $235 per beneficiary in 1970 instead of $158 per beneficiary, as estimated in 1965 when medicare was enacted.

Chart 9 shows what the projected estimated daily hospital rates are under the current projections. It is now estimated that in 1967, actual costs were $45. They are expected to go to $62 in 1970, $71 by 1972, $81 by 1973, and up to $102 by 1982.

Another major benefit under the hospital insurance program is extended care. The word "extended" refers to an extension of the medical benefits after a patient has been discharged from a hospital to a facility in which somewhat less intensive medical care is provided. A very strict definition of "extended care facility" was assumed by the actuary in his 1965 cost estimates, and because of what he judged to be the limited number of facilities then in existence, he assumed that on the average a medicare beneficiary would spend one-sixth of a day in an extended care facility in 1967. The daily cost was assumed to be about $11 on the basis of experience at that time. This made an average cost of $1.80 per beneficiary in 1967 under the original 1965 cost estimates, as is shown in chart 10.

Actually, however, the average cost was $18 per day, and the utilization rate was about six times what had been expected. As a result, medicare actually paid $18 per beneficiary on the average in 1967, about 10 times the earlier actuarial estimates.

The supplementary medical insurance program is funded on a different basis from hospital insurance. Persons over 65 who enroll in this program pay a monthly premium, currently $4, which is matched by the Government. The amount of the premium is to be set under the law by estimating the costs which will be incurred under the program during the 12-month period the premium will be in effect; this estimate is divided by the number of beneficiaries, and the resultant amount is paid half by the Government and half by the beneficiaries, over the 12-month period.

While it is true that the program has had a cash surplus ever since its beginning, and a cash balance which is projected to be $320 million by the end of June 1970, there has actually been a growing deficit on an accrual basis. The premium has been somewhat too low each year of the program thus far, and the actuaries now estimate that on an accrual basis, the deficit will be $351 million at the end of fiscal year 1970. Chart 11 illustrates the difference between the cash surplus and the accrued deficit.

Chart 12 shows alternative ways of restoring the actuarial soundness of the supplementary medical insurance program. The actuary has recommended that the monthly payment be increased at least 10 percent, from $4 to $4.40, in order at least to meet the costs incurred during fiscal year 1970. If that were not done, one way of restoring the actuarial soundness of one program would be to increase the deductible, which is now $50, to $80. In the alternative, costs could be controlled.

Chart 13 shows physicians' fees according to the Consumer Price Index. For about a decade between 1956 and 1965, physicians' fees had

increased at about a 3 percent a year rate, and the actuary assumed in 1965 that they would continue to increase by about 3 percent. However, they actually increased by 6½ percent each of the next 2 years. In 1967, the actuary made new assumptions that fees would go up by about 5 percent a year. Again, he was a little bit too low. Between December 1968 and April 1969, physicians' fees rose 2.8 percent, which represents an annual rate of more than 8 percent.

I might note that the Consumer Price Index for physicians' fees does not necessarily tell the story about medicare. The Social Security Administration has developed a separate index for five medical procedures that are particularly common in treating the aged. This index has shown in the last year a somewhat higher rise than physicians' fees generally.

Turning to chart 14, intermediaries and carriers—that is, the insurance companies, Blue Cross and Blue Shield, who handle the claims under the two medicare programs—have generally exceeded their original budgets. For example in 1968, the original budget sent to the Congress projected a need for $110 million for the intermediaries and carriers. The actual budget wound up being about 50 percent higher, $154 million. In 1969, the original budget was $150 million; the latest estimate is $193 million.

STATEMENT OF JAY CONSTANTINE, PROFESSIONAL STAFF MEMBER

Mr. CONSTANTINE. These charts outline the principal preliminary findings, Mr. Chairman, in preparing the staff report. On medicaid, we believe that the fiscal 1970 estimate, the revised estimate which the administration made in April is too low. They assume a total reduction of a little over $500 million, but that includes $120 million in reduced Federal matching for the mentally ill and aged, which will require legislation. In view of the legislative history of that provision it seems questionable whether they will get that legislation.

Another cutback assumed payment to doctors on the basis of the lowest Blue Shield schedule. They have since substituted another procedure which we feel will not realize any savings and may very well increase costs.

They also included in that $500 million reduction, a $238 million decrease resulting from reductions in State estimates of their 1970 costs. Half of that reduction, about $120 million, is essentially a bookkeeping transaction. It represents a shift of nursing home costs from medicaid to intermediate care facilities under old age assistance. It is just a question of which Federal program pays.

Among the important reasons we have found for the high costs in medicaid are the requirement by the Medical Services Administration that a hospital be paid on the same basis as under medicare and the encouragement of States to pay doctors on a prevailing and customary basis. Medicaid is both victim and a cause of inflation.

The administrative laxity in medicaid is omnipresent. There is very little effective control of the program at either Federal, State, or local levels with respect to costs and utilization.

On physician reimbursement under medicare we believe that the congressional intent has not been followed by the Department with

respect to limiting payment to physicians to not more than a carrier's own generally used basic schedule such as in Blue Shield. For example, in many cases, medicare's average payment is far higher than payments for comparable services under Blue Shield's most widely held schedule in an area. Blue Shield told the committee in 1965 that their fee schedules generally reflected the prevailing charges in the community. At that time, Blue Shield plans were required under their charters to pay at least an average of 75 percent of the prevailing charges. The staff believes that at that time, they probably did pay 75 percent, but they do not pay that much today as a consequence of medicare's inflationary pressure.

We have found over 5,000 physicians who were each paid $25,000 or more in 1968 under medicare, and thousands more paid similar amounts under medicaid. In many cases, we believe inflated physician incomes are not a product of abuse or fraud, but rather of lax regulation. That is, a physician who had been charging $200 for a procedure finds the program permits him to go up to $300.

Administration of medicare is costly and complex. They have developed an elaborate but ineffective structure for determining customary and prevailing physician charges. Medicare has inflated costs for the total population. There is evidence of that and we will include it in our report to the committee.

The program at its inception authorized virtually unprecedented payments to supervisory physicians in teaching hospitals. The patient is basically cared for by interns and residents who are otherwise paid for under the hospital insurance program. We have some gentlemen here from the General Accounting Office who have completed an audit of supervisory physicians in Cook County Hospital and will be available on that question.

Senator GORE. Does this mean that the supervisory doctor gets paid for treatment that an intern will provide the patient?

Mr. CONSTANTINE. Yes, sir.

We have evidence of widespread gang visiting. As part of our study we asked Social Security to get us information on all physicians who were paid $25,000 or more and after some reluctance, that task was undertaken. After we got that list, we found about 1,181 with what apparently were unusual patterns of practice. We wanted to know exactly how these doctors charge for their services, how much was paid to each for home and office visits, how much was paid for injections, and so on. Some carriers were capable of providing the information but many cannot come up with that kind of basic control data. The data we have been able to get indicates widespread gang visits. That is where many patients are seen by a doctor in a nursing home or hospital during the same day.

We found many visits which appeared not medically necessary. As a matter of fact, we found one carrier, Pennsylvania Blue Shield, which had detected these abuses and reported them—that is, the gang visits—to the Bureau of Health Insurance. They said that they had no response from the Bureau of Health Insurance so they decided that in view of the lack of interest there, they were just going to process the claims.

There has been fragmentation in billing which inflates costs but which is not computed in medical cost-price indexes. Fragmentation

occurs where a physician previously charged $10 for an office call and still does but now charges separately for lab tests which previously were routinely included in the original office charge—tests such as urinalyses and blood counts, et cetera. We have found doctors who each have something like $20,000 in visit charges, and about $25,000 more in lab charges.

Conflict-of-interest situations exist with respect to physician ownership of nursing homes, proprietary hospitals, and so on. One physician lives in a penthouse in a nursing home he owns and medicare paid him $140,000 last year for medical services.

Carriers and intermediaries are, in general, not doing the job that Congress intended they do. There are some exceptional situations where they are doing that kind of job, but in the main, we characterize their performance as rather loose with respect to cost control and utilization.

There are conflict-of-interest situations here, too. We have carriers who are involved in the sale of private insurance to institutions they serve as intermediaries.

Two Blue Cross plans reported to us on intermediary solicitation of business. That is where one insurer wants to take over another intermediary's hospital or nursing home. They go in and say, if you select us as an intermediary, we will be considerate of your interests.

Claims control procedures are quite poor.

Utilization review in hospitals is largely ineffective. As a matter of fact, one State medical society told us in reply to the staff questionnaire that utilization review in a hospital works well only where there is a shortage of beds. Otherwise, it is merely token.

On completed audits for hospitals, we still do not know how much medicare's costs were for the first year. It may be greater than the estimates we now have, because only about one-fifth of the hospitals have been finally closed and an even smaller number of nursing homes are finally closed with respect to their medicare costs.

In extended care facilities, utilization review is virtually nonexistent. Nursing home people frankly admit that it does not mean anything. As a matter of fact, Social Security even issued a regulation which said utilization review in a facility could be conducted by a committee all of whose members except one being permitted to have an ownership interest in the facility. We understand that they are considering changing that regulation.

In one State, there is no sample utilization review in any ECF as required by statute.

Chain operations have moved strongly into the nursing home field. We find a tremendous growth in chains based upon great expectations of making quite a bit of money. They are encouraged by medicare's reimbursement formula as well as the fact that they can also acquire hospital supply houses, pharmaceutical supply houses, to serve a captive nursing home and hospital market. Chain operators are making a special effort to sell stock to physicians in order to assure themselves of a good supply of patients.

Similarly, as we indicated, very few accounts have been finally settled for ECF's. Many ECF's are apparently providing a large number of services, which are not medically indicated in order to demonstrate

that their patients require that degree of care rendered by an extended care facility—rather than custodial care for which medicare will not pay.

The majority of the ECF's participating in medicare do not fully meet—despite claims of quality care—do not fully meet the conditions of participation for the program.

The 2 percent bonus above allowable costs which the committee has previously criticized has further helped to inflate costs. Medicare, despite the fact that it is supposed to pay only on a reasonable cost basis, pays inordinate amounts for unoccupied or standby bed costs. A hundred bed facility with only 10 medicare patients can be paid the full costs of the unoccupied 90 beds by medicare.

We have quite a few allegations of supplier kickback arrangements. Mr. Chairman, under your instructions, those situations are being reported to the Internal Revenue Service.

We have found inflated depreciation allowances and many sales of facilities at inflated prices in order to get maximum payments from medicare.

The incentive in present reimbursement is toward inefficiency, inasmuch as there are no effective limitations. We will pay personnel costs, for example, with no limit on the number of personnel paid for.

In both medicare and medicaid, there are inadequate and ineffective controls. There has been some improvement observed since the committee started making its inquiry more than a year ago.

There has been obvious tolerance of inefficient and uneconomical carriers and intermediaries, contrary to the legislative intent, which indicated that after the program's first year, fewer carriers and intermediaries would be used.

The cost of the program is apparently of secondary concern to the program's administrators. Casual reference is made in the trustees' report on the hospital trust fund to the fact that while there is a very serious deficit in medicare's financing, that can be taken care of by increases in the taxable wage base and the tax rate, none of which were accepted as financing alternatives by Congress in 1965. It was never contemplated that medicare finances would automatically benefit from wage base increases. As a matter of fact, it was contemplated that with wage base increases, tax rates might be reduced.

There is a complete lack of coordination between medicare and medicaid operations. We had one medicaid State health official tell us that they knew of physicians who were abusing medicare and who were also taking care of medicaid patients, but they were unable to get information from medicare on the abuses. Medicaid and medicare both pay hospitals, both pay physicians, yet there is a complete absence of coordination between the two programs.

That lack of coordination is at both Federal and State levels.

The CHAIRMAN. Mr. Secretary, we are going to follow the procedure under the Legislative Reorganization Act, which is that you will place the entire statement of Commissioner Ball and Dr. Land in the record and if you have a prepared statement, we will also include that in the record.[1]

[1] Mr. Veneman's prepared statement appears at p. 54; Mr. Ball's at p. 104; and Mr. Land's at p. 111.

We will ask you to summarize those statements not exceeding 15 minutes. The Senators will have read those statements by that time. Then we will proceed to ask some questions which come to mind.

You may proceed within those guidelines.

STATEMENT OF JOHN G. VENEMAN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; DR. FRANCIS M. LAND, COMMISSIONER OF THE MEDICAL SERVICES ADMINISTRATION; ARTHUR E. HESS, DEPUTY COMMISSIONER OF SOCIAL SECURITY; THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE; AND JAMES F. KELLY, ASSISTANT SECRETARY, COMPTROLLER

Mr. VENEMAN. Mr. Chairman, at the outset, I would like to join you in commending your committee, and particularly those specific members that you mentioned, for your diligence in trying to get at a problem that I think all of us are concerned with. I believe that it was through this committee that titles XVIII and XIX were conceived and nurtured and put into the statutes for the purpose of providing medical care to the aged and needy of this nation. It certainly was not the intention of this committee or any administrative agency to see it abused in any manner.

I also commend your staff for what I think is a very fine presentation of the problems, many of which are quite familiar to me.

The CHAIRMAN. Permit me to say that so far as I know, your Department has not withheld any information from us. If it has not been made available to us, it is just because they do not have it. We find no indication that there is any covering up of problems in your administration.

Mr. VENEMAN. I hope that line of communication continues, Senator.

I will attempt to summarize as briefly as I possibly can. As I mentioned, I served 2 years ago as the chairman of a joint committee looking into these medicaid problems in the State of California and I find that regardless of which side of this table you are sitting on, none of us wants to condone or defend abuse. So we are not here to defend the administration on the Federal level or on the State level, nor are we here to defend providers or defend the ownership of facilities. We are here to find out, just as you are, where the abuses are, where the errors are, and where the corrections can be made.

I shall not elaborate on the growth of titles XVIII and XIX. I think we are all well aware that we are now providing medical care to over 10 million people under one program, about 10 million under the other, and we have a potential of almost 40 million people who can be covered by these two programs.

I think the four points that Mr. Constantine made in regard to some of the cost problems were accurate in that we do have the problems of the rapid growth of the program itself—overutilization, lack of tight enough administration and some of the other obvious things that have occurred.

As a matter of fact, I believe the fact that we have gone into so-called mainstream medicine has caused this rapid rise in growth of the program. I think this really leads to what the audit reports of medicaid and some of the other information has really brought forth as one of the glaring problems we have, and that is the lack of administrative capability in the Department of HEW itself, lack of administrative capability in the State agencies, and lack of administrative ability by the carriers and intermediaries, who have a responsibility in this entire thing.

The 5 months that I have been in the Department at this level have confirmed my previous opinion that administrative deficiencies do exist on all of these levels. But I think under title XIX, the medicaid program, we do have to recognize that we are dealing with not one program, but 44 programs varying according to individual State plans. While all the States had some experience under the MAA and the PMC and some of the other programs, taking care of their medical payments prior to 1966, they had not been subjected to the tremendous rise that they have seen since the inception of medicaid, which was more than triple the expenditures.

I would like to mention to you very briefly the results of an audit report on medicaid that we have received from 10 States. I think that they have been submitted to the committee.

We anticipate that we will have audit reports from six additional States by the end of the month.

The audits demonstrate the existence of rather widespread administrative problems and the necessity to have some immediate action to protect the program objectives. I have just outlined one of the problems that the audit reports reveal.

Another is the matter to which Mr. Constantine referred, of duplicate payments, indications of excessive rates, excessive fees, other types of erroneous charges that have been made to the program, and again, the glaring thing is lack of adequate management controls by the States, or their agents over medicaid claims made by some nursing homes, pharmacists, and others.

The second thing the audit reports revealed is that systematic review of services is not being made. I think one of our requirements in the title XIX program is that there be an accurate and specific procedure for utilization review as part of the State plans.

There were noted incidences of excessive drug refills and over-utilization of services.

The audits also noted the need for assuring that the payments are only being made to those who are eligible. They revealed that in some cases, the identification cards were being utilized by persons who had not met or been deemed eligible for the program. A good deal of the expenditure of public funds depends upon the reliability of the eligibility standard. Mr. Kelly is with us today and he can further elaborate on the audit reports if you desire at a later time.

One of the problems that we have had, on the Federal level, and we certainly discovered it in California, is the lack of staff that we really need for the title XIX program. In 1966, we had 32 people to supervise the entire medicaid program in the Nation. Today, we have 100 and we have requested from the Bureau of the Budget an amendment

to the budget to provide 150 more positions for Medical Services Administration. But when you analyze this, I think that a staff of 250 people is a totally inadequate staff for a program that is dealing with this many dollars, with all the 44 States, and attempting to make sure that the State plans are adhered to.

In California, for example, we found that the Health Care Services Department had two investigators for the entire program in the State, one in the northern part of the State, one in the southern. It is virtually impossible to keep tabs on it if you are going to attempt to economize on personnel that are responsible for this great area.

With respect to medicare, HIBAC, the Health Insurance Benefits Advisory Council, recently submitted their report. HIBAC recognized that there is room for improvement in the administration of title XVIII, the medicare portion of the program. Medicare, I think we can say, has probably not been subject to the abuses and revelation of abuses as has the title XIX program. Also, it has not been burdened with the requirement for different State plans, a division of Federal-State responsibility, and the extreme insufficiency of staff that exists in title XIX. I think it is a little easier to control because you do not have so many elements involved. But there were several weaknesses that were identified and it is my understanding that the administration is going to recommend legislation to carry out some of the recommendations that the Health Insurance Benefits Advisory Council made.

For one thing, under the present law, there is no authority for the program to deny reimbursement to a licensed practitioner who has demonstrated a clear pattern of fraud, repeated overcharges of the program or use of supplies which are even harmful to the patient. We are recommending that authority be given under title XVIII to discontinue further reimbursement and to put all parties on notice to this effect, where on the basis of clear evidence, a finding is made that such action is justified by reason of such abuses. This is the first HIBAC recommendation on the list that has been sent to the Congress. Similar provisions under title V and title XIX we believe would strengthen State authorities to deal with a similar problem.

We also believe that it would be desirable to limit cost reimbursement under title V (the family-children's medical services) title XVIII and XIX, to the charges of a facility made to the general public for the same service. We have found situations where the application of the cost formula pursuant to the law may now result in institutions receiving payment from the program at a higher rate than it actually charges the general public. I think that a proposal to limit payment to charges is included in Senator Anderson's bill, S. 1195.

We also believe that there should be serious consideration given to withholding from Federal reimbursement the depreciation allowances for capital construction and interest on loans for plant and equipment where capital expenditures have been found not to conform with overall local or regional plans for health care facilities. This would support the efforts that State and local health care planning agencies are crying out in attempting to insure that health care facilities are actually needed and located in the appropriate place and are the kind of facility that would provide the best care at the lowest cost.

Apparently, there was a provision along these lines adopted in the Senate as a part of the 1967 amendments, but it was dropped from the

bill by the conference committee. I think, however, that there is a lot to be said for it.

We also believe that some consideration should be given to providing additional flexibility in our authority to fund demonstration and experimental programs in the incentive reimbursement area. We want to learn how to provide incentives to lower costs, rather than raise costs. I think the chart showing the rise in hospital costs makes a point of which we are certainly aware. The approach taken by the administration in the Hill-Burton program is one where the grants would go to facilities other than those which provide acute bed care, and I think it is becoming more and more apparent that we are going to have to try to find facilities other than acute bed hospital facilities to care for many of the patients that are eligible for care under the two programs.

Under both the programs, we feel that more can be done with utilization review. Peer review must become widespread, not only in hospitals, but also for other providers of medical services. That alone is not enough to control the costs, though. I think we need some new machinery in addition to self control by the providers. I find that too often, "peer review" becomes "peer justification" and I think that the public and the patients deserve better than that.

Some of the other questions that we have raised concern methods to stop fragmentation of medical services. We feel that a new approach which places emphasis on prepayment plans and new methods of delivery of medical services could reduce the rising cost of health care.

Let me just summarize by pointing out some of the initiatives that Secretary Finch and the Department have taken. First of all, we have asked the Commissioner of Social Security to make available technical assistance in the effective use of intermediaries to the Medical Services Administration of the SRS. Social Security has had considerable experience from the medicare program being handled through the intermediaries; 27 of the 44 States now use an intermediary in Medicaid and we feel that the expertise now possessed by Social Security could be a useful resource.

I also want to elaborate on one of the other changes we have made as a result of attempting to control some of the costs. We have eliminated the 2 percent allowance over identifiable costs for hospitals. We feel that there may have been justification for this allowance at the outset. At that time, it was difficult to determine reasonable costs and identify all the costs that should be noted, but after 3 years in the program, we believe that facilities should be able to identify all reimbursable costs.

There will be published in the Federal Register yesterday or today, the new regulations for controlling costs paid to other providers—physicians, dentists, and individual practioners who serve title XIX medicaid patients. This regulation would hold the level of fees to the January 1, 1969, level unless the payments represented a prevailing level of less than the 75th percentile of customary charges. But even if they did, should a State be below the 75th percentile, it would have to have justification for increasing the fees to the 75th level at this time. The justification would have to be concurred in by the State and have the approval of the Secretary. For all intents and purposes, we have frozen the fee level at that of January 1, 1969.

For subsequent years, after July 1, 1970, we are including a provision which would generally require limitation of increases to the level of the consumer price index for services exclusive of medical services.

Thirdly, we have built in a requirement for utilization review of the physicians' service paid with Federal participation.

I know there has been some suggestion, and we have even considered very seriously the possibility of tying this to Blue Shield plans or other carrier plans. I think there is legislation before you now which would do this. We asked Dr. James Haughton from New York to come in and assist us in developing these recommendations. Upon a little closer analysis, it was felt that the approach we adopted would probably have more impact upon controlling escalating costs than any other approach.

The CHAIRMAN. Would you mind explaining that again? I am not sure I understood that. That buzzer caught you right in the middle of the statement.

Mr. VENEMAN. We were talking about the reason that we did not link to the Blue Shield schedule for other public payments. I think we had to consider two or three things there. First, most of the Blue Shield plans are not as comprehensive as medicaid, so you would not only have to consider what they are paying for a particular service, but would also have to bring in dental and a wide variety of other services that are not incorporated in Blue Shield plans. You would have to develop some other standard.

Secondly, increasing numbers of the plans make some payments based upon usual or customary and prevailing fees. If you link to these plans for the future you could find yourself not controlling the costs because the standard would rise in accordance with the usual and customary charges as determined by the plans. These are among the factors that Dr. Haughton's committee took into consideration from the long range standpoint. We believe that we can control costs more effectively by administrative action.

Another thing that we are in the process of doing right now is forming a consultant group, headed by Walter McNerney, to investigate some of the problems discussed today—such as rising costs, fraud, inferior management, and other problems—in title XIX. This is not going to be another one of those continuing task forces or committees. We are asking them to look into the short range problems that exist right now.

One of the problems that I have discovered, is that we have several groups that are looking into medicare and medicaid. We have the Health Insurance Benefits Advisory Council, we have the Medical Assistance Advisory Council, we have the Social Security Advisory Council, we have some rehabilitation advisory groups. Quite often, we find that there is a lack of communication between them. The consultant group we are now setting up would be made up of approximately 20 or 25 people, and would include some persons who are members of these other councils and advisory committees. The continuing advisory councils that are established by the statute would continue the work that they have, in the light of the knowledge of new group's recommendations.

We think that the top priority is the need to meet the management problems of medicaid and we feel that the assistance of this group will go a long way toward it.

Mr. Chairman, again I thank you for this opportunity and will be available to answer any questions.

(Mr. Veneman's prepared statement follows:)

PREPARED STATEMENT OF HON. JOHN G. VENEMAN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and Committee Members, I am pleased to be the first witness in these hearings which you are holding on the Medicaid and Medicare programs. I am quite aware that the focus of your investigation is on the methods to improve the programs and to eliminate any possibility of or opportunity for fraud and abuse. I am also aware that specific cases of fraud and abuse create worry and frustration in professional circles and among beneficiaries.

A year ago I chaired a committee of the California Legislature which dealt with many of the same issues which we are now facing. No one condones wrongdoing. Persons guilty of fraud must be punished, but I think it is essential that we place these things in their proper perspective. What we are really talking about is the capacity of government both at the state and Federal level to detect and resolve problems such as this quickly and effectively. More importantly, if we place more emphasis upon strengthening our managerial capabilities, abuses and fraud should be greatly reduced.

Our lack of data—especially in some of the Title XIX programs—on such important matters as how much providers receive and how many patients are being served clearly shows some of the problems that exist. I think that we all would agree that these hearings must strengthen program operation and develop the kinds of controls which will make abuse infrequent and unprofitable.

Much of my discussion will be directed toward steps which we have already taken and which we propose to take to provide strong administrative and managerial control. The Department of Health, Education, and Welfare wants to make clear that its basic commitment is to the original objectives behind Medicare and Medicaid. We are committed to providing quality medical care to the aged and to other persons who could not otherwise afford it. This commitment carries with it a heavy responsibility for assuring that the administration of funds allocated for these purposes fully meets these objectives.

As you well know, both Medicare, Title XVIII, and Medicaid, Title XIX, programs are massive in their scope. Virtually all persons over 65, of which there are nearly 20 million, are eligible for services under the Medicare program and during this past fiscal year, this program paid over 6 million claims for in-patient hospital stays and over 25 million bills for physicians services. In addition, under Medicaid, 9½ million persons last year also received medical services. Thus, we are talking about programs which began in 1966 and were designed to serve the needs of at least 30 to 40 million people.

Since 1966 we have been faced with a rapid rise in the costs of medical care and services. Perhaps the Title XVIII and XIX programs may not have been primarily responsible for price increases, but we would not deny that they have contributed to it.

The desire for so-called "mainstream medicine" united many forces, both professional and beneficiary groups, behind the legislation in 1965. For the first time, many persons were given access to medical services of their choice. As a consequence, the demand for all services increased, and since the supply of manpower and facilities has not grown as the same rate rapid price increases resulted. However, this has been in a period when most prices have been rising and the cost factors affecting medical services are certainly more complex than these programs alone would account for.

This leads us directly to the administrative capabilities in the Department, in the states, and among the intermediaries. It is this combination that must deal with millions of people and billions of dollars in payment for medical care services. Let me say frankly that the 5 months that I have been in the Department has confirmed my previous opinion that administrative deficiencies do exist on all levels in the Medicaid program. That program is not one program but really 44 varying according to each state plan. While the participating states all had

some experience with vendor medical payments before 1966, in Public Assistance Medical Care and Medical Assistance to the Aged programs, the expenditures have more than tripled since Medicaid started.

States have in many instances demonstrated the lack of administrative capacity to manage programs of the scope and magnitude of Medicaid today. The number of doctors and other providers who now participate has vastly increased—in most places to a majority of all practitioners and facilities.

I would like to review briefly with the Committee the results of our audit of the Medicaid program, which has been completed in 10 states, copies of which have been submitted to this Committee. We anticipate audit reports covering 6 additional states will be completed by the end of this month. The audit demonstrates the existence of widespread administrative problems requiring immediate action to protect program objectives and to retain public confidence.

Although conditions varied among states, the following were problem areas of most concern in terms of overall program administration of Title XIX:

1. The audit found many instances of duplicate payments, excessive rates and fees, and other types of erroneous charges that would not have occurred if adequate management controls had been established by the states, or their fiscal agents, over Medicaid claims submitted by hospitals, nursing homes, physicians, pharmacists, dentists, and others.

2. Systematic review of utilization of services were not being made. Instances were noted of excessive prescription drug refills and other over-utilization of services. Unless the required utilization reviews are effectively carried out, there will not be adequate assurance that such instances are not in reality widespread.

3. The audit noted a need for improvement in the important function of assuring that payments are made only for persons who have been determined eligible for medical assistance. Considerable public expenditures rest on the reliability of these determinations.

Mr. Kelly, Assistant Secretary, Comptroller, is here to give further elaboration on the audit findings if the Committee wishes.

Federal and state governments have been negligent in their failure to provide the kinds and numbers of staff needed to give the necessary leadership, guidance and supervision which is needed to assure the effectiveness of these public expenditures.

In 1966, HEW had a division of 32 people to supervise the entire Medicaid program. Today, we have 100. We have asked the Bureau of the Budget to amend the Budget for 1970 to provide for 150 additional positions for the Medical Services Administration. This would include 10 additional persons in each of the regional offices to work directly with the states. This represents a major step in moving forward to achieve better control and supervision of the state programs.

States have also been deficient in providing adequate staff in terms of numbers and skills. We are proceeding with a review of all state plans to determine their capability of supervising the Title XIX program.

With respect to the Medicare program, the Health Insurance Benefits Advisory Council, which was established by law to advise on the administration of the program and which is composed of individuals drawn from the health field and from the general public, recently reported to the Congress that "the overall record to date can be viewed with a great deal of satisfaction." We can all be proud of what this program has accomplished, for it has substantially fulfilled the mandate of Congress. However, we recognize, as did the HIBAC, that there is also room for improvement in our administration of Medicare—Title XVIII.

The Medicare program has not been burdened with requirements for different state plans, the division of Federal-state responsibility, and the extreme insufficiency of staff which characterize the Title XIX Medicaid program.

However, a number of areas of weakness have been identified. Some of these would require legislative solutions. For example:

1. Under present Medicare law, there is no authority for the program to deny reimbursement to a licensed practitioner, who has demonstrated a clear pattern of fraud, repeated overcharging of the program or the use of supplies which are inferior or harmful. We are recommending authority under Title XVIII to discontinue future reimbursement and to put all parties on notice to this effect, where on the basis of clear evidence, a finding is made that this is justified by reason of such abuses. We must continually remember that only a very small

minority of the practitioners or suppliers of the Nation would be affected by such a change, but nevertheless it seems essential. It is the first in the list of HIBAC recommendations recently sent to the Congress. Similar provisions under Title V and XIX would strengthen present state authority to deal with this problem.

2. We believe it would be desirable to limit cost reimbursement under Titles V, XVIII and XIX to a facility's charges to the general public for the same services. There are some situations where the application of the cost formula pursuant to law may now result in an institution receiving more than charges collected from the general public. You will recall that this proposal is included in S. 1195, sponsored by Senator Anderson and others.

3. We believe serious consideration should be given to withholding from or reducing Federal reimbursement under all three programs to health care facilities with respect to depreciation of capital expenditures and interest on loans for plant and equipment where such expenditures have been found not to conform to an overall local or regional plan for health care facilities. This would support the efforts that are being made by state and local planning agencies to assure that expansion and modernization of health care facilities are made on a basis which encourages their most efficient distribution. For example, we want to prevent helping to pay for highly specialized equipment in adjacent facilities if one set of equipment would suffice. A provision along these lines was adopted by the Senate as part of the Social Security Amendments of 1967, but was dropped in conference.

4. We believe that more flexibility is needed in the authority to engage in incentive reimbursement experiments and demonstration projects. Broader legislative authority than that provided under the Social Security Amendments of 1967 would permit a wider variety of projects aimed at increasing the efficiency of health care delivery. It would also give greater assurance that we could negotiate for participation in professionally acceptable projects aimed at fostering more effective cost control methods. The Health Insurance Benefits Advisory Council also recommended an expansion of the present authority for incentive reimbursement experimentation.

These recommendations are certainly not all-inclusive but they illustrate the kinds of issues and remedies we must consider along with a number of other recommendations recently made available to you by the Health Insurance Benefits Advisory Council.

In both Medicaid and Medicare, we feel that much more can be done with utilization controls than has been accomplished to date. Peer group review must become widespread not just in hospitals but also for other medical services. But peer group review alone is obviously not enough to control abuses and escalating costs. We have issued regulations for Medicaid which provide that, starting July 1, 1970, no state may raise fees without demonstrating to the Secretary that its utilization review is effective and that it has effective measures to control fraud by practitioners and facilities. We need new machinery for this purpose—"self-control" by the providers of service is being given a chance, but by itself is inadequate. Too often "peer review" is simply "peer justification." The public and the patients both deserve better.

The last questions which so deeply concern us in these programs are part of a larger, longer-term issue of medical economics. There must be incentives to stop further fragmentation of medical services. We must encourage increased use of prepayment plans and greatly expanded experimentation in new methods of delivery of medical services.

The emphasis on incentives must be geared to keeping people well and preventing illness. We should devise provisions to penalize those participants in the program who are responsible for keeping patients in hospitals and nursing homes unnecessarily. Stronger emphasis must be given to shortening hospital stays and treating people at an earlier time on a shorter-term out-patient basis.

Finally, let me report to you on four new initiatives that have recently been taken by Secretary Finch.

1. The Secretary has directed the Commissioner of Social Security, on the basis of experience with Medicare, to provide assistance to the Social and Rehabilitation Service in the monitoring of intermediary services and the provision of technical assistance to the states in effective use of intermediaries under Medicaid. Twenty-seven states, out of 44, use fiscal intermediaries for at least some part of their program. Thus, Social Security Administration expertise in this

area is a resource which can make a contribution. Furthermore, more specific efforts are being made to assure closer coordination between the administration of Medicare and Medicaid, particularly in states where both use the same intermediary.

2. Secretary Finch has directed changes in regulations to eliminate the allowance to providers—2 percent to non-profit and 1½ percent to profit institutions—for unidentified costs. A flat percenatge allowance that increases as all other costs rise may, in effect, reward an institution for increasing its cost. This administrative change will apply to the Medicaid program, as well as to the Medicare program, since both programs pay hospitals on the basis of reasonable cost. We are working with the American Hospital Association and other representatives of providers to re-examine our entire reimbursement process to be sure that, with this change, and others we expect to make, reimbursement will be fair to all concerned.

3. The Secretary has published a new regulation to control escalating costs of payments made to physicians, dentists, and other medical practitioners who serve Medicaid patients. This regulation holds a state to the level of fees allowed under the payment structure it used on January 1, 1969, unless those payments represented a prevailing level at less than the 75th percentile of customary charges. States may increase the level with the approval of the Secretary but not to exceed the 75 percentile. In seeking ways to reduce the cost of program expenditures for physicians services under Medicaid, we considered limiting payments to the amounts established under Blue Shield fee schedules in the various states.

Upon analysis by a special Task Force we found that most Blue Shield plans cover primarily surgery and in-hospital medical services. On the contrary, most Medicaid plans cover physicians home and office visits, dental services, eye care, etc. So even if a Blue Shield schedule were utilized, it would still be necessary to develop another system of payment for a significant part of the total services covered by Medicaid.

Many Blue Shield plans make payments to physicians on the basis of their customary and prevailing charges. Most of the plans now offered to large group contractors include a provision for reimbursement on the basis of usual and customary charges. Where this is done, the payments tend to be higher than those authorized under Medicaid. In view of the increasing trend among the plans toward paying on the basis of customary and prevailing charges, tying Medicaid payments to Blue Shield plans could well result in increased Medicaid costs.

An important consideration of any Medicaid proposal to control rising costs is the participation of a substantial proportion of practicing physicians. We believe that our decision to limit physician reimbursement under Medicaid to a level that will cover charges made at the 75th percentile in a locality for a given service will generally serve to make medical services available to Medicaid participants and at the same time assure an appropriate limitation on program expenditures.

4. Secretary Finch has also announced the formation of a Medicaid task force, chaired by Walter J. McNerney, to investigate rising costs, fraud, inferior management, and other problems in the system. The task force members will include authorities in the fields of medical care, public assistance, and management, as well as representatives of existing advisory groups and top level HEW officials. This task force will not be a passive study group. It will play a dynamic outreach role in assessing these problems and developing management capabilities for dealing with them. By giving top priority to the need for meeting the management crisis in Medicaid, it is important not to overlook the basic program goals of providing quality medical care quickly and efficiently to those who need it.

Mr. Chairman, let me again thank you for the opportunity that this hearing provides for allowing the Department to express its views, initiatives and plans in relation to these very worthwhile programs. With the cooperation of Congress, I am confident we can correct the deficiencies that exist.

Dr. Land will discuss the Medicaid program, and Commissioner Ball will then go into greater depth with you with respect to the Medicare program. Other staff members are here to be of further assistance.

Thank you.

MEDICAID REPORTS

The following is a tabulation of the States that have been audited under the Medicaid Program, Title XIX of the Social Security Act. As indicated in the schedule, 10 audit reports have been finished and released and 6 are still in process. The estimated release dates are shown below.

State	Report released [1]	Estimated release date [1]
Massachusetts	June 25, 1969	
New Hampshire		July 18, 1969
Rhode Island		July 31, 1969
New York		July 17, 1969
Pennsylvania		July 13, 1969
Illinois	June 4, 1969	
Michigan	May 26, 1969	
Wisconsin	May 28, 1969	
Minnesota		July 13, 1969
Missouri		July 9, 1969
Oklahoma	Mar. 26, 1969	
Texas	Mar. 28, 1969	
New Mexico	Apr. 24, 1969	
California	June 25, 1969	
Oregon	Mar. 21, 1969	
Washington	Apr. 2, 1969	

[1] Total reports released, 10; total estimated release dates, 6.

The CHAIRMAN. Mr. Secretary, I am sure you realize that we are all part of the same team, the same Government. We sit on this committee and try to raise taxes to finance the Government and we try to provide some benefits along with it, so we can have a little pleasure spending some of the money we help to raise to finance this Government. We like to see that money spent efficiently because we know how hard it is to raise it and how unpopular tax bills are.

IRS REPORTING REQUIREMENTS

We are aware of the fact that if some doctors charge someone twice as much, or if they make 10 times as many house calls as necessary at a higher fee, or if they gang visit a nursing home—just walk through calling on 50 patients at $10 a head, $500 for a single walk through a nursing home in the morning, taking perhaps no more than 1 or 2 hours—at least we will get half of it back in taxes if we see that our tax collector properly finds out about the money.

I made a speech about this matter on the Senate floor and Senator Williams has also been very much concerned about it. It came to my attention when it was reported that insurance companies were not reporting their payments to doctors the same as others are required to do under the law. For example, if a building and loan paid a $10 dividend to you and they are required to report that to the Internal Revenue Service, the Internal Revenue Service comes to you if you do not report it and charges you taxes on that. If a bank credits $10 to your account because you earned $10 interest on your savings account, you owe taxes on that and the bank is required to report that to the Internal Revenue Service.

I was under the impression a similar reporting requirement applied to these insurance companies as well when they make payments to doctors and others, but I discovered that an exemption had been

granted them for their private business. Subsequently they requested your Department to aid in securing similar treatment under Medicare. I do not blame you for that. You were not there at that time.

Mr. VENEMAN. That is one advantage we have. All these audit reports were prior to 1969.

EXEMPTION FROM IRS REPORTING REQUIREMENT

The CHAIRMAN. They requested the Department of HEW to assist them in getting an exemption from the Internal Revenue Service so that they would not have to report by taxpayer identification number—usually the social security number—and identify the doctor to whom they made those payments. As a matter of fact, we discovered in some cases that they even had employees deleting from their records whom they made the payments to and stamping black ink on the name of the doctor. All medicare would get would be a code number. In some cases, that would be the doctor's telephone number, in some cases someone else's telephone number. In other cases, involving the same doctor it would be a telephone number in one office, another number for another office, and sometimes still another number. The specific names and addresses which we sought to get, your Department has had great difficulty in obtaining—even for us. We are gradually getting some of this information. Now I understand the insurance companies are pretty well reconciled to the fact that you are going to go to a use of the tax identification numbers. Is that correct?

Mr. VENEMAN. That is correct. I believe that is true, Mr. Chairman. I think that the reason they were not used previously was that because the program came into effect so rapidly it was decided that they would use their old intermediary identification, I believe.

Is that right, Mr. Ball?

Mr. BALL. Yes; that is right. They wanted to use for medicare the same numbers they had been using in their own business.

Mr. VENEMAN. Now I believe that they are willing to start using the social security number as the identification system.

The CHAIRMAN. I think they are still harboring the hope that they are not going to have to report what they are paying these doctors under these private insurance plans. Now, it does make a difference if a doctor does not pay taxes on what he is getting from the private plans. It might be that instead of paying in the 70-percent bracket, he would only be paying in the 30-percent bracket if he is not reporting the other income coming in to him.

Now, that is not directly your responsibility. However, it is relevant to your responsibility.

Mr. VENEMAN. It is relevant, but I think it is basically a Treasury administrative problem.

The CHAIRMAN. If I detect the mood of this committee——

Mr. VENEMAN. Personally, I have no objections to it. I have no hesitation at all about submitting names for tax purposes.

The CHAIRMAN. It is somewhat outside of your responsibility, but it is close to it. These private plans are sometimes paying some of these medical costs, are they not? In other words, both they and you may be paying?

Mr. VENEMAN. You mean the intermediaries?

The CHAIRMAN. I mean under private plans. Are there not cases where insurance companies, Blue Shield, Blue Cross, make payments for some of the same services you make at least partial payments on?

Mr. BALL. That is right, Mr. Chairman, yes.

Mr. VENEMAN. In fact, in some instances, a State will pick up the part B coverage. In other words, the State pays the $4 premium for coverage under medicare.

The CHAIRMAN. If I read the mood of this committee, my guess is that we are going to, if necessary, require by law that insurers provide this information on what they are paying under private plans as well as what's being paid under social security. Does that give you any problem?

Mr. VENEMAN. Not a bit. I think Mr. Ball sent a letter to Senator Williams yesterday that in essence indicates that it does not give him any problem, either with social security or the other.

Mr. BALL. Mr. Chairman, we have already taken a step to, as fast as we can, have the physician's social security number be the identification number that is used in the internal processing of claims by the carriers and in reporting to us. Now, that is within our own administrative discretion.

The problem of information reporting to Revenue is under consideration by them and I would say the only issue there that I am familiar with, Mr. Chairman, is the matter of whether there is authority to require reporting and whether it is desirable to require it in connection with the indemnity plans. That is where the patient is the one that files the claim for the bills that a physician has given him. And previously, it has been ruled that the law did not apply to that situation, although it might apply to direct payments to the physicians. That is the question there.

The CHAIRMAN. Well, if we want information, we will find ways of getting it, one way or the other. Senator Williams over here is very adept at that kind of thing. Off hand, my impression would be that if we want to do it, we can say both to doctors as well as to the insurance companies, if they want to claim a doctor-patient relationship as a defense against reporting money that is being paid, fine, they can claim that relationship, and they will not have to report the money they paid those doctors. But they cannot deduct it: They will just have to go ahead and pay taxes on it for claiming that they do not have to report that money. If they want to get by without deducting against taxes what they are paying to the doctors, that is all right with us. They can go ahead and pay all they want to and pay the taxes on that money in lieu of the doctors. So it would be the same thing, anyway, in terms of taxes.

But this would appear to us to be a case where we are entitled to have the information, if for no other purpose than to be sure the Government is collecting the taxes it ought to be collecting.

THE CONSCIENCE FUND

I am impressed by the growing conscience fund that is coming in. One doctor heard about the investigation and he sent you a check for $25,000, I believe, saying that after he had considered the matter,

he felt his conscience required him to return $25,000, the amount he thought he had collected excessively. Another doctor sent $10,000.

How big is the conscience fund right now?

Mr. BALL. Senator, I would not have an estimate on that total, but it is very true, as we conduct investigations into wrong doing and fraud, very frequently, the first response is to pay back what the individual thinks might end the investigation. Of course, it does not do that if there is actual fraud. But nevertheless, people do respond by paying back.

The CHAIRMAN. Have you not found some very, very bad cases of abuse?

ABUSE IN THE PROGRAMS

Mr. BALL. Yes, Mr. Chairman. I would like to emphasize, though, that although we have found many bad cases, this should not be taken as a reflection on the 200,000 doctors in this country. The percentage is obviously very small. But it is extremely important, nevertheless, that we catch the ones that are trying to abuse the program, publicize it, and thus it acts as a preventive. Senator Williams has put in the Congressional Record fairly recently a description of eight cases that we have turned over for fraud prosecution. I released a story on six more a few days later. There are about 700 under investigation at various stages. We will probably have another seven or eight for referral soon.

But I would also stress, Mr. Chairman, that the actual fraud part, important as it is, is not as big a cost problem as abuse that does not quite reach the level of fraud. We have greatly stepped up in the last year or year and a half with the carriers' various ways to emphasize controls over the utilization of services. I have for submittal to the committee a several-page list of the things we have done in the area of control over the utilization of services which otherwise might be a matter of abuse. These actions are very substantially beginning to pay off, Mr. Chairman.

(The information referred to follows:)

RECENT ACTIONS TO EXPAND MEDICARE COST AND UTILIZATION CONTROLS

REIMBURSEMENT AND HEALTH COSTS

1. Policy review during 1968, with the aid of expert consultants and HIBAC, of reasonable charges determination methodology leading to new carrier standards of performance on reasonable charges (December 17, 1968).

a. Prevailing charges to be set at mean plus one standard deviation or the equivalent, which may be the 83rd percentile (the 90th percentile previously used by some is not acceptable).

b. Prevailing charge may not be changed earlier than 1 year after the prior change.

c. Customary charge of a physician defined and significant time lag introduced for recognition of a new charge. A change in customary charge should be made only on the basis of adequate evidence.

d. Reasonable charge for laboratory services obtained from other laboratories but billed by a physician are to be related to the laboratory charge.

2. Increases in allowed charges restricted from January 1, 1969.

a. Customary charge to be increased only in individually identified, highly unusual situations where equity clearly requires such an adjustment.

b. Prevailing charge to be increased only on the approval of the Social Security Administration.

3. The provision on cost reimbursement of providers for payment of a 2 percent allowance for unidentified costs, deleted as of July 1, 1969 (*Federal Register*, June 27, 1969).

4. Ceiling on interim reimbursement rate for cost reimbursement set not to exceed charges (May 1969).
5. Establishment of refined rules limiting costs accepted for compensation of owners (August 1968).
6. Study of alternate reimbursement methods and development of experiments with alternatives (continuing).
7. Nine regional conferences on health care costs to develop the cooperation of persons outside the Government in seeking ways to keep down costs (concluded January 1969).
8. Regulations being developed to prohibit physician owners from participation in utilization review in institutions where they have a proprietary interest.

COVERAGE AND UTILIZATION CONTROLS

1. Refinements in policy and processing of extended care facility claims to secure improvement in rate of denial where continuous skilled services are unneeded (instructions of June 1968 and April 1969).
2. Study of utilization review in hospitals and preparation of improved technique for surveying with utilization review plan checklist, form SSA–1530 (1968–69 continuing).
3. Study of guidelines used by carriers in claims review (April 1968 and continuing).
4. Instructions to all carriers on method of appraising and improving claims review (national meetings held in January 1969).
5. Policy and procedures tightened for payment of supervising physicians in a teaching setting (surveys and on-site visits; additional carrier instructions, April 1969).
6. Tabulation and distribution to carriers of data on physicians with highest amounts of reimbursement and analysis of results (1968 and 1969).
7. Preliminary developments in system for identifying hospitals statistically whose lengths of stay are unusually long, by diagnosis and other patient characteristics.
8. Experiment with medical foundation review of Medicare claims in California.
9. More exacting criteria governing when physical therapy services may be paid for under the program (April 1969).
10. Regulation being developed to reduce time intervals for physician certification of need for in-hopsital care.

FRAUD AND UNETHICAL PRACTICES

1. Increased staffing and emphasis on program integrity and fraud detection and prevention (1968 and continuing).
a. Special personnel designated by carriers.
b. Specialist designated in regional office.
c. Special staff organized in central office.
2. Change in regulation to permit issues of questionable practice to be referred to medical socities (December 1968).
3. Investigation of allegations of fraud against program and referral of cases to the Justice Department for consideration of prosecution (continuing).

POSSIBLE CHANGES NOW BEING DEVELOPED

1. Regulation to further clarify payments allowable to supervising physicians in a teaching setting.
2. Regulation change to prevent possible unintended profit in case of termination of Medicare participation by a hospital or extended care facility, or change of ownership, after payment of accelerated depreciation.
3. Legislation proposed to—
(*a*) Give authority to bar from the program physicians and other providers of service who abuse the program;
(*b*) Limit cost reimbursement so as not to exceed charges;
(*c*) Limit cost reimbursement where construction occurs contrary to planning recommendations; and
(*d*) Widen authority for experimentation and demonstration.

The CHAIRMAN. It is my understanding that another doctor just recently offered a check for $45,000. So there are three doctors who built the conscience fund up $80,000. I think that will pay our committee costs for its investigation.

ABUSES REPORTED BY INDIVIDUALS, NOT INVESTIGATIVE UNITS OR CARRIERS

But the thing that does concern me about this thing, and I think it is perhaps in your field, Mr. Ball, or Dr. Land's area, most of the abuses that we are uncovering are coming from people writing in; they are not coming from your investigative units and they are not coming from the carriers. For example, you know the horrible hospital situation which occurred, where those people are about to be prosecuted, getting 80-year-old women in there and butchering them at Government expense. I am not going to name the person responsible or the hospital, because I understand that under the Warren-Fortas decisions, if you identify the people and what they did, then you cannot prosecute them. But this type of thing was reported to the FBI by a disgruntled doctor who had been a part of that setup. Then some of the worst abuses we are uncovering are reported by people who have been victimized.

Now, it seems to me that the carriers ought to be reporting this to you and where they are not reporting it, you ought to have investigative units finding it.

Mr. BALL. We are doing both, Mr. Chairman, and we also get a very large proportion of our leads from the patient or from other sources, as well as from various kinds of screens and investigations where we take the initiative—where total payments are high, for example.

But one process that we have is very helpful in alerting patients to the possibility of a problem. That is, we always inform the patient when we make a payment to a provider or to a physician concerning him. It is from that process that frequently—I do not mean frequently, but every once in awhile—a patient will come back and say, he never received any such service. Then we start an investigation on that.

But much more than that, Mr. Chairman, we have developed now computer screens in carrier reviews that will identify some of these problems that Mr. Constantine put on the chart there of gang visits, or patterns of service that do not seem to fit the diagnosis that has been given on the bill, and initiate an investigation. I know you realize that as a matter of routine now, all carriers are asked to investigate physicians who have an accumulation of a large payment in the course of a year.

PATIENTS DO NOT KNOW HOW MUCH WAS PAID ON THEIR BEHALF BY THE GOVERNMENT

The CHAIRMAN. Under medicaid, as you know, patients are never informed as to how much was paid by the Government on their behalf. Frankly, some of us think that we ought to insist on that "explanation of benefits" procedure in the future, so that when a person has been treated under medicaid he receives the same type of notice of payment that Social Security gives. In effect, "Here is what was paid on your behalf by the Government and if you are not satisfied, let us know."

Well, I have imposed a 10-minute limitation on myself and my 10 minutes have expired. I want other Senators to have a chance to ask questions during this morning's session. Then we will come back on a second round and there will be no limitation.

Senator Anderson?

PUBLICATION OF IMPROPER PAYMENTS

Senator ANDERSON. A great many of these cases deal with improper payments. Do you favor publicizing these payments?

Mr. VENEMAN. In cases of overpayment, Senator?

Senator ANDERSON. Yes.

Mr. VENEMAN. Yes, there has been. I think that Mr. Ball can probably respond more accurately as far as the title XVIII, medicare program, is concerned. But as far as the title XIX program is concerned, in cases where overpayment or overutilization has been made and has been revealed, these things have been made public. In fact, that was the whole purpose of the hearings that I held in Los Angeles.

Senator ANDERSON. What should the first requirement of a sound medicare program involve? Should it involve proper balancing of income and outgo?

Mr. VENEMAN. Of course, we have a unique situation in some of these programs. Title XIX in particular. It is the rest of our public assistance program, where we have an open-ended appropriation. I think the first requirement of the program should be to comply with the intent of Congress in the statutes by which the function was authorized.

ACTUARIAL BALANCING IN THE HOSPITAL INSURANCE PROGRAM

Senator ANDERSON. But Congress would like to have medicare in balance. We had a great deal of argument about it.

Mr. VENEMAN. I think Mr. Ball has clarified it. Perhaps you are referring more to the title XVIII portion and insurance concept.

Mr. BALL. Senator Anderson, I would certainly agree with you that it is very important to bring the hospital insurance program back into a long-range actuarial balance and we are giving very serious consideration to a proposal that would accomplish this—I hope we can get it cleared out in the next week or two. If I could just take time to give you the factual background in this; at the present time, the hospital insurance program shows a long-range actuarial balance of minus 0.29 percentage of payroll under the long-range 25-year, estimates. What we would propose is a stepped up contribution schedule. People now pay six-tenths of one percent toward hospital insurance. But there is in the law a graded schedule that ultimately would reach 0.9 percent in 1987. The proposal that we are considering would be to put that 0.9 percent rate in sooner, but not have the rate any higher than it is now. But if you put the 0.9 percent rate in in 1975, you would about bring that hospital insurance program into balance.

Now, I would like to take this opportunity to point out that the actuarial estimates for the hospital insurance program were changed between the last trustees report and the present one. The last trustees report showed a small plus balance in hospital insurance. This one shows the minus 0.29.

I have a memorandum here from Mr. Myers, our Chief Actuary, that with your permission I would like to put into the record at this place. It explains why the actuarial balance changed.

(The memorandum referred to follows:)

MEMORANDUM

From: Robert J. Myers, Chief Actuary, Social Security Administration.
Subject: Reasons Why New Trustees Report Shows Higher Cost for Hospital Insurance Program than Previous Report.

There has been considerable misunderstanding concerning the reasons why the most recent trustees report shows a higher cost for the Hospital Insurance part of the Medicare program than the previous report showed. The principal reason is not related to any increase in the cost of the program, but rather it is the result of the fact that experience on an accrual basis under the program, now available for the first time, has shown that the assumption concerning admission rates to hospitals in the estimates made prior to the inauguration of the program was too low.

The statistics reflecting the experience for the first 18 months of operation of the program are now relatively complete; they were not available at the time the previous trustees report was prepared, and therefore the assumption concerning hospital admissions used in the previous trustees report was the same as that used in the estimates made prior to the inauguration of the program. In other words, the actual program cost with respect to this factor did not change between the two valuations, but we now have improved information on what the true cost is.

There has been no significant change in hospital utilization under the Hospital Insurance program since it was first inaugurated. Both admission rates and average duration of stay have remained approximately the same since the beginning of the program. In the case of average duration of stay, the experience is approximately the same as the assumption used in the estimates made prior to the inauguration of the program, but the originally assumed admission rates have proven to be too low.

The change in this assumption constitutes the vast majority of the explanation of why the current valuation shows a higher cost than the previous one.

The assumptions concerning the average per diem cost of hospital care have not been changed significantly between the two trustees reports. Actually, the assumptions in the previous trustees report proved to be slightly high for the most recent experience, but they have nevertheless been left substantially unchanged, so as to provide some margin of safety.

There are other minor factors which are somewhat counterbalancing. For instance, the estimate of future administrative costs has been reduced as a result of examination of current experience, and the assumption as to utilization in extended care facilities has been slightly increased.

ROBERT J. MYERS.

Mr. BALL. In summary form, the reason is largely the fact that the estimates were based on experience before hospital insurance went into effect and thus were based on too low assumptions concerning hospital admission rates of older people. And as soon as we got some experience, the first time we had experience on an accrued basis under the hospital insurance program—and the first time we had it was for this trustees report—it was necessary to change those estimates.

Now, the point I am making is, that it is nothing that happened in the administration of the program. As Mr. Myers' memorandum indicates, he does not believe that utilization of hospitals by older people has changed since medicare went into effect. There is no evidence that utilization is increasing. It is merely that his estimates were based on false assumptions. He just really did not have the experience until we actually had a program. So that is the reason, almost entirely, for this imbalance in hospital insurance, which we would like to give serious consideration to correcting through moving up that ultimate rate.

POSSIBILITY OF NEED TO RAISE $4 MONTHLY PREMIUM

Senator ANDERSON. You now have a monthly premium billing of $4 under pt. B?

Mr. BALL. That is in the supplementary medical insurance, Senator, yes.

Senator ANDERSON. How much does it actually cost now?

Mr. BALL. Well, you know, as Mr. Constantine pointed out, the only correct way to measure this program is on an accrual basis and there is quite a delay between the time of services rendered and perhaps the individual files his claim and it is processed and paid. So we are not really in a position to say exactly what the situation is today. By and large, we feel that the $4 rate will turn out to be sufficient for the fiscal year that just ended and that it will probably be insufficient for the fiscal year we are just moving into. Exactly what it should be for this coming fiscal year on an accrual basis, no one will know, finally, until the year is over. The Chief Actuary recommended a rate of $4.40.

The CHAIRMAN. Why don't you try to have part B in balance?

COST CONTROLS AFFECTING MONTHLY PREMIUM

Mr. BALL. Mr. Chairman, it is my personal judgment that with the kind of cost controls that are now in effect in this program, and they are now very strict in the medicare program as they relate to physicians' fees, it is my personal position that $4.40 will be too high for this coming fiscal year.

Mr. VENEMAN. But I think, Senator, it should be pointed out, that some of those controls were put into effect after the rate was established at $4 last year, in order to keep within this point.

Mr. BALL. Yes, some were already in the mill, Mr. Veneman, and some were established as a result of that decision.

Just to show you some of the results there, the carriers have reduced in this last period—in the last month or 2—they have been reducing the physicians' bills submitted to them before they reimbursed them, reducing them down to what they consider a reasonable charge, to the extent of 5.2 percent of the total dollar. Now, that compares with 3.2 percent in 1968 and 3 percent in 1967, and 2.4 percent in 1966. It is an increasingly effective operation.

In May, they reduced at least one item in 23.6 percent of all the physician bills that were submitted. Now, between that and increased utilization coverage review and audit review, we are estimating pretty close to $300 million savings this coming fiscal year, as a result of administrative action. And although I agree that $4 will probably not be enough, I cannot say exactly where it will come out, Senator.

Senator ANDERSON. Should we not try to balance it?

Mr. BALL. Yes, Senator, we certainly should. As you understand, of course, the cash situation, as Mr. Constantine's chart showed, is sufficient without any question; the problem will be to decide exactly where the rate should be when the next rate is promulgated in December.

Now, I want to be clear on this: When I say $4 will probably be enough, I am talking about a rate for the current fiscal year. In De-

cember, we will be promulgating a rate for the following fiscal year, and unquestionably, that rate will have to be above $4.

Senator ANDERSON. It seems to me it might need to be raised a great deal more than $4 if all these bills are to be paid.

The CHAIRMAN. Senator Williams?

USE OF SOCIAL SECURITY NUMBERS IN IDENTIFYING ALL PAYMENTS

Senator WILLIAMS. Mr. Veneman, I understand that, based on the letter I received yesterday from Mr. Ball, you are going to initiate a program in the future where you will use the social security number or the tax number of the doctor on all payments. Is that correct?

Mr. VENEMAN. That is correct, if I interpret the letter properly, which I read yesterday.

Senator WILLIAMS. I would ask that that letter be put at this point in the record, Mr. Chairman.

The CHAIRMAN. It is so ordered.

(The letter referred to follows:)

JUNE 30, 1969.

Hon. JOHN WILLIAMS,
Senate Finance Committee, U.S. Senate, Washington, D.C.

DEAR SENATOR WILLIAMS: I would like to summarize the current status of our activities in the Medicare program concerning several matters about which you have recently expressed concern.

We are proceeding as you suggested to furnish hospitals, extended care facilities, physicians, laboratories, and other suppliers of services under Medicare with summaries of the statutory provisions that prescribe civil and criminal penalties for efforts to obtain money through the filing of false claims.

We are considering also the question of adding penalty statements to the forms used in claiming payments. The difficulty here is that when the patient seeks reimbursement directly on the bill he received from his doctor, the physician is not in any way associated with any claims form and would not be exposed to any penalty statement as part of the claims filing procedure. Nonetheless, at such time as our forms are reordered for printing or are redesigned to take into account additional desirable changes in format, we will include a penalty statement where it will most likely come to the attention of the physician or other provider seeking direct reimbursement.

The question of informational reporting for income tax purposes is, of course, a matter within the jurisdiction of the Treasury Department. Our concern has been that the application of informational reporting apply equally to payments made directly to physicians through the assignment process and payments made to patients as indemnification for physician bills. We have felt that it might be damaging to the widespread use of the assignment method—which is much more efficient and economical to operate and which is now applied to nearly two-thirds of the bills—its various special provisions are attached to the assignment method alone. We have discussed with Internal Revenue and they have under consideration our view that if informational reporting is required it be made equally applicable to both types of payments.

Whatever the final decision is on informational reporting we intend that all carrier reporting under Medicare be converted, as soon as feasible to the use of social security numbers. During the early part of Medicare, carriers had great technical programs with high volume bill processing and were permitted to use their own numbering systems for their internal Medicare processing and for reporting claims information to social security.

We agree that it will be a desirable development now that so much progress is being made with carriers' record mechanisms to have them maintain their statistical and claims record information under the doctor's social security number. We do not require additional legislative authority for this action. The question is simply one of administrative measures, but it will take some further time because these involve computer changes for carriers.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

Senator WILLIAMS. When will this take effect? I know you said at the earliest practical date. Does that mean July 1; or when?

Mr. BALL. Senator Williams, the exact timing of that really has to be worked out with the individual carriers, because I am sure you will realize it changes their computer processing and hundreds of thousands and millions of bills are in process and we will have to meet right away with the carrier group and work out a scheduling date for that to go into effect.

Senator WILLIAMS. In order to be reasonable and so we will all understand each other, could we say that August 1, that will be in effect, or would you need legislation requiring it?

Mr. VENEMAN. One of the problems, as Mr. Ball has pointed out, is some of the computer changes necessary to carry that out.

Senator WILLIAMS. I realize that, but we are giving them 30 days.

Mr. BALL. I am really not in a position to say whether that is a practical time limit or not. I would like to consult with people who have to do this in the carrier group and report back to you.

Senator WILLIAMS. If you would, I would appreciate a report as soon as possible, because to be frank with you, it may be necessary to help you by legislation. I am a little impatient that this has not been done before.

Now, Dr. Land, will medicaid continue to use the same obscure formula or are you going to help by requiring that when doctors get paid, the administrators use the social security number?

Dr. LAND. Yes, sir.

Senator WILLIAMS. Do you think you can get yours in effect within, say, 30 days?

Dr. LAND. I think if we can do it by regulation, Senator, we can do it within 30 days.

Senator WILLIAMS. Thank you.

RECEIPT OF SOCIAL SECURITY BENEFITS BY MEDICAID RECIPIENTS

There is one other point, Mr. Veneman. Under the medicaid program—as I understand it, in any of the States as administered—we will assume for the moment that the welfare recipient is drawing social security benefits, but is not required to pay his hospitalization and medical costs. He has no other income, no other resources. Under medicaid, you would pick up that difference between the social security payment and the total cost of the bill; is that correct?

Mr. VENEMAN. That is correct. What usually happens, Senator, is that we can pick up the part B premium under the title XIX program and pick up deductibles if that person is in fact eligible for the public assistance program or eligible for group 2 participation.

Senator WILLIAMS. That is correct; it can be partially picked up under medicare and partially under medicaid. That is the difference.

Mr. VENEMAN. That is right. The other thing we do, Senator, of course is when title XVIII benefits expire, they they become title XIX recipients.

Senator WILLIAMS. That is correct. But in all cases, as I understand it, to the extent that the individual is receiving a social security check, that payment, that check goes toward the defrayment or payment of that portion of his cost, is that correct?

Mr. VENEMAN. I will have to let Mr. Land respond to that. Whether or not they retain—you mean all the social security——

Senator WILLIAMS. All or any portion of it. What portion do you retain?

Mr. VENEMAN. I think it would vary.

Dr. LAND. I think that this would depend on the determination of need of the recipient and whether or not this person over 65 drawing a social security check was also on public assistance.

Senator WILLIAMS. But we are assuming all those factors.

Dr. LAND. On public assistance, then no part of that would be taken away.

Senator WILLIAMS. And under what circumstances would a part of the social security benefit be used, social security check be used to defray the cost?

Dr. LAND. I think that—Mr. Ball just said that if he were not eligible for medicaid, a portion of his social security check would be used to pay certain costs.

Senator WILLIAMS. The reason that I asked that question, is that in some areas, it is being required. I am advised by the staff that if the individual is on public assistance, the social security payment is counted as a resource.

Mr. VENEMAN. Counted as income; right. His grant would be determined taking account of his resources.

Senator WILLIAMS. The reason that I ask this question is this: It has been called to our attention that in one or two cases, a man would be in a nursing home and they would be crediting x amount as being received from social security. Then the remainder would be billed either to medicare or to medicaid, and would be picked up by the various agencies. There is no way of determining, as I found, how much this John Doe was receiving from social security, because again, he, too, is given a "Swiss number" as identification.

Now, the question I ask is why do you not identify each patient that is in one of these nursing homes—under medicaid programs or welfare—by his own social security number? Then it would be a very simple matter to check this out to see whether a portion of the social security payments is being held erroneously. It takes a Philadelphia lawyer to figure it out now.

PATIENT PROFILES

Mr. VENEMAN. Senator, I might point out that one of the big weaknesses we have now in the entire program is that in many of the States, they do not even have a patient profile by name or even a doctor's history profile. Unless we get those—I think the ultimate is to have the name and social security number so you can have the cross check. But we are having enough trouble putting together patient profiles.

Senator WILLIAMS. What's the difficulty in identifying this patient by his own social security number? You would not find any two alike. In another case, you would not have to set up 50 people working overtime trying to come up with a different series of numbers. We are about to run out of numbers.

Mr. VENEMAN. This can be done administratively, I think.

Senator WILLIAMS. You think it can be done?

Dr. LAND. I certainly think it is feasible, yes, sir.

Mr. VENEMAN. I wonder if I can just get your question straight again, Senator. I find something rather intriguing in it.

Did you indicate that there are facilities, nursing homes, where a nursing home will receive the patient's social security check and payment from title XIX and payments from title XVIII?

Senator WILLIAMS. That is the allegation, but when we go to run it down, we find we have about 40 John Does and then it takes a complete investigation to find out which one of them is in that nursing home. It just seemed to me that identification of patients would be very simple if we used every man's social security number.

Mr. VENEMAN. I will ask both Mr. Ball and Mr. Land, sitting here, to advise me whether or not it is possible for the Social Security Administration to make a social security payment check directly to a facility.

Senator WILLIAMS. Oh, no. I do not think they do it. I am not sure they could be paid directly to the facility.

Mr. BALL. We do that in some instances, but it is in the situation where the individual has been determined not to be able to handle his own funds, and in addition, we are unable to find any relative or other person with a close personal interest in him. Then in a few cases, we will make the head of the institution the representative payee for that person. But that is a low priority approach. But we will do that.

Of course, Senator, a very large proportion of people on old-age assistance and, I would think, Medicaid, too, already have social security numbers. I think your idea is feasible.

Senator WILLIAMS. Oh, they have numbers, I am sure of that.

One other question. My time is running here, and we will go into detail on some of these questions a little later.

LAXITY SEEN IN AUDITING OF MEDICAID PROGRAMS

What disturbs me is why there seems to be no record of these programs being audited prior to the last few months. I have examined with interest these 10 or a dozen audit reports which you sent up to us about 3 or 4 weeks ago.

Mr. VENEMAN. I will let Mr. Kelly respond. I think the audits have been in progress for sometime.

Senator WILLIAMS. If I may pursue it, each one of these audit reports which I have received are dated 1969. They refer to periods, prior periods. Are there no audit reports completed in 1967 and 1968? Is this the first time that this program has really been audited after there was a little interest created up here on Capital Hill?

Mr. VENEMAN. These reports, Senator, apply to the title XIX program. I think title XVIII has had a continuous audit going on since its inception.

TEXAS MEDICAID AUDIT

Senator WILLIAMS. Then confine it to title XIX. Were there no audit reports—I am referring to the one here on the State of Texas, for example. "This audit covers a period from the inception of the title XIX program in Texas from September 1, 1967, through June 30, 1968. There had been no prior audit of the program."

Yet there were prior audits of the Texas program by the Comptroller General that were submitted to the Department in 1967, where he called the same problems to the attention of the Department that is now called to attention in this 1969 audit report, and nothing has been done in either case. Now, is there no liaison between these different auditors? Do you not read these Comptroller General's reports?

Why was it that the auditors who prepared this 1969 report did not know about the Comptroller General's report, which found a similar problem in 1967. He said he reported to you in 1966, overpayments of $4 million, and recommended that something be done about it. There is a letter from HEW assuring that they would do something about it. Yet here we find that this last report, prepared just a few weeks ago, said that this overcharge is about $11.5 million. What I want to know is do you read these audit reports and what are you going to do about it?

Mr. KELLY. Yes, Mr. Chairman, there is a close liaison between the HEW audit agency and the Comptroller General's office. Each draft report that they receive is summarized for the Secretary. A response is obtained and sent to the Comptroller General on it and we then advise the Congress and the Bureau of the Budget of the action we have taken as a result of the audit report.

Senator WILLIAMS. What action have you taken?

Mr. KELLY. On that particular case, I do not know and I would have to get it for you, Senator Williams.

Senator WILLIAMS. Would you furnish it at this point in the record?

Mr. KELLY. Yes, I would be glad to, sir.

(The information referred to follows:)

STATE OF TEXAS AUDIT REPORT CONCERNING INSURANCE CONTRACTS FOR MEDICAL CARE

RÉSUMÉ OF GAO AUDIT

United States General Accounting Office states that the procedures used, with Department approval, to recover excess funds, accumulated under an insurance contract for the medical care of old-age assistance recipients, did not result in the adjustment of Federal-State equities required under the approved State plan and consistent with the applicable provisions of the Social Security Act.

The initial insurance contract between the State and the contractor provided that, within 90 days after the period covered by contract, the contractor was to render a final accounting and repay the State, upon demand, the excess of premiums received over total claims paid by contractor plus his allowable administrative expenses. Accordingly, the contractor determined the total refund due the State, including earnings on the excess premium payments. With approval of the Department, he repaid the excess funds to the State by offset against premiums payable by the State during the period of a second contract. With respect to the second contract period, the State then claimed Federal participation only in the net premium payments to the contractor. Under this arrangement, this State was able to claim on a more favorable basis, under the Federal matching formula, than if they had a cash recovery.

HEW AUDIT OF TEXAS TITLE XIX PROGRAM

The Texas State Department of Public Welfare were functioning under the misconception that their agreements with Group Hospital Service Inc. (Blue Cross-Blue Shield of Texas) were "health *insuring*," while in reality they were "fiscal agent" in nature. The audit agency determined the agreements to be fiscal agent agreements and were supported by the opinion of Assistant Regional Attorney for HEW.

Principal findings were:

1. The element of risk had been removed from the contracts through a retroactive adjustment feature.
2. Large federal overpayments to GHS in premiums for actual administrative services at the assistance matching rate rather than the 50% administrative rate.
3. Withdrawal of funds by GHS in excess of actual program disbursements (assistance expenditures). This resulted in a loss of interest income to the Federal Government of approximately $48,750 per month.
4. Premium rates are unrealistic; are not based on objective cost data.
5. Lack of internal central procedures to preclude program abuse.
6. Procedure for certifying and authorizing nursing home care is inconclusive.
7. Procedure is lacking for certifying that premium payments for Part B of title XVIII are correct.
8. TSDPW exercises little control over sub-contracting arrangements between GHS and other parties.

ACTIONS CONTEMPLATED

In order to achieve a resolution to the above audit problems a team consisting of two Medical Services Administration headquarters and regional staff and a member of the Department of Health, Education and Welfare audit agency from Region VII will visit the Texas State Department of Public Health in the very near future.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., July 30, 1969.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: In accordance with the request of Senator Williams, there is enclosed for the record a statement setting forth the status of actions taken and planned with respect to matters disclosed in the General Accounting Office report dated January 31, 1967, on medical care provided under the federally-aided old-age assistance program in the State of Texas and in the subsequent HEW Audit Agency report dated March 28, 1969, on the Texas Medicaid Program.

We will keep your Committee informed regarding future developments in this matter.

Sincerely yours,

JAMES F. KELLY,
Assistant Secretary, Comptroller.

Enclosure.

STATE OF TEXAS AUDIT REPORT CONCERNING INSURANCE CONTRACTS FOR MEDICAL CARE

RÉSUMÉ OF GAO AUDIT

United States General Accounting Office states that the procedures used, with Department approval, to recover excess funds, accumulated under an insurance contract for the medical care of old-age assistance recipients, did not result in the adjustment of Federal-State equities required under the approval State plan and consistent with the applicable provisions of the Social Security Act.

The initial insurance contract between the State and the contractor provided that, within 90 days after the period covered by contract, the conractor was to render a final accounting and repay the State, upon demand, the excess of premiums received over total claims paid by contractor plus his allowable administrative expenses. Accordingly, the contractor determined the total refund due the State, including earnings on the excess premium payments. With approval of the Department he repaid the excess funds to the State by offset against premiums payable by the State during the period of a second contract. With respect to the second contract period, the State then claimed Federal participation only in the net premium payments to the contractor. Under this arrangement, this State

was able to claim on a more favorable basis, under the Federal matching formula, than if they had a cash recovery.

The Department is aware that differing conclusions can be drawn in regard to the propriety of the Federal payments to Texas which the Comptroller General considered unauthorized. The method adopted by the State in using and accounting for excess funds accumulated under the medical care insurance contract was judged to be acceptable by the Department at the time it was implemented, and within the bounds of administrative discretion and authority.

The Comptroller General recommended that the Department obtain full recovery from the State for the amount he considered to have been improperly claimed by the State. While we did not disagree that the method adopted by the State in making the adjustment could, in light of subsequent evaluation, be subject to some criticism, we were unable to concur in the view that it was improper and that the State should be required to refund the amounts already paid. The State acted with the express concurrence of the Federal agency, and in good faith expended the funds for program purposes. Had the State not received these funds, it might well have reduced program benefits. Thus, the State acted in reliance upon Federal approval. In the continuing Federal-State program, it is essential that the States be able to operate securely on the basis of Federal assurances. As a matter of law and equity, the Department could not find a sufficient basis for requiring reimbursement by the State retroactively.

HEW AUDIT OF TEXAS TITLE XIX PROGRAM

On July 15, 1969, two key staff members of the Medical Services Administration, Social and Rehabilitation Service, went to Austin, Texas to obtain additional information concerning the HEW Audit Agency report on the Title XIX program in Texas covering the period September 1, 1967 through June 30, 1968.

On July 16, 1969, they conferred with Dallas Regional Office staff and representatives of the Branch Office of the HEW Audit Agency in Austin. A meeting was then held with the Commissioner of the State Department of Public Welfare and his staff.

The Audit Agency report states that Group Hospital Service, Inc., had accumulated $14,096,153, representing premium payments for medical services which were in excess of actual program disbursements for medical services. The State agency concurred in this finding and stated that it was its practice to permit premium payments to accumulate in this fashion as a hedge and periodically to use the funds as offsets against premiums due. By February 1969 the balance was $11,961,571.02 which was used to pay the monthly premiums due Group Hospital Service, Inc., for the months of February ($3,949,182.26), March ($4,001,697.66) and April 1969 ($4,010,690.10). No additional Federal matching was claimed since this money had already been matched. Since then disbursements by GHS for program purposes have exceeded receipts from premiums and as of June 30, 1969, there is a minus balance with GHS of almost one-half million dollars. Therefore, there is no surplus of premium payments for program benefits over disbursements for services to be recovered at this time. According to the State this has resulted from a reduction in the premium rates effective February 1969, increased utilization of services and an increase in the level of payment for services.

A crucial question which has not been resolved is whether the contractual arrangement between the Texas agency and GHS represents health insurance or a fiscal agent relationship. The HEW Audit Agency takes the position that this is not insurance since the element of risk for GHS does not exist. The State agency does not agree with this contention. After further consultation with General Counsel and the HEW Audit Agency, Medical Services Administration soon will make its recommendation on this issue to the Administrator, Social and Rehabilitation Service.

If a decision is made that this is a fiscal agent contract rather than an insurance arrangement, then the Administrator will also decide whether to take any action to recover any part of the $887,868 which the HEW Audit Agency claims represents the difference in the Federal Financial Participation rate applicable to GHS administrative costs claimed as assistance expenditures.

Mr. KELLY. In connection with the medicaid audits, we organized in 1968 an approach to auditing medicaid. Our approach was designed not to just produce an audit report for each of the States that would

go to the State agency and our regional people, but to do it in such a way that we could provide to the Secretary, to the Administrator of Social and Rehabilitation Services, and to the Medical Assistance Commissioner, a composite of our findings so that they could get an evaluation of their program and what their problems are. We set out to do 16 States, which constitute about 85 percent of the money that has been spent. We laid out a single audit program. And then we tested that audit program and then sent the instructions out to our regional offices. We condensed the audits at the field establishment in June of 1968 and the last one of the 16 we started in June 1969.

We have now issued 10 of the reports. We have six more that we will issue by the end of this month. We have a draft composite report available for the Secretary and we expect to polish that draft up and have it in the Secretary's hands as the evaluation of the findings in all 16 States by the 1st of August.

Senator WILLIAMS. I will discuss it a little further later. I see my time has run out.

The CHAIRMAN. Senator Gore?

ACHIEVEMENTS OF THE MEDICARE PROGRAM

Senator GORE. Mr. Secretary, as one who labored for years to bring about the enactment of medicare, I would like to inquire about some of the positive achievements. To what extent have elderly people in our country obtained first rate hospital care, as a result of medicare, which they had not heretofore received?

Mr. VENEMAN. I think there has been a great deal of improvement in the availability of health services for both the aged and the low income. I think that prior to the enactment of the medicare program, the only persons in the aged categories that were being taken care of were under Government programs were those that would qualify under the Kerr-Mills bill, the MAA program.

Senator GORE. And this was regarded as a charity proposition?

Mr. VENEMAN. That was tied to the eligibility provision—tied to low income, right.

Senator GORE. Is it not true this program, which is now suffering growing pains and inaugural pains, has saved lives or extended the life-span for millions of our people?

Mr. VENEMAN. I think that is absolutely true, Senator, and I think it is a very unfortunate thing—I think Mr. Ball and others mentioned it—that those few people that have caused problems within the program from the standpoint of abuses and fraud have really distorted the fact that many of the objectives of the medicare and medicaid programs have been met. This is one of the problems that we are confronted with. We still have a good education system in the United States, but it, too, is being clouded by some of the actions of just a few people.

Senator GORE. The principal opponent of the enactment of medicare was the American Medical Association. We did not let it prevent the enactment. I do not propose to let members of that group destroy the program.

Mr. VENEMAN. I would agree there that none of us would permit any interest group, no matter who it might be, to destroy the program.

But I think it is rather interesting because in California, when we were working on the implementation of title XIX, to put it in effect in our State, the greatest support we had was that of the California Medical Association. I opposed the first bills, the ones that they were actively endorsing. We finally got fairly good implementation legislation through, but they were the chief proponent of the title XIX legislation.

DOCTORS SEEN SUPPORTING MEDICARE

Senator GORE. Well, at the time we were considering the legislation, my observation was that an overwhelming proportion of doctors opposed the program. They talked about socialization and how medicare was destroying the medical profession and the doctor-patient relationship. It is my observation now that most doctors accept the program and support it and are not trying to profiteer from it. Would you agree with that?

Mr. VENEMAN. I would agree with that statement.

Senator GORE. To what extent are you receiving cooperation from the AMA in policing this program?

MEDICAL PROFESSION COOPERATING

Mr. VENEMAN. I think we have had good cooperation from the medical profession, both the American Medical Association—perhaps not as a group, because in many of the programs, you work with the local societies. But the professions themselves and particularly the medical profession, I think, have assumed some rather significant leadership in adopting some of the foundation programs, where the doctors themselves help make the program work. We have one in the San Joaquin program in California, somewhat of a pilot program. We lean heavily upon the medical profession for utilization review. I do not think anybody can be critical of the cooperation we have received from the professions in trying to make this program work.

Senator GORE. That is good. It has been my impression that although the medical profession as a whole fought enactment of the program, once it became law an overwhelming proportion accepted it and——

Mr. BALL. If I may add one other point that backs what you are saying, the local medical societies have by and large also proved very helpful and receptive to disciplinary action when we bring cases to their attention of a physician who makes too many calls for a given diagnosis or who overcharges. They have been willing to take quite a bit of responsibility. And in this San Joaquin foundation that the Under Secretary referred to, there is actually an agreement between the California Blue Shield Plan under medicare and this foundation to review the medicare claims. Utilization and costs have been cut down since that has been in effect.

SUCCESS OR FAILURE DEPENDS ON MEDICAL PROFESSION

Mr. VENEMAN. Senator, I think it should be pointed out emphatically that the success or failure of these programs depends upon the medical profession. It is a doctor who determines whether or not you

go to a hospital or whether or not you are ready for a nursing home or some other extended care facility, whether or not you require a prescription. Without their cooperation, we could not make it work at all.

Senator GORE. I would agree with that, Mr. Secretary, but it seems to me the carriers are seriously at fault in this program and we may have erred, in the enactment of this program, in providing for an almost unbridled discretion in the carriers.

DETAILED REPORTING NEEDED FROM CARRIERS

Is it not a fact that the carriers have not been able to provide either you or the investigators of this committee the amount of fees paid to individual doctors or for what purposes they were paid?

Mr. VENEMAN. I think there are some serious administrative problems in some of the programs that are being administered by the intermediaries, particularly when it comes to developing such information as I mention, the patient profiles and provider profiles. But they ultimately develop the information.

Mr. BALL. Senator Gore, I think for the record, I ought to make it clear here that I know of no problem, no significant problem with the majority of carriers furnishing the amounts that they have paid various physicians. The matter that has been difficult is with the degree of detail that has been asked for that says, how many injections did this individual get? How much was paid for this specific kind of service? It is true that big improvements can be made in the detailed reporting of the carriers.

Senator GORE. Did not one of the carriers tell you that they did not know how much it had paid to a given physician, or for how many different patients it had paid? I do not wish to name the carrier. I have it here before me.

Mr. BALL. I am not aware of this, but—I am informed that there is one such carrier.

Senator GORE. It is a large carrier, too. It does not know how much it paid to a particular doctor, any particular doctor, for any of the patients.

Mr. BALL. I believe what he said was that it would be a great difficulty for them to dig that out.

Senator GORE. Well, they told our investigators they did not know.

Then there is another point. What is medical necessity? One carrier says it does not make any inquiry at all.

Mr. Ball and Mr. Secretary, the picture that is unraveling here is that the carriers are, in a pro forma way, a routine way, paying every bill that comes in without investigation as to whether it is for medical necessity, for how many calls, or how many times a call is being made on a given patient. Now, something is seriously wrong, either with the administration or with the law.

Mr. BALL. Senator, I am sorry, but I do not really feel that is a fair characterization of carrier performance across the board.

Senator GORE. Well, I am glad to hear you say that.

Mr. BALL. You can pick out an incident here or there or a particular carrier in response to a particular question. But I would like to put in the record, if you will allow me at this point, that as a result

of a whole series of actions we have taken with the carriers in the last year or year and a half, and I would like to list those actions if I could at this point in the record——

Senator GORE. Would you indicate to what extent you have a response in each case?

Mr. BALL. Yes; I certainly will.

(The information referred to follows:)

SUMMARY LIST OF STEPS TAKEN TO IMPROVE INTERMEDIARY PERFORMANCE

DUPLICATE CLAIMS CONTROLS

A number of actions have been taken to improve controls utilized by the carriers to detect submission of duplicate claims or possible duplicate payment. We have placed increased emphasis on appraisal of duplicate claim screening procedures during contract performance reviews and recurrent site visits by regional staff of the Bureau of Health Insurance. This has been buttressed by the initiation of carrier systems validation testing procedures and by the development of a strong duplicate claim detection module in the Model Part B Carrier System which even if not used in whole by the carrier clearly identifies the factors which must be included in an efficient EDP screening process. We are now planning for the early implementation of a continuing procedure to identify the effectiveness of the carriers' processes for duplicate payments detection through screening a 5 percent sample of payment records reflecting payment actions taken by the carriers.

REIMBURSEMENT FOR THE SERVICES OF TEACHING PHYSICIANS

We are now in the midst of an extensive program designed to promote the necessary level of understanding on the part of all parties involved in the reimbursement of physicians in the teaching setting. We have made a series of on-site visits to intermediaries and the related carriers. These indepth reviews take 2 weeks to complete and also include on-site visits to several of the hospitals with teaching programs which are served by the intermediary under review.

CARRIER SYSTEMS TESTING

The Administration started conducting tests of carriers' operating systems in August 1968. Each system's test is conducted at 79 specified carrier locations throughout the country. As of June 30, 1969, 9 separate systems tests have been conducted. Each test is designed to determine the adequacy of certain specific functions in a carrier's operation. Although the tests focus on data transmission and processing their structure affords an accurate measure of the application of statutory provisions such as the carry-over deductible. After the results of the tests are analyzed by SSA, the carriers are informed of the results and, where necessary, the corrective action to take.

PROVIDER AUDIT COST CONTROLS

We are completing development of the audit program and cost report forms to be used in conducting combined audits of providers under titles XVIII, XIX, and V. Pending implementation of the combined audit program, information developed during title XVIII audits is being shared with State agencies with a subsequent savings in Federal and State outlays for audit under titles XIX and V.

Intermediaries have received standards under which limited scope audits may be conducted under title XVIII. It is estimated that limited scope audit may result in a 30 percent reduction in audit work.

CONTRACT PERFORMANCE APPRAISAL

On-site reviews in depth of the contractors' operations are conducted on a regular basis by central office teams. As of June 30, 1969, there have been a total of 183 contract performance reviews completed. This comprises review of 84 Part B operations and 99 Part A operations. Thus, virtually all Part A and

Part B contractor operations have been reviewed at least once and certain contractor operations have been reviewed twice. The Administration has selected certain key areas representing current primary concerns in contractor operations for special emphasis by the review teams during these on-site reviews.

In addition, in July 1968 BHI instituted a program of monthly carrier visits by regional office personnel to assess those aspects of carrier operations which are of timely concern. Among those areas which we have identified as items of particular national interest are: currency in workload processing, effectiveness of duplicate claims controls, activities in establishing and maintaining utilization safeguards activity, the adequacy of informal review and fair hearings procedures, and the reasonable charge methodology employed to implement the established criteria. Monthly reports which appraise these and other areas are sent into SSA central office. These reports identify and highlight current operating problems that might otherwise go undetected for a much longer period.

LEVEL OF CARE REVIEWS

SSA has conducted 16 studies of the performance of intermediaries and providers to determine specific problems encountered in the extended care facility program. Three more such studies are planned for July. As a result of these studies, certain problems have been identified concerning the types of patients eligible for ECF benefits and specific health services they receive. Instructions have been issued to all intermediaries which provide detailed criteria for intermediaries to use in making determinations concerning the coverage of inpatient extended care and adjunctive services.

EDP SYSTEM FOR PART B CLAIMS PROCESSING

The Social Security Administration has developed an electronic data processing system for processing Part B Medicare claims. In the system's development the experience of the carriers has been taken into account and the best features of individual systems included. The design and composition of the EDP system is such that the carriers can readily adopt all or parts of it for use in their operations. To date, ten carriers have made commitments to use part or all of the system. Eight carriers will adopt the system in its entirety while two will adopt parts of it.

REPRESENTATIVE GROUP ACTIVITY

In order to assure proper implementation of contractual agreements with the contractors, representative groups of intermediaries and carriers were established early in the program. The main activities of these groups are to provide advice on the content of proposed regulations and general instructions and to meet regularly with SSA in order to discuss issues which are of current concern. These meetings are scheduled on a quarterly basis and provide a valuable opportunity for the mutual exchange of ideas at a high administrative level. The meetings result in a two-way flow of information which enables SSA to be aware of contractors' problems and views on developing policies and procedures and permit the contractors to obtain a more complete rationale for SSA actions.

STATE AGENCY PROGRAM REVIEWS

Early in 1967, SSA instituted on-site appraisals of State agencies' Medicare operations to determine whether program instructions and standards were being interpreted properly and applied by the State agencies. Program review teams have visited all States at least once since the surveys were begun. Each review is followed by a report setting forth national problems which have been identified as well as the problems which relate to the individual State agencies. Bureau of Health Insurance Regional Offices are asked to follow up with State agencies to assist them in correcting deficiencies noted in the program reviews.

Beginning in July 1968, SSA teams in cooperation with the Community Health Service of the Public Health Service began on-site surveys of providers and independent laboratories obtaining first-hand information from clinical and other records to compare with the findings of State agencies in their certification reviews. The purpose is to identify weaknesses in the State agency certification process and assist in their correction. To date, direct provider surveys have been conducted of 34 hospitals, 40 extended care facilities, and 39 independent laboratories, which were located in 35 States.

CONTRACTOR PERFORMANCE INDICATORS

In establishing a system for measuring the various facets of contractor activity, we have developed a range of performance indicators to determine the extent to which the intermediaries and carriers are meeting their contractual obligations. From the inauguration of the program a chief concern has been currency in claims processing and payment. This is identified in terms of the number of week's work on hand at the end of the month computed by dividing the pending claims load by current claims processing. It is indicative, therefore, of a carrier's recent ability to process its workload. With this as a measure of the carrier's processing time, is joined data on the percentage of claims pending over 30 days. This indicator expresses the number of claims pending over 30 days at the end of the month as a percentage of the total number of claims pending at the end of the month.

As a further indicator data is compiled for each contractor on production per man day, relating the contractor's total manpower resources required to operate the Medicare program with the volume of claims processed. This, with a figure on the labor cost per claim processed, i.e., the cost of the labor resources in relation to the contractor's output, gives a measure of the efficiency of the claims operation.

On a regular reporting basis data is presented on the proportion of payment records received in SSA that contain accounting errors. Since these may involve an improper payment, erroneous payment records are returned to the carrier for corrective action. The extent of these returns provides a measure of carrier performance. In addition, data is developed on the proportion of queries for eligibility and utilization information on which complete action cannot be taken, usually the result of carrier procedural problems.

OPERATING PARS

As a step beyond the performance indicators, we are establishing operating pars as a quantitative standard of the Administration's concept of acceptable performance. Through the continuing analysis of performance indicators, these measures of reasonable performance are being refined. The contractor's quantitative performance then can be classified as creditable, acceptable, substandard, or unsatisfactory against this standard.

PROGRAM VALIDATION VISITS

SSA has performed 15 studies in selected areas throughout the country involving a number of providers to determine whether the quality of care rendered patients, as well as the accounting and utilization procedures and other factors, meet program requirements. More such studies are being planned for the coming months. Intermediaries are informed of the findings of these studies, which identify specific actions that must be taken. These include, for example, improvements which must be made in the intermediaries' claims examining and reimbursement control operations as well as in the performance of the providers with regard to billing practices and provision of only necessary ancillary services.

UTILIZATION OF SERVICES

The SSA Office of Research and Statistics has developed a program for providing utilization data on all hospitals participating in the Medicare program. These statistics identify the average number of days that beneficiaries are confined to hospitals when their condition falls within certain diagnostic categories. These statistics will permit comparisons of the patterns of care of individual facilities with the average experience of similar providers, thereby enabling intermediaries and the Administration to identify facilities following utilization practices not falling within acceptable limits.

As part of our continuing effort to limit reimbursement under Part B of the program to those physician and other medical services which are reasonable and necessary, all carriers were asked to describe in detail the safeguards against overutilization of such services which they employ. These were evaluated and those systems which appeared to be most effective were brought to the attention of all carriers. We have also compiled examples of situations in which overutilization has been found to occur.

Recently, a series of regional meetings were held which were specifically devoted to exchanging ideas on ways to control the overutilization of physician and other medical services. A committee composed of carrier representatives and physicians is presently being composed which will attempt to develop criteria for use by all carriers in identifying claims involving an overutilization of service.

REPORT ON CARRIERS NOT MAKING INQUIRY AS TO THE MEDICAL NECESSITY OF SERVICES PROVIDED MEDICARE BENEFICIARIES AND THE INABILITY OF THE CARRIERS TO FURNISH DATA ON PAYMENTS MADE TO INDIVIDUAL DOCTORS

In the hearing the point was made that a carrier had reported inability to furnish data on payments made to individual doctors. Forty-eight carriers were requested to furnish information on the amounts reimbursed under Medicare for the services of certain physicians who had been reimbursed $25,000 or more from Medicaid in the calendar year 1969. Twelve carriers indicated they could not, at the time of receipt of the request, supply the requested information. The general difficulty lay in the limitations of the carrier's systems capacity and capability to accumulate and extract data in such fashion as to produce the information requested in a short time and at reasonable cost.

Since the request was made, however, three of the twelve carriers that could not immediately supply the information requested have expanded their systems capacity to produce the required information. One of these had been in the process of developing a new electronic data processing system for a number of months and this has not been completed.

Seven of the other carriers that could not immediately furnish the information requested indicated they can furnish approximately the requested information with the deviation from the request centering on providing data on allowed charges rather than amounts actually paid and in some instances in a time span greater or less than the calendar year 1968. As a result, the information requested was obtained by drawing on the Medicare central office data bank which could produce the information more expeditiously.

The remaining two carriers are in the process of developing the necessary computer programs to extract the data. One of these, although it had not perfected this phase of its process, has been in the forefront in developing computer capability to identify potential problem situations in the utilization or delivery of medical services. In other words, the ability to identify problem cases is not especially correlated with the ability to determine the amount paid to a named physician.

With regard to an intermediary or carrier not making inquiry as to the medical necessity for the services provided beneficiaries, our surveys have revealed instances of deficiencies in clerical review processes resulting in failure to identify and take action on questionable cases. Wherever such situations have been detected, they have been brought immediately to the attention of the contractor's top management for correction.

CARRIER PERFORMANCE

Mr. BALL. I am saying that carrier performance did leave a lot to be desired in this program and can still be improved, but it has come a very long way. In the next fiscal year, we estimate that by their review of this question of medical necessity and the legal coverage of services, a point that we are stressing with them, there will be a saving of about $120 million in the program from that operation. We estimate that program costs will be reduced another $90 million as a result of their reduction of fees that are billed to them, but that they refuse to recognize as reasonable charges, and then another $100 million as a result of audit.

I might just make this broad point if I could, Senator. That is, we have from the beginning taken the view that the Federal interest was so strong that we had a large responsibility to monitor carrier per-

formance and to push them in various directions for review of utilization, for strict control of fees and costs. But it has not been possible to put this all in at once.

Senator GORE. I understand, Mr. Ball.

Mr. BALL. When the program started out, we let the carriers do it pretty much the way they would run their own business.

Senator GORE. I cannot imagine they would run their own business this way.

Mr. BALL. That is about the size of it. They were doing about that much review in their own business.

Senator GORE. They may have followed their own bookkeeping, but they have not injected the pressures here.

Mr. BALL. I would say that you would find that most of the carriers have felt that they have done a much stricter cost control job for us than they have for themselves. We are increasingly requiring it whether they have or not. We are establishing a great variety of national standards that they have to meet and are insisting on their performance.

Senator GORE. The clerk has given me a note that I have time for only one more question. I would like to return to the positive contributions to our way of life.

GOOD HOSPITALIZATION WITHOUT THE STIGMA OF CHARITY

Is it not true, Mr. Ball, that millions of old people, in minority groups as well as the poor generally, and in some cases the more prosperous, have had good hospitalization without the stigma of charity for the first time in their lives?

Mr. BALL. Yes, Senator.

Senator GORE. To what extent has this extended life?

Mr. BALL. Senator, I cannot make, of course, a real estimate on that point, but there is no question but what, in many individual instances, it has extended life and in many, many more, it has meant a real difference in the quality of life because of cataracts being removed, hernias being repaired, and the old person is able to function in a much better way. As you suggest, this has been done in a way entirely consistent with the self respect and dignity of the individual. They come to the hospital with their own physician, not as a charity case. The concept of charity has just about disappeared for older people as far as hospital care is concerned.

For minority people in many parts of the country, it has meant access to the best care in hospitals for the first time.

Senator GORE. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bennett?

POSSIBLE REDUCTION IN NUMBER OF CARRIERS

Senator BENNETT. Mr. Chairman, I have been interested in following the questions of my colleague. It would be interesting if we could blame the carriers for the failure of administration that really belongs to the Department of Social Security. Because you are the ultimate source of responsibility. It is your supervision that should have caught the doctors, the carriers, and some of the patients. So I have no brief

for any mistakes the carriers have made any more than I have a brief for the doctors who have abused the program. But I would remind you that under the law, it is your responsibility. And if the carriers have misbehaved, you have the authority to replace them. It was the understanding of the law that though you chose 40 or 50 carriers to start with, this was going to be done as a matter of gaining experience and by this time, we probably could have expected a reduction in the number of carriers. Is that not so?

Mr. BALL. I do not know what the figure would be, Senator, but we have taken the general view that to start over again with a new carrier in a territory with a new investment and a new training job is a very serious matter. We have gone along with carriers when they have not seemed to be ideal performers as long as there was good evidence that they could be greatly improved and could take the proper measures in a little longer time.

Now, I am not at all adverse to saying that the next time we reexamine the matter of extending these contracts, it might well be desirable to reduce the number somewhat, and where we have a very good performer who can takeover another State and a relatively poor performer there who has continued to be a poor performer, we ought to move.

Senator BENNETT. This argument that it costs more to correct them than it does to keep them going is the basic argument that has been used for the perpetuation of bureaucracy since the beginning of time. I hope you will not depend on it too much.

COST CONTROL

I have listened to the discussion today and I was interested in your comment about the fact that the fund is not being kept up to its level, when you said, we can solve that, all we have to do is step up the time when we go to the high rate. Of course, we can solve problems by increasing the taxes all the time. And I wonder if this is not one of the built-in problems that we face with this program. Everybody connected with it has an incentive to increase his personal benefits from it: the hospital, the physician, the carrier, and the patient. The patient should be the ultimate source of benefit. But these other people also are involved. You have just taken the 2 percent away from the hospitals and we are all being flooded with telegrams which say this is a deprivation. Maybe you should do it to some other hospital, but you should not do it to us, the wires say.

I wonder if that is not the nature of the program? It is a benefit in the end for which the Government pays at least the residual. It is natural for people in Goverment to say, well, we can solve that problem just by increasing our revenue. Does not everybody in this program have an incentive to keep the cost of the program high rather than to control it? And how are you going to overcome that?

Mr. VENEMAN. Senator, I cannot—I certainly do not want to leave the impression that the decisions that we made in trying to bring some cost control features in during the first couple of months of the Secretary's assuming the position, such as cutting off the 2 percent, such as developing in some time cost control mechanisms for pro-

viders, has been the most popular thing in the world. I could not agree with you more, that there have to be some limitations. I think the program itself lends itself to being taken advantage of and creating rising costs. That is why some decisions have be made, not simply by HEW but jointly, between us. We are going to take some heat. No question about that.

Senator BENNETT. Are we to assume that there will be rising costs automatically because of these incentives? Are we going to continue to be told a year from now, 2 years from now, well, that was an improper actuarial assumption? We have since discovered that we did not assume enough; therefore, we must expect these costs to continue to rise? Or are we going to be able to get though enough so that they can be fitted into the fund that has been provided for them? This is what worries me.

Mr. VENEMAN. Well, Dr.—I mean Senator, I think we have a lot of problems.

You can see who I have been talking to the last few weeks.

Senator BENNETT. Maybe I am giving you some psychiatric treatment here.

Mr. VENEMAN. One of the problems we are confronted with, really, when we start talking about controlling costs—was it in New York recently that some of the pharmacists are boycotting the program? At a certain point—what we have attempted to do is to generate and develop these regulations which would cause as many of the providers to remain in the program as possible, Now, sure, we can take some rather dramatic and drastic steps which could have the effect of causing a lot of providers of service just to say, I do not want to participate in the title XIX program.

Now, where do we go from there? I think we lost sight of the objectives and the principles that Senator Gore made reference to; that is, to attempt to provide health care for the aged and the low-income people in an atmosphere that is as much away from the context of welfare and maintains as much dignity as possible. If doctors refuse to participate or if dentists refuse to participate, or if drug stores refuse to provide drugs for what we have done, our alternative is for government to do it. Then have we reversed the cycle? We have to look at these decisions that we are making in an overall context and not just from the standpoint of saying that we can arbitrarily make this decision and such will occur, because we may go back to—you know, we tried to get away from the public hospital concept, the county hospital care. Let us not get ourselves into a position where we return to it.

Senator BENNETT. You are in a dilemma, there is no question about it. If you are going to resolve that always by the process of providing the greater service and raising the taxes, then I think the time might come if you cannot within the Department provide a method of controlling costs, we in Congress will try to provide a method. This means we will be writing Federal legislation regulating doctors' fees and prices for prescriptions and hospital day care costs and looking down the road and then looking across the water at what happened in Great Britain. I wonder if there is any way of avoiding that kind of a solution to the problem?

Mr. VENEMAN. Well, let's hope there is, Senator. I think that some of the things we have to give serious consideration to, is perhaps the concept of prepaid care, which, on a somewhat more general basis, would apply to the poor, such as the kind of programs we have in San Joaquin Foundation programs and some of the others. I think Secretary Finch has emphasized on many occasions, that we have to start giving consideration to lower cost facility care. I think, you know, this has to be the movement. We have to move into preventive medicine instead of placing the emphasis, which is unfortunately the case in many of these programs, taking care of people after they are sick. It may take more of an activity on the part of the Government, but it may have a long-term dividend in terms of reducing the situations in which we will pay well over $100 a day for average hospital care.

Senator BENNETT. The point, I think I have gotten out of these revelations and the information that has come to us, is that the system is on trial. You have operated now for 2 or 3 years and it has been demonstrated that there is something basically wrong with the system. A man can benefit himself improperly under the present rules. Now, can you make rules that will eliminate that? If you cannot, sooner or later, we in Congress will be asked to make those rules.

Mr. VENEMAN. This is the direction of our efforts, Senator, to make those rules.

Senator BENNETT. I will close by telling you a story. I like to do that.

Many years ago, in the little company with which I was connected, the management decided that they would set up a little fund to which they would contribute half and the employees would contribute half. This is many years ago—50—so that when a man got sick, and in those days, there was no sick leave, there was no insurance—there would be a little money coming to him. Certain employees began to turn up sick quite frequently. So, on one unhappy occasion, a committee from the association called on him and they found him in bed with his clothes on. Of course, he was properly chided, and his answer is a classic, and it applied to your problem. He said "I means to 'ave me share."

Now, you can control this situation, so that a man who means to 'ave his share, will not take advantage of you and eventually force the elimination of the present freedom that exists in the organization and force us to take it over and write specific rules?

I have done most of the talking, Mr. Chairman, but I have used up my 10 minutes.

INCREASE TAXES OR REDUCE BENEFITS?

The CHAIRMAN. Senator Talmadge?

Senator TALMADGE. Mr. Secretary, in the staff study that I hold in my hand here, chart 6 indicates that the projections in 1966 were that hospital insurance trust funds will be something more than $3 billion in 1975 and that at the current rate of expenditure, it will be completely exhausted and bankrupt within 6 years. That means that the taxes must be increased for the insurance trust fund or the benefits reduced. Which are you prepared to recommend?

Mr. VENEMAN. You ask the tough ones.

I think we have to have a combination. I think it is reasonable to assume, that as there is rising cost, it depends on what happens to the economy, but I assume the economy will continue to go up, there will be some increases, of course, in the cost of health care. Now, I am not so sure that it was the intent of Congress to really reduce the benefits that we have in title XVIII. I think what we have to do, is do the things that this committee is directing itself toward, to make sure, that the payments that are being made under the program, are being made for appropriate types of care and being made properly. I do not think that any of us--I am not sure that I am going to be prepared to make a recommendation to reduce benefits. But I do not think that any of us, if faced with the issue, would be reluctant to increase the tax rate if it were necessary, to carry out the kind of program that the legislation requires.

STAFF STUDY SEEN INSTITUTING CORRECTIVE ACTIONS BY HEW

Senator TALMADGE. Why was it necessary for the staff of the Finance Committee to institute an investigation before corrective action has taken place within the Department on many of these things?

Mr. VENEMAN. I think our timing was almost the same. I think one of the first persons I talked to after the Secretary took his position, was one of the legislative staff people from this committee.

Senator TALMADGE. I would like to have Mr. Ball comment on that.

Mr. BALL. Senator, my comment would be, that many of the matters that I have been speaking about and many of the things in the lists that I have asked, be submitted to the committee preceded the consideration by the staff. I would not want to say at all that their work has not been helpful to us in bringing to light additional problems to which we have reacted. But, in many, many instances, they were things that we were aware of and were already working on.

Senator TALMADGE. Are you aware that carriers have indicated to the committee and the staff that they first became aware of possible abuse by particular physicians only after they prepared the elementary payments data that we requested?

Mr. BALL. No, I am not aware of that, Senator but my staff worked with the committee staff on the data that was to be requested.

Senator TALMADGE. That was reported by many of the carriers to the staff of the committee. I was wondering why they have not been doing that all along.

PUBLICATION OF NAMES OF DOCTORS RECEIVING MORE THAN $25,000 A YEAR

Now, again, Commissioner Ball, please, you are providing us with the names of the doctors who have received $25,000 a year or more under medicare. What limitation does the law place on the publication of this information?

Mr. BALL. Senator, the law and the regulations under social security limit the publication of all information that is collected in connection with the operation of the social security program as far as individuals are concerned except as specifically stated in the statute and in the

regulations, where there are a few excepted situations. One is with the immigration laws. Another is related to protection of the President, and a few specific instances like that, except that there is a blanket authority in the law and regulations where, as Commissioner of Social Security, I could make an ad hoc exception in a particular instance to release information. It has been our interpretation that it was not intended to use this authority as a continuing thing and that if we were going to release information for a whole group of cases on into the future that it ought to be put specifically in the regulations.

Senator TALMADGE. Why can't we make this information available to the medical societies, where they can help police it and also take corrective and remedial action against doctors who have violated the law and are violating their medical ethics?

Mr. BALL. We do that, Senator. There have been special modifications of regulation No. 1, governing confidentiality, I think published in December, which does authorize us to do that, to turn information on individual doctors over to medical societies for disciplinary purposes, and we are currently operating in that way.

Senator TALMADGE. I would think that would be a very effective organization in helping to police the actions of its members. It is very effective.

In some of the intermediaries and carriers, there are indications that some of them are not doing a good job, but there are also occasions that some are not being told in what respect they are deficient and that they are not being told how they might improve their services. What are you doing to help them do a better job?

Mr. BALL. Well, Senator, we are doing a great deal more than most of them want, I would say. The general view that we are taking is an increasingly strong one in requiring them to do a large number of specific things in the area of utilization review of services, in the kind of screening that they must have, and telling them how they operate in much greater detail than we used to. As you can expect, there is some tendency on their part to want to operate independently and an increasing concern on ours that they be brought up to what we think is a desirable level of performance.

Now, very specifically, the way we have operated with them is our regional staff out in the field is in very constant communication with them and they make onsite visits frequently. Then we have a central office group which makes longer visits to evaluate their whole operation and we are now moving—we have made a decision recently—to put actually a monitor on the site of each of the large carriers so we live right with them the whole time to see that the standards and types of performance that we require are carried out and so we can be helpful to them in solving any problems.

GEORGIA VILLA NURSING HOME

Senator TALMADGE. I am concerned about the role of the intermediaries because of a case of which I have personal knowledge. A friend of mine, Mr. Glenmore Carter, operates a very fine nonprofit nursing home called Georgia Villa. His institution is one of the finest in the Nation. In fact, it was the first in the Nation to qualify for participation

in the medicare program. For over 2 years, Mr. Carter has operated on good faith and provided a very high level of care for his patients. According to the computations of his accountants, the intermediary owes him about $132,000. After the intermediary audited the books, it claimed that Mr. Carter owed $132,000. Repeated inquiries from our office have been completely nonproductive. Mr. Carter thinks the law says one thing; the intermediary says that the law says something else. My contact with your office on the part of my staff convinces me that nobody in the Social Security Administration knows what the law is.

Now, you would think that any program which involves the expenditure of millions of dollars in taxpayers' money would have tight, clearly defined guidelines. When you consider the confusion in this program, it is small wonder that the costs have gotten out of control. I am not an expert on accounting procedures, but I believe that the intermediary takes the position that Mr. Carter's nonmedicare patients must bear part of the cost of his high intensive-care medicare patients. I think this is contrary to the intent of the law. Whatever the nuances of regulations may be, I believe that nursing homes participating in your program should be given a clear understanding of what the procedures are that they must follow. I would hate to find institutions like Georgia Villa bankrupted because of ambiguities and contradictions in the medicare and medicaid programs.

Would you like to comment on that?

COSTS FOR MEDICARE PATIENTS CAN'T BE CHARGED AT A HIGHER RATE

Mr. BALL. Yes, Senator; we have called that case in from the intermediary to give it central office review and that is now going on. I can tell you what the basic issue is here. I do not believe it is lack of clarity. I think it is difference of opinion. I think he understands what our position has been, but does not like it.

The issue here is that we have taken the view that an extended care facility that is qualified to perform under the medicare program—where the whole facility is qualified—the costs for the medicare patients can't be charged at a higher rate than the charges for other patients.

Now, the contention of some of these proprietors is that they have to spend more money for the medicare patient than they do for the others. The way we have operated to allow that to happen is to ask them—if they really are giving a higher level of service to Medicare patients—to set up a distinct part of their operation and if that is really a higher level operation, then we can figure our costs in relation to that. But when they has a medicare patient here, a private paying patient right next to him, another medicare patient, another private patient, and they want us to pay higher amounts for the medicare patients than they charge for the others, we feel that it is dangerous and would be a real hole in the tight administration from the standpoint of cost control. That is what the argument basically is with this home.

Senator TALMADGE. I am informed that my time has expired.

Thank you very much.

The CHAIRMAN. Senator Curtis.

ARE INCREASING COSTS OF MEDICAL PROGRAMS INEVITABLE?

Senator CURTIS. So far in these hearings, one might get the feeling that we are faced with sizable increases in the cost of all the medical programs under the various titles of social security. Is that correct?

Mr. VENEMAN. I think that is a reasonable assumption, Senator, assuming that the programs continue at the existing level.

Senator CURTIS. Now, if we were to eliminate every case of fraud and abuse, would those problems of increasing cost disappear?

Mr. VENEMAN. I do not think they would. I think the estimate on the basis of information that we have received through audits also conforms with the information we had in the investigation in California. About 1 percent is what the estimated losses through fraud and abuse and overutilization amounts to. I do not think that is going to change the trend of rising costs. I think it has to be done, but it is not going to change the cost very much.

Senator CURTIS. I am glad to hear that, because I agree that we should not tolerate any abuse or fraud if it can be stopped, but I think it would be most disastrous to have the word go out to the country that these various medicare programs were in trouble financially and they were going to have ever-rising costs because of corruption or fraud or abuses. That is a minor cause; is that not true?

Mr. VENEMAN. I think your point is very significant and that you place the emphasis in the right place, Senator.

Senator CURTIS. Yes. In other words, we have a program here that is quite far reaching. Medicaid went far beyond what anybody on this committee ever dreamed of. I did not vote for it, but it went very far. And if you eliminate all the fraud and abuses, we are going to have some very serious cost problems that were not before us even as late as last year. Is that not true?

Mr. VENEMAN. That is true, and, Senator, I think the other thing we have to recognize, in response even to Senator Talmadge's question as to whether or not taxes are going to be raised or benefits reduced, I am sure that you, as we are, are not getting too much pressure to reduce benefits in title XVIII. The pressure is coming from those who want to include drugs, from those who want to include chiropractic services, from those who want to include optometric services. The pressures we get for changes in the medicare program are for expanded services and not for reduction in the amount of benefits.

Senator CURTIS. I know how you can lessen that pressure, too. Along with the other information you get out, if you would notify everyone what they have paid in social security taxes over a lifetime, they would find it so small that they would not be carried away by political arguments that additional benefits should be added.

When did medicare go into effect?

Mr. VENEMAN. July 1966. It was enacted in 1965, effective July 1966.

Senator CURTIS. The individual who retired before July 1, 1966, has never paid a thin dime for medicare, has he?

Mr. BALL. That is correct, sir. That is in the hospital insurance. In part B, as you know, of course, he pays the $4 a month in part B.

Senator CURTIS. Yes. This distinction between charity and welfare and medicare, to a great extent, is a politician's myth. This program is

being carried on by the people who are working now, only it is a different type of tax. Of all the millions of people who were beyond 65 and had retired by July 1, 1965, they paid nothing. Now, those that were near retirement, a year or two or four or five, what is the medicare tax bill.

Mr. BALL. It is 0.6 percent up to $7,800.

Senator CURTIS. And what is the maximum if he paid on the maximum?

Mr. BALL. Up to $7,800.

Senator CURTIS. And 0.6 percent would be what?

Mr. BALL. That would be $46.80, I believe.

Senator CURTIS. Yes.

Senator ANDERSON (presiding). What is the answer, to be sure?

Mr. BALL. $46.80.

Senator CURTIS. So someone who has paid $46.80 for 5 years would have paid in less than $250, and that is not very much of a prepayment on modern hospital bills.

I would like to ask, how many cases of fraud have you had in the State of Nebraska with respect to doctor's fees?

Mr. VENEMAN. Is Nebraska in the audit report, Mr. Kelly?

Dr. LAND. We do know that under medicaid, there have not been any.

Senator CURTIS. How about medicare?

Mr. BALL. They are checking on that. There were none.

Senator CURTIS. And how many cases of fraud have you had in respect to hospitals in the State of Nebraska?

Mr. BALL. I do not believe there would be any in the case of hospitals, Senator, but they will check that to be sure.

Senator CURTIS. And how many cases of fraud have you had in connection with extended care facilities in the State of Nebraska?

Mr. BALL. I have not checked it for the State.

Mr. VENEMAN. Senator, I think we ought to clarify here that fraud is a criminal violation. I do not think you will find very many cases of fraud that have actually been taken to the court in any place in these United States, unfortunately. There are many cases of abuse. But actual fraud cases, I think even in the larger States, you will find very few that have actually gone to court.

Senator CURTIS. I understand that.

Mr. VENEMAN. It is very difficult to get the evidence.

Senator CURTIS. I will change my question to abuses of any consequence.

Mr. BALL. Senator, I would really have to analyze those some 700 cases that we have investigated for possible fraud and other cases we have checked and see what proportion of them were in Nebraska.

Senator CURTIS. Well, my point is I have nothing but contempt for anyone who chisels, whether you call it abuse, or fraud or what. But I believe that when great attention and publicity are focused on the cases of fraud and abuse we have, there is grave danger that the general public will feel that if we eliminate all of that, we would face no financial problems in medicare and medicaid. That is not the contention of the Department at all, is it?

Mr. VENEMAN. That is not the contention at all, Senator.

Senator CURTIS. How much did we collect in medicare taxes in calendar 1968?

Mr. BALL. You mean for the country as a whole?

Senator CURTIS. Yes.

Mr. BALL. I will have that for you in just a minute, Senator.

Senator CURTIS. And what was the accrued amount of claims against medicare? What is the estimate of that for 1968?

Mr. BALL. In the trustee's report, Senator, we are talking now about fiscal 1968.

Senator CURTIS. It is carried there by fiscal years?

Mr. BALL. I can give it to you either way.

Senator CURTIS. Make it calendars.

Mr. BALL. Calendar 1968, the contribution income for the hospital insurance program was $4,157 million. There was added to that payments from the general fund of a little over a billion dollars. That is the group, you remember, that were more or less blanketed into the program who were not insured under Social Security. And benefit payments—now, these are actual payments, not on the accrued basis, but actual payments for hospital insurance. That was $4,000,000,181. As far as hospital insurance is concerned, there is not a great deal of difference between the actual payments and the accrued basis. Now, that is hospital insurance. Are you also interested in the supplementary medical——

Senator CURTIS. Not at this time. In other words, it came out about even?

Mr. BALL. Well, there was an excess of income over outgo of almost $900 million, Senator. The reason it looks as if they were about the same is you were not taking into account the billion dollars from the general fund that was for the payment of people who were uninsured.

Senator CURTIS. To perpetuate the myth, because most of the recipients have not paid anything for Medicare, is that not true?

Mr. BALL. It is true of the present group of retirees.

Senator CURTIS. Yes.

Mr. BALL. Specifically for hospital insurance, Senator. You and I have discussed this general issue many times.

Senator CURTIS. Oh, yes.

Mr. BALL. The long-range program I think is correctly described as a prepayment plan. The people who are now young are paying toward this protection and they will. As a going, long-range institution, I think it is incorrectly described the way you are describing it, but you are factually correct about the present group.

Senator CURTIS. I think it is in the long range as you have described it.

Mr. BALL. Yes.

Senator CURTIS. But up to now, it is not quite that.

As a matter of fact, your receipts would be less than your expenditures if you eliminated the $1 billion from the general fund, would it not?

Mr. BALL. By a few thousand dollars, yes.

Senator CURTIS. Now, will the tax rate for Medicare. When does that go up automatically, if at all?

Mr. BALL. It goes up in a series of steps.

Senator CURTIS. I mean just the next one.

Mr. BALL. It goes from 0.6 to 0.65, beginning in 1973 under the present schedule, then rises gradually, as you know, until it is 0.9 in 1987. The employer matches that rate with a like amount.

Senator CURTIS. But there is no increase until 1973?

Mr. BALL. That is correct.

Senator CURTIS. Do you think there needs to be one?

Mr. BALL. Yes, I personally do. The Department and other parts of the administration are now considering a recommendation that we have made. We believe that in the hospital insurance program, it is important to move up that ultimate contribution rate and have a slight increase in the allocation in the early years. The old age and survivor insurance part—the cash part of the Social Security—at present is significantly overfinanced and it would be important, we think, to put this hospital insurance fund back into approximate balance.

Senator CURTIS. Would it be possible, and I realize my time is up, would it be possible to have this Medicare tax rate fixed so that you just kept the fund in balance as nearly as possible year after year? Instead of talking about increases 5 years from now and 10 years from now, every year increase whatever is necessary based upon the best available estimate on the last year's experience?

Mr. BALL. For just that year?

Senator CURTIS. Yes.

Mr. BALL. I think that is possible, Senator. We have thought, and I think both the committees, both here and in the House have thought, that it was important in a program like this, where the commitments increase in the future as the population gets older, that we know, at least for 25 years ahead, where according to our best judgment, later costs are going to be so that we do not increase costs now, thinking that is all there is to it. So we thought it was an important principle to put right into the law a gradually increasing contribution schedule that, as best we could estimate, would fully meet the costs of the future, too.

Senator CURTIS. I agree, certainly long-range costs merit attention. But since we have no situation such as in the title II benefits, where we are starting out about on an even balance, it might be well to inaugurate a tax system that would just maintain a balance automatically.

Mr. BALL. Of course, in hospital insurance, there will be these increasing costs if for no other reason than the growth of the older population. But the procedure you are suggesting is followed in the voluntary medical insurance part of the program where the rates are set only for one fiscal year ahead and estimates are only furnished for a couple of years.

Senator CURTIS. In other words, raise the tax just as you raise the assessment?

Mr. BALL. Yes.

Senator CURTIS. That is all I have.
The CHAIRMAN. Senator Byrd.
Senator BYRD. Thank you, Mr. Chairman.

COST OVERRUNS

I am a member of the Senate Committee on Armed Services and as such, I have been exposed a good bit to cost overruns. But I do not believe I have run into a cost overrun equal to the overrun on the extended care benefits. The extended care benefits in 1967 cost ten times the original estimate of 2 years before. So when I go back to the Armed Services Committee, I am going to carry with me that information which I think the committee members will find of interest.

Mr. BALL. Senator, would you allow me to comment on that?

Senator BYRD. I would be very glad for you to comment.

Mr. BALL. I think it is important for the committee to understand what caused that situation. The actuary, in making estimates on extended care, assumed that in the beginning of the program, there would be relatively few extended care facilities. He estimated that later on, there would be as many as we have today. So there was no significant underestimate of the long-hange situation on the number of participating facilities. But there were more extended care facilities in operation sooner than he expected. And that was just a matter of not realizing how many extended care facilities would qualify for the program as soon after enactment as was the case.

He later stopped making separate estimates for extended care facilities, because hospital benefits and extended care benefits are interrelated. It is the cost of the two together that is most important. This whole extended care benefit, as you undoubtedly know, is only about 5 percent of the total cost of the hospital insurance program. In other words, it was an error of a short-term nature in a small part of the cost of the program.

Senator BYRD. I thank you, Mr. Ball, for the explanation. It is a better explanation than I have gotten as to cost overrun on the F–111 or the C–5A.

INTERNAL REVENUE SERVICE RULING ON REPORTING MEDICARE PAYMENTS TO PHYSICIANS

I would like to explore for a moment a question raised earlier by Senator Long. That is that $2 billion in medical fees paid by the insurance companies to doctors under the medicare and medicaid program or programs were not reported to the Internal Revenue Service. My understanding is that HEW requested the IRS to issue a special regulation whereby the insurance companies would not need to report those fees. I want to say that I think the overwhelming majority of the doctors of our Nation are completely honest in their handling of tax matters. But I am intrigued by the fact, if it is a fact, and I have been given that information, that HEW encouraged and requested the IRS to issue a special regulation which would not require the insurance companies to report those fees. Could one of you comment on that?

Mr. BALL. Senator, to the best of my knowledge, that is really not quite a correct statement of what happened. As I understand the

situation, we asked the Internal Revenue Service for a ruling on this matter. We indicated that if it applied only to the situations where payments were made to the doctor directly—that is, the assignment situation—and did not include the group where the patient was the billing party, that fact might have a tendency to favor physicians not taking assignments, which is the economic and efficient way to do this. But to my knowledge, there was no request that they issue a special ruling that would exempt this area as a whole.

Senator Byrd. Did the IRS issue a special ruling?

Mr. Ball. To my knowledge, they had not issued any ruling on this as recently as a few months ago, and as far as I know at this time, they have not issued a ruling.

For the completeness of the record, I should indicate that many Blue Shield plans, as I understand it, particularly in the situation that I believe either Senator Anderson or Senator Williams were speaking of where there is complementary coverage with medicare by the Blue Shield plan, are actually reporting medicare payments. There has not been required by a ruling, but they have just gone ahead and done it.

Senator Byrd. Did HEW request IRS to go slow on initiating a ruling in this regard?

Mr. Ball. Well, for the exact wording of what was done here, I think I had better turn to Mr. Hess or Mr. Tierney, who are more familiar with the detail on that.

Was there a request that they go slowly?

Mr. Hess. I do not think there was a request in this sense. There were staff discussions back and forth in which we transmitted to Internal Revenue our concerns that many of the plans said they would not be able to meet such a requirement at that time through their computer operations. We pointed out that requiring reporting for assigned cases but not others could have a very inhibiting effect on physicians taking an assignment, which was a delicate matter at the moment. And we continued in discussion with IRS. The question has been raised several times in the last couple of years and they have continued to tell us they have it under advisement.

This is all on top of a preceding ruling. As you know, we are dealing with a code provision and a preceding ruling in which they had ruled that the code requirement for reporting applies to payments made directly to the physician and that when the payment is made by way of indemnity to the patient—which is a large number, millions and millions of our bills—then there is no ruling to report that kind of a situation. And the physician who chooses under our program, as some do, not to take an assignment would be scott free under the present situation as we understand it. We have asked Treasury to look into that again.

Senator Byrd. Do you not plan to implement this—I believe August 1 was the agreed upon date.

Mr. Hess. We are talking about implementing a requirement that carriers use the social security number for all of their internal record-keeping operations and all of their reporting to us for claims payment purposes. I can't speak for the Treasury Department as to whether they will need to request or want to request any additional technical clarification or authority or whether they will be able on

their side—with respect to the jurisdiction they have—place a requirement for informational reporting by that date.

Senator WILLIAMS. Will the Senator yield for the moment?

Senator BYRD. I yield.

Senator WILLIAMS. It was also the understanding that you would file a W-2 form with the Treasury Department stating, as other organizations do, the amounts paid by the carrier. What is the use of making these assignments and getting the information if you do not file it?

Mr. BALL. Senator, I really think it is important to make this distinction just in terms of our authority here. What I agreed immediately to do in that letter to you of yesterday and repeated here today was to require all processing by a social security account number. I have the authority to do that. Now, the requirement that the carriers send informational reports to the Treasury in connection with income tax is a matter within the jurisdiction of the Treasury and we have had discussions with them and they have it under consideration, but I really can't commit them to a position on that. As the Secretary said, we have no objection.

Is that distinction clear, Senator?

Senator BYRD. Yes, thank you, sir.

CARRIER REVIEW OF UTILIZATION AND MEDICAL NECESSITY OF SERVICE

On page 14, Mr. Ball, of your statement to the committee, you say that across the country, the intermediary and carrier review of utilization and the medical necessity of service has become increasingly effective. Then you say it is estimated the cost of the program will be reduced by $120 million this year as a result of this. Then you proceed further to say that as a rule of the reduction in fees charged by physicians, it is estimated that the program costs will be reduced another $90 million, while audit activity of providers will reduce costs another $100 million.

As I add those figures, and I presume they should be added together——

Mr. BALL. Yes.

Senator BYRD. It means there will be a cost revision of $310 million.

Mr. BALL. Correct, sir.

Senator BYRD. That is for fiscal 1970.

Mr. BALL. Yes, sir. That is as a result of these actions taken by carriers and auditors.

Senator BYRD. Amounting to $310 million.

Mr. BALL. Yes, sir.

Senator BYRD. Would that be another way of saying that for the past year, the cost of this program was $310 million more than it should have been?

Mr. BALL. I do not believe one can draw that judgment, Senator. These are increasingly effective procedures. Actually, these figures are a projection of the May situation. Now, that does not mean that it was zero before then. There had been reductions at the rate of about 3 percent in the total money represented by physicans' bills in 1967. Now, it is going to 5 percent. So the figure previously was not as high as $90 million on the reduction of physicians' fees, but it was a

significant figure before. I do not mean these reductions to be $310 million over last year, but to be $310 million as a result of these actions that carriers take in reviewing bills.

Senator BYRD. Put it this way, then: If these actions had not been taken, I judge from your statement that the costs will be $310 million more than you anticipate they will be?

Mr. BALL. No; I think maybe I need to back up and define this a little better, Senator. I think we are in a little——

Senator BYRD. I am just reading from your own statement.

Mr. BALL. Yes. I think maybe the statement is not completely clear.

The point of these estimates is that carrier review has resulted in actually reducing the physicians' bills that are submitted to the extent of about 5 percent, and projecting that, that is a saving of $90 million.

Now, also, their recent reviews in the area of medical necessity and coverage have resulted in reductions that, when projected, make about $120 million a year more. My point is that in the previous year, they also did some of this. It is not $310 million more over the previous year. It may be closer to $100 million more over the previous year.

Senator BYRD. Let us take your next sentence. These figures are the amounts actually attributed to the review in specific situations and do not take into account the probably much larger effect—much larger effect—of preventing other situations from developing.

Mr. BALL. Correct.

Senator BYRD. So as I visualize it, you foresee that the cost of the program will be, to use your words here, the estimated cost of the program, and I am adding the three together, will be $310 million less as a result of these activities.

Mr. BALL. Yes; or if I could turn it around the other way, Senator, if the carriers did not perform these strict reviews of claims as they are now increasingly required to do, then we would be paying out $310 million more.

Senator BYRD. And if you relate that $310 million to the chart which is on page 23 of the committee document, page 23, chart 11, you envision a deficit in the supplementary medical insurance, a growing deficit which I take to mean $351 million. Now, of course, that $310 million would not be applied against that deficit, all of it would not be applied against that deficit, would it?

Mr. BALL. No. The way the estimates used in the committee document were made was through the projection of the experience that we were having in the previous year. Thus, the estimate that the staff has chosen to use here is the one that assumes that increases in physician fees will be recognized to the extent of about 5 percent and additional utilization to the extent of about 2 percent. That is what produces this estimated deficit and the theory that there should have been a $4.40 rate.

Now, what I said earlier, Senator, was that in my own judgment, some of the steps that we are taking toward very strict cost control now—and I am not sure I have made it clear to the committee that the carriers have been directed to not recognize increases in physicians' customary fees, except in very unusual circumstances, where they especially justify it, and that they cannot raise the pre-

vailing level of fees without Social Security approval. This is the kind of thing that is causing these reductions that I am referring to here. It is my judgment that with these reductions this accrued deficit will not be as large as shown in the chart here. The actuaries have not agreed that necessarily, this will be the result. We will find out when the year is over.

Senator BYRD. Mr. Chairman, my time has expired. Could I ask one brief quesstion?

The CHAIRMAN. Yes.

Senator BYRD. On page 18 of your statement, Mr. Ball, you say that as of late June, 14 medicare cases were pending with the Justice Department. Is that the total number of cases that have been brought to prosecution?

Mr. BALL. That is the total number, yes.

Senator BYRD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Jordan.

Senator JORDAN. Thank you, Mr. Chairman.

Perhaps I should ask a couple of questions of Mr. Ball, in order to help me answer my mail.

REASONS FOR 2-PERCENT ALLOWANCE TO HOSPITALS

First, Mr. Ball, the 2-percent bonus that went to hospitals, has now been removed and I understand it was set up administratively. Why was it set up in the first place?

Mr. BALL. Senator Jordan, I think I should indicate that in my judgment, the 2 percent was not a bonus. That is a word that colors the discussion, of course. The 2 percent was an allowance for charges that had not been specifically recognized in the basic formula—that is, cost-, not charges—in the basic formula. The Senate Finance Committee conducted I guess it was a morning-long session on the whole reimbursement formula, in which we went into this issue at considerable length. In brief, let me say, that at the beginning of the program, there were about four or five cost elements that the hospitals argued were not being taken into account specifically in our reimbursement formula. We agreed that, without finding in every case that all of these four or five things were present, an overall allowance of 2 percent—an approach which had been followed by many Blue Cross plans—would be a reasonable way of meeting the problem and keeping the general formula simpler.

But, I would not at all agree, that the 2 percent was over and beyond cost. It was over and beyond defined and accounted for cost.

Senator JORDAN. Over and beyond the identifiable item in the first place?

Mr. BALL. Yes.

Senator JORDAN. How much money was involved here?

Mr. BALL. It is about $85 million in the current year.

LAG IN PAYMENTS FOR HOSPITAL SERVICES RENDERED

Senator JORDAN. The second type of letter I get is why can't we get swifter payments, faster settlement for hospital services rendered to medicare and medicaid patients. Our staff had this to say: "The

costs of hospital benefits during medicare's first year of operation are not fully known, because only 22 percent of hospitals have completed settlement with the Government. This lag of several years in settling accounts with hospitals, makes medicare estimating and accounting very difficult." I will say it makes hospital operation very difficult, too, Mr. Ball. What do you have to say?

Mr. BALL. I might say that these are two different matters that might be confusing in the record.

Let me say this, that payment to hospitals are very current and have been almost from the very early days of the program. The way it is handled is, that they are paid on an interim rate, which is an estimate of what they are going to get under the program. Then, at the end of the year, there is a totaling up and they either owe us money or we owe them some money. Now, the audit program has been completed in the first year for over 5,000 cases and what is holding up final settlement is simply that some hospitals do not want to agree with some particular item in the audit. When the staff says there has been final settlement in only 20 percent, that does not mean that the Government has not decided what the final amount should be, it just means that the hospital still wants to argue about something.

Senator JORDAN. The hospital is not willing to accept——

Mr. BALL. That is right, but they have been getting the money on an interim payment basis.

Senator JORDAN. How much is involved here, Mr. Ball?

Mr. BALL. Oh, we would estimate that the final audit will probably increase the initial payments that have been made—if you take the program as a whole, across the country—by a few percentage points. Something less than five. But the argument is on the amount of the increase and probably a total of a fraction of a percentage point is at issue.

NURSING HOME CHAINS

Senator JORDAN. In our staff report, they call attention to another matter of concern. That is the alarming growth in chain operations in the nursing home field. Some of these chains, it is said by our staff, actively solicit physician purchase of stock to assure high occupancy rates. Other chains purchase stock of hospital supply and pharmaceutical supply houses. This leads to arrangement with respect to intercompany sales at what might very well be higher prices than would otherwise be paid—a form of captive market used to milk the medicare trust fund.

How do you respond to that kind of a statement?

Mr. BALL. I really at this point, Senator, do not have enough factual information to back it, or completely contradict it. Let me say, we are concerned about particularly one aspect of present reimbursement principles as far as the sale of these extended care facilities is concerned. That is how the matter of accelerated depreciation actually works out in practice. I think our rules may well be all right, but I am not sure that in all cases, they are followed well enough, but even on the rules, I want to reexamine them. So with a group of outside consultants, we are going into that aspect of this matter.

Now, we, too, have been obviously struck by and concerned about this stock market phenomenon——

Senator JORDAN. The great interest in nursing home chain stock on the market?

Mr. BALL. Whether there is a reasonable connection with reimbursement policy, is something really to study and find out. I do not know.

Senator JORDAN. This has been recommended as the place to put your money now.

Mr. BALL. One group that we looked into just the other day, for example—without naming it—we found that the price had moved very rapidly in the market. But the great majority of the homes in the chain were not participating in the medicare program. They were providing it for other patients.

LAXITY OF FEDERAL OFFICIALS WITH RESPECT TO MEDICAID

Senator JORDAN. Now, with respect to medicaid. Our staff review made this statement, and I would ask you to comment on it.

Federal officials have been lax in not seeing to it that States establish and employ effective controls on utilization and costs, and States have been unwilling to assume the responsibility on their own. The Federal medicaid administrators have not provided States with the expert assistance necessary to establish and implement proper control. Also, they have not developed mechanisms for coordination and communication among the States about methods of identifying and solving medicaid problems.

Now, I think the Secretary said in his opening statement that medicaid, probably had to deal with 44 different States and all the different or regional differences among some of them. But what is your answer to this charge?

Mr. VENEMAN. I would agree with the charge, Senator.

Senator JORDAN. You agree with it?

Mr. VENEMAN. Yes.

Senator JORDAN. What can we do about it?

Mr. VENEMAN. One thing we have to do immediately is make sure we have compliance with State plans, that the State plans do carry out the intent of the legislation. I think anything of this nature is somewhat inexcusable, but I think that it is understandable. When several States have initiated and adopted programs of the magnitude of title XIX medicaid, there are bound to be some problems in the first couple of years.

States do it in various ways. For example, we went through legislative sessions to get implementation legislation in California. In some States, the legislatures simply said to the administrative branch, the executive branch, implement title XIX. So it was all done on the administrative level.

Many of these States submitted plans which I think all of us, both on the Federal and the State level, were grasping to determine whether or not some of the provisions could be carried out or would be effective. I think that we are again—just like the 2 percent for the hospitals—the honeymoon is over. Now is the time to make sure the plans are enforced.

INCIDENCE OF FRAUD IN THE MEDICAL PROGRAMS

Senator JORDAN. I think you said in your statement, too, Mr. Secretary, that the incidence of fraud was not so great as the borderline abuses just short of fraud. I think we all recognize that the great

majority of the people engaged in health services are good, honest people, but there are those who are not and abuses on the borderline short of fraud and fraud itself have captured our attention here this morning. In the Secretary's statement, or in Mr. Ball's statement—I think Mr. Ball is the author of this statement—"Each potential fraud or violation is reported to us by the carriers upon discovery." He went on to say that in cases of suspected fraud, the Social Security Administration becomes directly involved and Senator Byrd pressed on it. Some 1,200 cases of suspected fraud have been identified and investigated and most of them were found to be innocent mistakes in bookkeeping or one thing or another.

Then over on the next page, it says as of late June, 14 medicare cases were pending with the Justice Department.

To your knowledge, Mr. Secretary, or Mr. Ball, or any of you people, has there ever been a conviction for fraud under medicare or medicaid?

Mr. BALL. I believe that in the only medicare case disposed of by a court so far, they entered a plea of no contest.

Mr. VENEMAN. There have been convictions under title XIX. I know of some specifically in California where there have been convictions. But we had an attorney general investigate out there and it is extremely difficult to get enough evidence for a good criminal case on fraud. That is the tough thing.

Mr. BALL. But I would say, Senator Jordan, that out of those 1,200 cases, there are still 700 that are in various stages of process. On these, 14 cases now pending with the Department of Justice five or six will be added to them within next few weeks. Those 700 are not all going to turn out to be cases that can go to court, but we have not dismissed the 700. I think there were 500 in which there did not seem to be a basis for prosecution.

Senator JORDAN. One final question, Mr. Secretary. Do you think that the hearings and the deliberations of this committee are likely to have a salutary effect as a deterrent on the abuses that might lead to fraud?

Mr. VENEMAN. Yes, I do, Senator. I think that is in the very nature of any group such as this prestigious committee which brings to the public's attention that these do exist. Again, I think we should emphasize, as Senator Curtis has emphasized, that it is a relatively small number of the providers that we allege have been involved in either abusing the program or fraudulently taking advantage of it. But I think the mere fact that the public is made aware that it is happening will have a deterrent effect on many providers of the services under both title XVIII and title XIX.

Senator JORDAN. I hope so.

Thank you, Mr. Chairman.

Mr. BALL. Mr. Chairman, could I make one point? I know that this staff report is of a very preliminary character. But it occurred to me that it might be of use to the committee and helpful in completing the record if you would allow us to comment on some of these points and tentative conclusions that are in this report. Although we agree with many of the points, in other instances, I think there are places that you might like to have our views specified.

Senator CURTIS. I think that would be very desirable.

The CHAIRMAN. Fine. I would suggest by all means you do that. We will incorporate that in the record.

(The material referred to appear as Appendix A, page 287.)

The CHAIRMAN. Let me just lay it right on the line with you and tell you what really concerns this Senator and I think is going to concern the Congress about this matter.

MEDICAL PROGRAMS CONSTANTLY EXCEED COST ESTIMATES

Since we enacted the medicare program in 1965, we have been compelled to increase taxes by $35 billion over a 25-year period, an average of over a billion dollars a year. We did that in 1967 at the request of the Department of Health, Education, and Welfare. Now we are told here today that it will be necessary to increase taxes by another 0.29 percent of payroll, if I understand it correctly, to cover additional increased costs under part A of medicare. Our staff tells me that this will cost another $44 billion over the next 25 years. Taken together, this represents a cost increase of $79 billion over a 25-year period, or an increase averaging $3 billion a year more in taxes over the 1965 estimates.

Now, part B of medicare will also exceed cost estimates by a large amount, how much I do not know, but perhaps as much as a billion dollars. Medicaid also appears to be exceeding cost estimates by about $800 million a year. Taken together, that amounts to a potential increase in costs of as much as $5 billion a year. And mind you, that is just the current increase in cost estimates over the last increase in cost estimates since 1965. That is just about a 4-year period.

How much of this cost increase could have been avoided and are we in for more increases in estimates in the near future?

Mr. BALL. Mr. Chairman, I would like to comment on the statement that it is likely that the voluntary supplementary medical care will be a billion dollars over estimate. I want to say in defense of the actuaries that I do not believe that is true. I think it was contemplated from the beginning that this dollar premium would have to rise, just on a year-by-year basis, and it was expected that as wages and other costs rise, that premium would have to go up. The actuary actually recommended that there be a rate of $4.40. So if that had been in effect, then I am sure, as far as the estimates are concerned, it would be sufficient. As a matter of fact, I have indicated that I think that is somewhat high.

Now, in the hospital insurance area, as I indicated earlier, almost the entire reason for the change between the previous trustees' report and this trustees' report—in other words, that minute 0.29, that additional amount, is a change in the underlying data that relates to hospital admissions. It is not anything that happens in the program. It is merely that before the program started, we did not have good information on utilization of services in hospitals by older people. That is just a correction of that estimate. I do not see any reason to think it will ever happen again.

Now, the estimate in hospital insurance allows for rather substantial increases already in the daily hospital rate. Now, whether they have allowed enough, whether those estimates of rising hospital costs are adequate; but they do allow for a quite substantial increase.

Senator WILLIAMS. How do you explain that?

The CHAIRMAN. Let me get this straight with you. According to my figures here, it roughs out to an increase over estimates averaging about $4.8 billion. Now, according to your calculations, how much does this amount to an increase over estimates? I mean looking at the estimates you gave us previously.

For example, in 1965, you gave us the original medicaid and medicare estimates. In 1967, you gave us the new medicare and medicaid estimates. I am looking at a 1967 conference medicaid estimate for fiscal 1969 that is at least $800 million out of line. I am looking at a 1965 estimate which would appear to be $79 billion under, over a 25-year period. In a 1-year period that would appear to average $3 billion over in costs. How much do you think these three programs are over and above estimates?

Mr. BALL. Mr. Chairman, I would be glad to review these figures with the actuaries and insert that exact answer in the record. But I am not disputing the overall amount of increase as against the estimates that were previously made. I was saying only that in the supplementary medical insurance plan, the actuaries felt that the estimate should have been higher. We should have a higher income and a higher outgo in that part of the program. I am not disputing your figure on hospital insurance; I am only explaining the reason for it. For the first time, we have good information on admissions to hospitals which we did not have before.

The CHAIRMAN. Maybe so, but the figures I am citing on part A, that $79 billion, that is your actuaries' figure?

Mr. BALL. Unquestionably they have revised estimates based on actual experience under medicare.

STEADILY INCREASING HOSPITAL AND NURSING HOME COSTS

The CHAIRMAN. We have been doing a lot of talking to you, Mr. Ball, about the fact that there have been some cases of downright fraud where some doctors may even have to go to jail. There have also been much more numerous cases of overbilling, overcharging, where we should be able to recover something. Let us face it, what we have been talking about here in this doctor area is not the big part of the excess costs. The big part comes in hospitals and nursing homes costing more than you estimated. Is that not right?

Mr. BALL. The major reason for the increase over the previous cost estimates is in greater hospital utilization; admission to hospitals. That is by far the biggest part of the explanation of the increases in the long range cost estimates.

The CHAIRMAN. We have had situations where hospital help has been underpaid historically and where hospitals have not been able to acquire the buildings and the equipment they wanted. Would it not be correct to say that to a large extent, they have seized upon this as an opportunity to load off on these Federal programs—primarily medicare—the expense of raising the salaries of a lot of hospital personnel, and also of acquiring a lot of new equipment and perhaps some new buildings?

Mr. BALL. Senator, I do not believe I would make such a sweeping statement. Although, there is a point on which I agree with you. Medi-

care is reimbursing institutions on a cost basis. When you join that fact with the fact that other third parties, like Blue Cross and others, are frequently on a cost reimbursing basis, the hospital knows it is going to be reimbursed for cost, even though cost is rising significantly. It does lessen their resistance to buying more expensive equipment and increasing wages. But this is not all due to medicare. It is part of a general pattern of reimbursement that does not have incentives in it for keeping costs low. I am hoping that out of some of the experiments we have been authorized to begin and have started on—one involving the hospitals in Connecticut, Senator Ribicoff's statement, looks quite hopeful—that in the next year or two we can come up with some changes in this reimbursement formula which will have incentives to encourage economic and efficient operation. I agree with you that the present system does not have any such incentives.

The CHAIRMAN. Let me just give you a simple example. You refer in your statement to situations where the hospital traditionally took care of many old people without charge, because those people did not have money with which to pay, or if they did pay, it was a token payment. That is sort of an old-fashioned part of medical ethics that may no longer exist. Some people once thought that if someone came in that condition, you should not turn him away without some help.

Now in fact, in most instances, we are paying for those people under these Government programs, medicare and medicaid. Well, when we now pay for those beds, if the hospital or the nursing home were not seeking to make more money, they could have reduced the charges to all the other paying patients. So far as I know, there are no instances where that has happened. What they did was take that additional revenue and put it into either a pay raise to hospital help or to buy new equipment. Or they may have invested in something else. Do you know of any cases where they took the increased revenue and used it to reduce the costs of beds?

Mr. BALL. I think that would be hard to decide, because as you have said, there are various other factors that increased hospital costs, and the only way that this line of reasoning would have shown up is that maybe charges didn't go up in some instances as much as they otherwise would have.

I think you would agree with me, too, that hospital salaries had been lagging behind the rest of the wage pattern in this country and it was to be expected that unless there was some catch up in the wage structure of hospitals they would be at a major competitive disadvantage in getting people to work for them. So some of this increase, I think, was quite necessary and desirable.

The CHAIRMAN. It seems to me that here, even by the calculation that you come up with, I submit you are going to show up with an increase over original estimates of at least $4 billion a year. That is from 1965 to 1969, and I very much fear that if we do not ride herd on this program, in the next 6 years, we may see another increase of $4 billion a year.

Mr. VENEMAN. Senator, if I may interrupt, I think there is another factor in this whole facility cost increase that we might as well face up to. I think when XVIII and XIX went into effect, everybody—including local and State governments—tried to figure out how they

could stretch their State or local dollars as much as possible. States found eligibles in mental institutions who would qualify under XVIII and XIX, and we are matching the dollars which had traditionally been State expenditures. One of the things I think we will recommend to the Congress is a limitation of the Federal payment under title XIX to those persons in mental institutions to a 120-day maximum. They were treated previously as State responsibilities, responsibilities of the State governments. We have spent a great deal of Federal money in matching the payments for patients in these facilities.

MAINTENANCE OF EFFORT PROVISION

The CHAIRMAN. Well, we have another problem here, too. That is, we included a maintenance of effort provision in the law. I think I was the granddaddy of that proposition. I took it to conference on several occasions, trying to guarantee that when we passed a welfare increase, old people got it instead of the States using that saving somewhere else.

As the author of that thing, I met myself coming back, a head-on collision, just made full circle and met myself coming back. Louisiana had some programs which we thought were actually excessive. Then we said, "Why can't we save some of this." We are now told we cannot do it, it is against the law. That is the same thing I initiated for a completely different purpose. It is now preventing us from saving some money which we could use for other appropriate purposes.

Dr. Land, in a situation where a State had a very elaborate program far more than the national average, if increased Federal matching meant it would be providing far more care than you think could be justified, far more than the average for the Nation, do you think there is an appropriate consideration which could be made where they could take some savings in their budget?

Dr. LAND. Yes, I would agree to that, and I think the maintenance of effort provision should be revised.

The CHAIRMAN. I used to call it the pass-along provision. If we put some money on the Federal end, we did not want the State cutting back. I, myself, never tried to put that thing into effect more than about a year at a time, with the idea that after about a year, it had served its purpose and we might be actually forcing a State to waste a lot of money.

Would you agree that where a State is providing excellent care, better than the average for the country, if that State thinks the additional Federal matching would just force it to waste money or to raise salaries in ways which could not be justified, or pay for something they need not otherwise pay for, the State should be able to economize on the program, which would also mean a resultant Federal saving?

Dr. LAND. I agree with you completely, Senator.

The CHAIRMAN. Thank you very much, gentlemen. I would suggest that we recess now until 2:30. I cannot be back at that particular time, but I will be here by about 3:00, I hope. Senator Anderson will preside and I think Senator Williams will keep you busy until I get here.

(Whereupon, at 1:20 p.m. the committee recessed to reconvene at 2:30 p.m. of the same day.)

AFTERNOON SESSION, 2:30 P.M.

Senator ANDERSON. We start off with Mr. Ball.

Mr. Ball, if there are any points you did not cover this morning, take them up now. If there are any additional points you wish to make at this time, please go ahead.

STATEMENT OF JOHN G. VENEMAN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; DR. FRANCIS M. LAND, COMMISSIONER OF THE MEDICAL SERVICES ADMINISTRATION; ARTHUR E. HESS, DEPUTY COMMISSIONER OF SOCIAL SECURITY; THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE; AND JAMES F. KELLY, ASSISTANT SECRETARY, COMPTROLLER

Mr. BALL. Mr. Chairman, I believe to save the time of the committee, if it would be acceptable, I would just like to have my prepared statement submitted in the record. A very large number of the points in that statement have been covered by the discussion and I would not propose to read it unless you wish.

Senator ANDERSON. Is there any objection to receiving the statement of Mr. Ball or Dr. Land?

The statements are accepted in full.

(Mr. Ball's and Dr. Land's prepared statements with attachments follow:)

STATEMENT OF HON. ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY

Mr. Chairman and Members of the Committee: I would like to take this opportunity to report to you on the accomplishments of the Medicare program and to indicate some of the problems that we have encountered in administering the program and to tell you what we have done and are doing about these problems. In some instances, as the Under Secretary has indicated, we believe that legislative changes are needed to improve program operation.

Today marks the third anniversary of Medicare. Although the program was very controversial in the beginning, I believe it is now fair to say that like other parts of the social security program this national system of health insurance for older people is an accepted part of American life and is generally recognized as contributing greatly to the health and security of our 20 million older citizens. From every indication that we can get, Medicare is a popular program which has won the acceptance of the overwhelming majority of older people, their sons and daughters and the professionals in the health care field.

I'm not going to spend very much time in this brief report in detailing for you the accomplishments of Medicare because I believe these accomplishments are well known. I intend to spend most of my time discussing the operation of the program and how it can be improved.

First, however, let me remind you of the general setting in which the Medicare program operates. Medicare came into being in response to the basic dilemma that faced older people and private insurers in attempting to provide protection against the cost of medical care in later life. The fundamental dilemma was that older people have a need for much more medical care than the average younger person and yet on the average, because most older people are retired, their incomes are much lower. Consequently, they could not afford in old age to pay a premium high enough to cover the cost of care. The solution as far as the most expensive part of medical care is concerned has been to set up a hospital insurance program on a prepayment basis Part A of Medicare, so that people

pay toward this protection while at work without having to pay additional amounts after retirement. Then we have a supplementary voluntary plan primarily to cover physicians' fees, Part B of Medicare, toward which the individual currently pays $4 a month and the government matches his contribution with a like amount.

The two parts of the program provide for coverage of a wide variety of services, making it possible for the physician to choose the appropriate level of care for his patient. That is, Part A covers not only inpatient hospital care but extended care for people who can leave the hospital but still need full-time nursing care, home health care for those who can be taken care of in their own homes but are homebound and need the part-time services of visiting nurses or physical or speech therapy and other types of skilled care. Outpatient hospital care is covered under Part B as are physicians' services wherever performed—at home, in the doctor's office, a hospital, nursing home and so on. This coverage of a variety of services was designed to correct the situation that has existed in many other insurance plans that have put major emphasis on expensive inpatient hospital care. At the same time, the program omitted certain types of medical care which are particularly difficult to administer and control such as out-of-hospital prescription drugs, long-term nursing care, and the provision of dental care.

Special provisions were also included in the program to emphasize the importance of quality care by requiring institutional providers of services to meet various standards. Special provisions for helping to control unnecessary hospital and extended care utilization were also included. All institutions are required to have utilization review committees and physicians must certify to the medical necessity of certain types of care and the continued need for hospital and extended care.

The basic design of the administration of the program has been to lodge the Federal responsibility in the Social Security Administration but to rely for the determination of reasonable costs and charges and for bill-paying and reimbursement on intermediaries and carriers. These organizations are primarily Blue Cross and Blue Shield plans and private commercial insurance companies that previously had experience in the health insurance area.

I believe that by and large this whole approach has worked well. Although we have elaborated or revised various regulations and administrative decisions as we have gained experience under the program, and although we now believe that certain legislative changes are desirable, by and large, the structure provided by the Congress in the basic law, the fundamental approach, is, in our opinion, sound.

The accomplishments of Medicare are well recognized. First of all, older people in this country are getting about 20 percent more hospital care than they received before Medicare. This has not only extended lives but added quality to the lives of older people.

These people moreover receive medical care under conditions consistent with their self-respect and dignity. They go to hospitals as patients of their own personal physicians. The concept of charity care in a hospital hardly exists now for older people.

For many people, Medicare has meant access for the first time to the best hospitals. Members of minority groups have access to quality care on the same basis as everyone else. All the hospitals and extended care facilities and independent laboratories and other institutions that participate in Medicare must meet standards of quality. This benefits everybody in the community, not just older people.

Older people now have a sense of security whether they have large medical bills or not in knowing that the possibility of a very expensive illness wiping out one's lifelong savings has been largely removed.

The Medicare program depends for its success upon the understanding and cooperation of large numbers of people and a variety of institutions. Twenty million older people, just about all those over age 65, are covered automatically under the hospital care portion of the program. Of these people, 96 percent have also signed up for the voluntary part of Medicare and pay $4 a month to get additional coverage for physicians' bills. Over 16 million hospital stays have been paid for during the first 3 years. Over 62 million medical bills have been paid under the supplementary plan.

There are about 7,000 hospitals involved, 200,000 physicians and 5,000 extended care facilities in addition to 2,300 home health agencies, 2,650 private labora-

tories and many other health service providers. Some 130 Blue Cross and Blue Shield and private insurance contractors help in the administration of the program and 52 state agencies are involved in the certification of eligibility of providers in terms of quality standards. About 5 million people a year enter hospitals under Medicare and 8 or 9 million are reimbursed for physicians' bills.

Developing the informational program, the policies, forms and procedures, the organization and interrelationships, the communications network, and the data processing capability for handling this massive operation were among the first problems that faced the program.

But to turn now to the problems that confront us still and will face us in the future in the operation of the program.

INCREASING COSTS

I would put first of all the problem of increasing costs. This is a problem which Medicare shares with all other insurers in the medical care area and in fact with all purchasers of medical care. This is a problem which stems, of course, from long-range trends predating the Medicare program. In some ways the Medicare program has itself helped to aggravate the trend and in other ways it has been a moderating influence.

In the area of physicians' fees, in all likelihood, Medicare contributed to the sharp rise in the rate of increase in physicians' fees that coincided with the advent of the program. For many years physicians' fees had been increasing at a rate slightly less than the increases in the general level of wages but shortly before the beginning of Medicare fees started to increase at a rate significantly above the increase in the general wage level. Since the principles of the program call for reimbursement based primarily upon the customary charge of the physician, in all probability the advent of Medicare led many physicians to review and revise their charges. Also, more fundamentally, Medicare further increased the pressure of demand for the limited supply of physician's services by making it possible for more older people to compete for these services.

On the other hand, it is very likely that several actions taken recently in the Medicare program have had the effect of helping to restrain the level of physician fee increases. For example, carriers are increasingly reducing physician fee billings before reimbursement and, unless the physician agrees with the reduction, they inform the beneficiary that the billing is beyond the reasonable charge allowed by the program. In May, reduction occurred in at least one item in 23.6 percent of all billings. Translated into dollars saved, for the past few months, for example, the total amount of physician charges were being reduced at a rate of 5.2 percent before reimbursement was made. This compares with an average of 3.2 percent in money reductions in the first half of 1968, 3 percent in 1967, and 2.4 percent in 1966. Moreover, I would expect that the decision not to increase the premium rate under Medicare for this coming year in itself has had a restraining effect.

In the hospital area, in daily hospital charges year after year, large increases considerably predated Medicare. In this area, increased prices are not primarily the result of increased demand but rather the result of higher costs. Wages and salaries constitute about two-thirds of all hospital costs and while formerly lagging behind compensation in other areas have risen rapidly in recent years, and in the hospital area there have not been significant offsetting increases in the productivity of labor so that increasing wage costs have to be passed on in price. Then too, improved medical techniques have resulted in more expensive procedures and equipment. Medicare's effect on hospital prices is unclear. In many hospitals where there were relatively low occupancy rates before Medicare, the effect of the program has been to increase occupancy and thus to reduce per diem costs, because overhead in such a situation remains relatively stable.

It is also true that in paying for the full cost of the care of the aged under Medicare, many hospitals have been relieved of a part of what was once a charity load, and such costs no longer have to be passed on to other insuring agencies or the patient who pays for himself. On the other hand, Medicare is a part of the general trend of reimbursing hospitals on the basis of costs so that the resistance of the institution to taking on additional costs has been further reduced.

In any event, regardless of the causes of increasing costs, we have been very conscious of the need to design Medicare policies so as to make the greatest possible contribution to restraining cost increases.

Over the long run, perhaps the most important thing that can be done to relieve the pressure on medical prices is to reduce the demand for the most expensive type of treatment, both by preventive measures and by making sure that alternatives to expensive care are available and are insured as fully as inpatient hospital care is insured. This is just what the Medicare program is designed to do. Although Medicare provides coverage of these alternatives to inpatient hospital care not all communities have adequate extended care facilities or home health agencies, and there may well be, in some instances, unnecessary hospital utilization because of a lack of these less expensive alternatives in some areas.

On the supply side, also, it is clear that we need more physicians and, equally important, we need to make sure that the physician's skill is reserved for the level of care that only he can perform. It is necessary, therefore, to further develop the paramedical specialities and to promote arrangements that facilitate the most efficient use of the physician's time.

In a series of nine regional conferences around the country we have brought together private insurers, representatives of labor and other consumer groups, the medical profession, hospital administrators, employers, and all those with a stake in the health care system to discuss and promote the long-term measures necessary for cost reduction. In several states now these meetings are continuing under local and state auspices.

In Medicare administration, we have been putting increased emphasis upon the review of the necessity for medical services and their proper utilization. This direction, as much as fee control, in our judgment is the way in which the cost of this program and of medical care as a whole can hopefully be kept within bounds. I am presenting for the Committee's information a summary of the most important actions that we have taken in recent times directed at the matter of cost control and proper utilization of services.

This list includes such items as the computer identification of physician-patient contacts which appear abnormally frequent for a particular diagnosis or procedure; the prior approval of revisions in the prevailing charge screen as well as the moratorium on all but specially justified increases in customary charges; the computer identification of length of hospital stays that appear to be out of line; the possible reduction in the recertification period by physicians; and many other matters.

One of the more promising projects in the area of utilization review is now underway in California with three of the States's foundations for medical care under subcontract with California Blue Shield. Under this project the foundations review Medicare claims in San Joaquin, Kern and Fresno counties. These foundations are arms of the county medical society and operate on the basic premises that one of the most effective controls on charges is the elimination of payments for unnecessary utilization of services and that the detection of this unnecessary utilization of services can be performed best with the help of peer group review.

In the counties where these foundations are reviewing Medicare claims, both charges and utilization have been reduced.

Across the country intermediary and carrier review of utilization and the medical necessity of services is becoming increasingly effective. It is estimated that the cost of the program will be reduced by $120 million this year as a result of carrier review of the medical necessity of services and other aspects of the legal coverage of services. As a result of the reduction in the fees charged by physicians before reimbursement, it is estimated that program costs will be reduced by another $90 million, while audit activity of providers will reduce costs another $100 million. These figures are the amounts actually attributed to the review in specific situations and do not take into account the probably much larger effect of preventing other situations from developing.

As you know, we have been engaged in a reconsideration of the approach to reimbursement for institutional care. This effort has a number of different aspects. It includes a review we are making, together with the American Hospital Association, of the efforts made by hospitals that have taken special steps to control costs. It includes, further, the work on which the Blue Cross Association has taken the leadership in assessing the various experiences Blue Cross plans have had with a variety of reimbursement approaches. It includes a number of

new experiments now underway which we are monitoring—two sponsored by Medicaid, one in San Joaquin County, California, and one in Clackamas County, Oregon; one supported by Medicare in Maryland; and one in Pittsburgh supported by the Public Health Service. We have also worked out new reimbursement approaches—a rather difficult task of design and negotiation—shortly to be applied in Connecticut and New York City and likely to go into effect soon in California. We have been working with the American Hospital Association on a number of additional experiments some of which appear to be likely prospects and we have been talking, too, with the American Nursing Home Association about other possibilities for experiments.

PROGRAM INTEGRITY AND FRAUD PREVENTION

Program integrity and the detection of program abuse and fraud is, of course, a matter closely connected with cost control. From the early days of the program, we have been alert to the potential for abuse. It has been possible, however, to put increasing emphasis upon measures to prevent and detect abuse as the carriers and intermediaries have gradually overcome the almost overwhelming workloads that they were confronted with at the beginning of the program.

That is, as their capacity to process claims has grown in relation to the demand on them, it has been possible to push for more and more refined claims review and more and more emphasis upon the detection of irregularities.

Many carriers have developed charge data which enable them to readily identify individual physicians and others whose bills in a given period significantly exceed what would normally be expected in ordinary practices and our central office statistical operation produces a list of physicians with the highest payments. This list is distributed to carries for their use in program review. Other claims screening procedures permit carriers to identify physician-patient contacts which appear abnormally frequent for a given diagnosis and therapeutic procedure, unusually high use of specific procedures, and significant changes in charging patterns.

Through such mechanisms carriers are able to identify questionable cases and conduct preliminary investigations to determine whether the situation appears to be such as to warrant referral to the state or local medical societies for disciplinary action or one in which a fraud investigation seems to be merited. Each potential fraud violation is reported to us by the carriers upon discovery.

In cases of suspected fraud, the Social Security Administration becomes directly involved. Since the beginning of the program over 700 cases of suspected fraud have been identified and investigated. This figure refers only to those cases in which there was an allegation or other indication of an intent to defraud. It does not include the many overpayment recovery actions taken by intermediaries and carriers in situations of unethical practices or overutilization which are handled directly with providers, physicians and State and local medical societies.

In about 300 of the 700 cases, further investigation disclosed that there was insufficient evidence of intent to defraud to justify a full investigation leading to a recommendation of prosecution. Often simple clerical error or misunderstanding was all that was involved. Such cases were closed and actions taken to recover overpayments. The remaining cases are under continued active investigation.

Cases in which the evidence seems clearly to indicate an intent to defraud are referred to the Department of Justice where final responsibility rests for determining whether criminal action should be taken. As of late June, 14 Medicare cases were pending with the Justice Department.

Program abuse and fraudulent activities involves only a very small proportion, of course, of the physicians and other providers of services involved in the program but we consider it a matter of first rate importance to prevent and detect whatever activity of this kind there is. Every carrier is required to assign special staff to the matter of program integrity and fraud detection and investigation. Centrally, we also have a program integrity staff who examine policy and procedure from this standpoint, as well as several investigators engaged in ferreting out wrongdoing. As the committee knows, most of the cases that have been cited in recent weeks in the area of fraud and questionable practices under Medicare have come from the activity by the Social Security Administration.

MONITORING CARRIER PERFORMANCE

Another area of concern in the administration of the program has been the monitoring of carrier and intermediary performance. From the beginning we have taken the view that the responsibilities of the Federal government in the Medicare program require very considerable direction on our part. On the other hand, by assigning major roles to the states, Blue Cross plans, commercial carriers and group practice prepayment plans the statute indicated an intent to have the system operate on a decentralized and pluralistic basis. In determining our policies allowance had to be made for differences in approaches so that local special problems can be accommodated and so that there would be room for experimentation. It has been natural that many of the carriers and intermediaries have emphasized their own independence where we have increasingly taken responsibility for reducing the degree of variations in approach and for establishing more uniform applicability of desirable standards of performance.

I am submitting for the Committee's consideration a summary listing of steps that we have taken to improve intermediary and carrier performance.[1] These steps include special visits by Social Administration teams to providers such as hospitals and extended care facilities to validate the program performance of the carriers and to detect any need for changes in policies and instruction. They include the fact that Social Security Administration will soon provide every intermediary and carrier data that will help to identify practices and costs that are out of norms.

Regional office staff visit carriers frequently to monitor their performance, and in depth reviews are made by central office staff less frequently. We have now decided to have full-time on-site staff located with the largest carriers on a permanent basis. Other steps include the development of a model computer system for intermediaries which will make it possible for all carriers to have a sound systems approach to claims review and processing. SSA has tested the effectiveness of carrier systems by submitting test claims for hypothetical patients and then reviewing the handling of the claims. The list of the steps we have taken to strengthen carrier and intermediary performance includes many other matters.

Review of Policy and Procedures

Our own policy and procedures are under constant review and we have made many changes on the basis of experience with the actual operation of the program. We have, for example, recently issued instructions tightening up on the administration of payments to supervising physicians in teaching hospitals; we are now engaged in a re-evaluation of the entire reimbursement formula following the decision to drop the 2 percent factor for unidentified costs; we are reviewing with a group of outside consultants the operation of the provision for accelerated depreciation, particularly in connection with extended care facilities which terminate their participation in the program, and we are presently giving special attention to some excessive use of physical therapy services in certain extended care facilities.

In our desire to control program costs, however, we have also been mindful of the fact that the statute requires that we pay the full costs of care for Medicare beneficiaries in the institutions that serve them so that none of the costs of their care are shifted to other patients. We have also been mindful of the fact in our concern for cost controls that the statute clearly underwrites the objective of providing quality care for older people on the same basis as for all paying patients.

And we have been mindful in our concern for cost control that certain policies could reduce program liabilities without reducing the costs of care and result merely in shifting costs from the program to the beneficiary. We would be greatly concerned, for example, if in any substantial portion of cases carriers over any considerable period of time were setting reasonable charges for reimbursement purposes at a rate significantly below what physicians were actually collecting from Medicare patients. We will be watching this situation very closely in relation to our present policies on customary and prevailing charges. It is for this reason, too, that we have thought it unwise to push in the direction of having Medicare charges equate to Blue Shield charges in those states where the Blue

[1] See p. 77.

Shield charges are significantly below what physicians are customarily charging their other patients. For example, in some 14 states—Alabama, for example—the Blue Shield schedule in the most widely-held plan does not bear any reasonable relationship to current physician charges and it is expected that the individual will pay the difference between the indemnity amount paid by the Blue Shield carrier and the amount that the physician actually bills. In nine other states, the Blue Shield rate is lower than the customary charge because it is set up on a full-payment basis only for people of quite low income, few of whom subscribe to Blue Shield, and others are expected to pay above the fee schedule. In still other states, of course, Blue Shield plans are following the customary and prevailing approach and particularly in the definition of prevailing charges may be less restrictive than present Medicare guidelines.

In conclusion, Mr. Chairman, I would like to join the Under Secretary in saying that we welcome this inquiry by the Committee and that we look forward to the various program and operational improvements that we would expect to arise from the Committee's work. We would stress, particularly, the need for some additional legislative authority as outlined in the Under Secretary's statement.

Recent Actions To Expand Medicare Cost and Utilization Controls

REIMBURSEMENT AND HEALTH COSTS

1. Policy review during 1968, with the aid of expert consultants and HIBAC, of reasonable charges determination methodology leading to new carrier standards of performance on reasonable charges (December 17, 1968).
   (a) Prevailing charges to be set at mean plus one standard deviation or the equivalent, which may be the 83rd percentile (the 90th percentile previously used by some is not acceptable).
   (b) Prevailing charge may not be changed earlier than 1 year after the prior change.
   (c) Customary charge of a physician defined and significant time lag introduced for recognition of a new charge. A change in customary charge should be made only on the basis of adequate evidence.
   (d) Reasonable charge for laboratory services obtained from other laboratories but billed by a physician are to be related to the laboratory charge.
2. Increases in allowed charges restricted from January 1, 1969.
   (a) Customary charge to be increased only in individually identified, highly unusual situations where equity clearly requires such an adjustment.
   (b) Prevailing charge to be increased only on the approval of the Social Security Administration.
3. The provision on cost reimbursement of providers for payment of a 2 percent allowance for unidentified costs, deleted as of July 1, 1969 (*Federal Register*, June 27, 1969).
4. Ceiling on interim reimbursement rate for cost reimbursement set not to exceed charges (May 1969).
5. Establishment of refined rules limiting costs accepted for compensation of owners (August 1968).
6. Study of alternate reimbursement methods and development of experiments with alternatives (continuing).
7. Nine regional conferences on health care costs to develop the cooperation of persons outside the Government in seeking ways to keep down costs (concluded January 1969).
8. Regulations being developed to prohibit physician owners from participation in utilization review in institutions where they have a proprietary interest.

COVERAGE AND UTILIZATION CONTROLS

1. Refinements in policy and processing of extended care facility claims to secure improvement in rate of denial where continuous skilled services are unneeded (instructions of June 1968 and April 1969).
2. Study of utilization review in hospitals and preparation of improved technique for surveying with utilization review plan checklist, form SSA–1530 (1968–69 continuing).
3. Study of guidelines used by carriers in claims review (April 1968 and continuing).

4. Instructions to all carriers on method of appraising and improving claims review (national meetings held in January 1969).
5. Policy and procedures tightened for payment of supervising physicians in a teaching setting (surveys and on-site visits; additional carrier instructions, April 1969).
6. Tabulation and distribution to carriers of data on physicians with highest amounts of reimbursement and analysis of results (1968 and 1969).
7. Preliminary developments in system for identifying hospitals statistically whose lengths of stay are unusually long, by diagnosis and other patient characteristics.
8. Experiment with medical foundation review of Medicare claims in California.
9. More exacting criteria governing when physical therapy services may be paid for under the program (April 1969).
10. Regulation being developed to reduce time intervals for physician certification of need for in-hospital care.

FRAUD AND UNETHICAL PRACTICES

1. Increased staffing and emphasis on program integrity and fraud detection and prevention (1968 and continuing).
   (a) Special personnel designated by carriers.
   (b) Specialist designated in regional office.
   (c) Special staff organized in central office.
2. Change in regulation to permit issues of questionable practice to be referred to medical societies (December 1968).
3. Investigation of allegations of fraud against program and referral of cases to the Justice Department for consideration of prosecution (continuing).

POSSIBLE CHANGES NOW BEING DEVELOPED

1. Regulation to further clarify payments allowable to supervising physicians in a teaching setting.
2. Regulation change to prevent possible unintended profit in case of termination of Medicare participation by a hospital or extended care facility, or change of ownership, after payment of accelerated depreciation.
3. Legislation proposed to:
   (a) Give authority to bar from the program physicians and other providers of service who abuse the program.
   (b) Limit cost reimbursement so as not to exceed charges.
   (c) Limit cost reimbursement where construction occurs contrary to planning recommendations.
   (d) Widen authority for experimentation and demonstration.

PREPARED STATEMENT OF FRANCIS L. LAND, M.D., COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICE

I welcome this chance to appear before you to discuss the Medicaid program. It comes at an opportune time. As Undersecretary Veneman has indicated, the Department is taking steps to improve the program and I look forward to several helpful changes.

My close association with it over this period of time prevents me from being startled or shocked by the problems this committee is looking into much as I deplore them. Certainly neither fraud, nor poor administration, nor low standards of care, nor overutilization on the part of patients can be condoned or stripped of importance. But given the manner in which the program originated, and the conditions that surrounded its administration in Washington and the States, they are not too surprising.

Medicaid—title XIX of the Social Security Act—was passed on June 30, 1965, and offered Federal matching funds to States to encourage them to offer medical assistance programs to low income people. I have heard Medicaid called a "sleeper" since all attention was focused on the conflicts attending the birth of Medicare. Medicaid, on the other hand, was born largely unnoticed—its full implications unappreciated—the need for large scale federal planning unrecognized.

The Welfare Administration saw it as an extension of medical assistance programs already offered to welfare recipients.

No one seemed to realize the need for new kinds of professional personnel in both State and federal administrative agencies. Little attention was given to the need to estimate costs, to determine the demand that could be expected for certain kinds of services, to ascertain the availability of medical practitioners and facilities to provide them, or to design and encourage innovative methods for delivery or paying for them.

And so the program began to operate almost immediately with a minimum of planning. I should not have used the word program. Medicaid, as Undersecretary Veneman has said, is not one program. It is as many programs as there are States that participate. In January 1966, as soon as federal matching funds were available, 8 Medicaid programs began to operate, and by July 1966, there were 18 more. Even Medicare which is the same program everywhere in the United States did not begin to operate until July 1966 after a year's tooling up.

In 1965 and 1966, responsibility for the program rested with the Medical Services Division of the Bureau of Family Services, a division that employed 23 people on July 1, 1965. Only 35 more positions were authorized after the law was passed. It was not until August 1967, when the Social and Rehabilitation Service was created and the Medical Services Administration became a separate Bureau, that any recognition was given to the extent of its responsibility. Even now because of the limitations of personnel freezes, it has grown to an organization of only 76 positions in Washington and 24 in the 9 Social and Rehabilitation Service Regional Offices.

In the meantime, the number of State programs has increased to 44.

I do not want to take the time here to describe the impossibility of supervising a huge and complex program with a handful of people.

We are not unaware of the shortcomings of the Medicaid programs in the States. Our evaluation teams have told us that State units are incompletely staffed, that skilled personnel is in short supply, and that control procedures are incomplete or nonexistent.

In the early days, because States had not anticipated the numbers of patients and providers and bills that would be involved, they were swamped with paper work. Some States have just caught up with the backlog and are beginning to pay bills fairly promptly. They are just beginning to have time to think about problems like utilization review and quality control.

Undersecretary Veneman has told you that he has asked the Bureau of the Budget to approve 150 additional positions for Medical Services Administration. Let me tell you very briefly the urgent jobs these people would do.

One hundred of them would work in the 10 Regional Offices where they can give technical assistance to help the States correct errors and fills gaps found by our own evaluation reports and the HEW Audit Reports.

The 50 people added to the central office would work in these areas:

Program Planning and Development—to guide State programs toward the overall goals described in title XIX.

Program Evaluation—to increase the frequency with which we review and evaluate State programs. (We now evaluate only 12-15 States a year.) The additional staff would also survey and help States to strengthen their programs of utilization review—a function strongly emphasized in the law and of direct interest to this committee.

Nursing Home Care—to implement the wholly new program created by the 1967 Amendments that requires us to provide policies and guides concerning quality of care given in these facilities as well as safety and sanitation, licensing of institutions and administrators, and relationships between hospitals and nursing homes.

Drug Costs and Utilization—to formulate policies about the utilization of drugs in medical care and to provide guides and standards for payments for them.

Mental Health—to develop policy to assure high quality of care and to improve methods of financing care for the aged mentally ill who are cared for by title XIX

funds, and to provide guidelines to coordinate activities under the several Social Security Act titles that deal with the care of the aged in mental institutions.

Program Management—to develop regulations to help States effect economies in reimbursing providers of medical care and developing standards and techniques for medical cost auditing.

Cost Estimating—to improve methods of analyzing and estimating costs of services to be provided under Medicaid.

Advisory Council—to study areas of interest to the Medical Assistance Advisory Council and the National Advisory Council on Nursing Home Administration in the course of their mandated work.

In conclusion, let me thank you for this opportunity to talk with you and say again that I am looking forward to new and better ways to improve the Medicaid program on which so many low income people depend for health care.

COMPUTING ALLOWABLE REIMBURSEMENT OF HOSPITAL OR NURSING HOME COSTS

Senator ANDERSON. Senator Williams.

Senator WILLIAMS. Mr. Ball, one of the questions that comes to mind is the manner in which you compute the per diem rates which you allow on the bed costs of medicare patients in nursing homes or hospitals. What costs do you figure in your computations such as the salaries of doctors, the salary of the managers, other charges—how do you figure them?

Mr. BALL. Senator, rather than go into the very detailed principles, let me just cover some of the highlights.

Would it be valuable, Senator, do you think, to put the entire reimbursement principles in the record?

Senator WILLIAMS. No. I have seen them. I cannot understand them.

Mr. BALL. Just take the hospital situation. All the ordinary costs attributable to patient care are included but covered cost does not include certain items extraneous to patient care, such as the operation of a flower shop or the store that might be in the hospital. By and large, all of the health service expenses of the hospital are included.

Then, you have the problem of allocating costs between the medicare patients and other patients in the hospital and there are alternative methods by which that is allocated.

But perhaps I ought to indicate first, Senator Williams, that in addition to ordinary operating expenses, as you will remember, there are other allowances—for instance, you are allowed to include as part of the reimbursable cost for service depreciation on the capital value of the hospital.

Senator WILLIAMS. Right there, that is the point I want to get at. Now, say nursing home A's construction cost is $400,000. You would allow in your computation depreciation on that $400,000. We will say that valuation is without the land. Then you have the normal depreciation that is permitted under the law which would be figured as a cost. Is that correct?

Mr. Ball. That is correct. Of course, it is the medicare share of that.

Senator WILLIAMS. I understand that. Then in addition to that, we

will assume if doctors or others are on the payroll as managers, the managerial services, that, too, would be allowed as a cost in computing the allowable reimbursement, is that correct?

Mr. BALL. Yes, Senator. Not the services of the physician in patient care but, as you said, in the management of the hospital.

Senator WILLIAMS. I am thinking of salaries.

Mr. BALL. Yes, for the management of the hospital.

Senator WILLIAMS. The management.

DUPLICATION OF PAYMENTS TO DOCTORS

Now, we have had instances where a hospital and nursing home would be set up and maybe four or five doctors would be drawing good salaries, maybe reasonable salaries, full-time salaries. But in addition to that, they attend patients—you know, they submit a patient charge. You allow them to make that charge on patients also, do you not and in effect a duplication of payments, which is what I am speaking about.

Mr. BALL. I believe it is not really quite that situation. What is allowed in part A as a salary is not for patient care. Patient care comes under part B. Under part B, a claim is filed for service for an individual patient.

Senator WILLIAMS. But the point is that if the doctors are on a salary, they would be reimbursed under part A, is that correct?

Mr. BALL. No, not all of them by any means.

Let us take an example, Senator. I am not resisting your point; I just want to clarify this.

In Henry Ford Hospital in Detroit, for example, practically all the physicians who practice there are salaried physicians. Those salaried physicians are not included in part A unless they are engaged in the management and operation of the hospital. When it comes to giving patient care, their salaries are not included.

Senator WILLIAMS. Let us assume they are engaged in the management services of a hospital. Then it would be included, isn't that so?

Mr. BALL. Part of it.

Senator WILLIAMS. If that same doctor had patients, some of the same patients in the hospital, would he also be paid under the other section of the law, part B, for those services?

Mr. BALL. Yes, for that part, Senator.

Senator WILLIAMS. Even though he is on a salary? That arrangement is considered proper and approved by you?

Mr. BALL. Yes, so long as we keep separate the payment that is made for his management services and the part that is for his patient services to prevent duplication. We do not allow them to be duplicated.

Senator WILLIAMS. If they do duplicate, what happens? It is a violation of the law? If situations are discovered where there is duplication, is there a violation of the law?

Mr. BALL. Senator, on that point, I would like to ask Mr. Hess to reply on those cases where we have found some duplication.

Senator WILLIAMS. Well, you are the Administrator. I have a lot of confidence in you. What is your opinion? Is it a violation of the law?

Mr. BALL. I believe, Senator, if we knew there was a duplication, it would be certainly against the principles that are established and it would be an audit exception; it would be a violation.

Senator WILLIAMS. It would be a violation.

SUDDEN INCREASES IN FAIR MARKET VALUE OF NURSING HOMES

Now, on another point, we will go back for a moment to depreciation charges. We have this nursing home, we will use that as an example, that cost $400,000. Now, I understand, and you explained how you would, in computing payments for this home—say a 100-bed home—you would take into account the depreciation on this $400,000. Suppose this nursing home, the same one, changes hands and is sold to a parent organization or other group for a million dollars and it is a cash transaction. Upon what basis do you compute your allowances for depreciation in that instance?

Mr. BALL. I believe, Senator, that it would be based on the fair market value of the institution at the time it was sold; not necessarily the million dollars. If the $400,000 home has risen in value, then in the new situation it would be the fair market value, not necessarily the $400,000.

But let me just check with Mr. Tierney.

Senator WILLIAMS. I discussed this with you several times about a month ago, Mr. Ball, and I told you then if you did not have any answer then, I wanted it.

I will just repeat the example. The case is of a nursing home which we will say cost $400,000. Then there is an individual or group that goes public and they raise the money and then they buy this same nursing home for $1 million in cash. That is a cash transaction. Does that establish the fair market value?

Mr. BALL. Not necessarily. That is my point, Senator. That million dollars may include not just the fair market value of depreciable assets, but frequently quite a large claim is made for good will on a going operation. We would allow as the new depreciation base only that part of the price that was the fair market value of depreciable assets, eliminating any part that——

Senator WILLIAMS. There are no maybes in this, and I am assuming that there is nothing included for good will or other assets, but they paid a million dollars for the building itself and it was a cash transaction.

Mr. BALL. Then you are generally correct.

Senator WILLIAMS. Then you would allow, you figure that a million dollars is fair market value?

Mr. BALL. Of course, fair market value would be appraised. It is the fair market value if that is what it is appraised for.

Senator WILLIAMS. Now, under your medicare proposals, you allow a return on capital of what, approximately?

Mr. BALL. Only in profitmaking institutions, Senator. There is a special provision passed by the Congress which related return on capital to one and a half times what the Social Security Trust Fund would draw and I believe now it would be 8 to 9 percent.

Senator WILLIAMS. The point I am making is with that particular example. Here was a home, first valued $400,000 for depreciation; now it is recognized as a million dollar establishment after a cash transaction. If you allow 8 to 9 percent, you get 8 to 9 percent return on a million instead of $400,000. Is that not part of the cause of this automatic escalation we are getting in the rise of costs? Is that not one of the major factors?

Mr. BALL. I would think it is not a major factor. Senator, but——

Senator WILLIAMS. A very important factor.

Mr. BALL. I would think not, because this relates only to profitmaking institutions, where you have this 7.5 percent, and they are a relatively small part of the total institutional care. Take all ECFs, it is only about 5 percent of the cost of part A and in the hospital area, which is the expensive part, there are mostly nonprofit institutions and they do not get that 7.5 percent. But it is an important point.

Senator WILLIAMS. Let us not dismiss it on the basis that it is only 5 percent or 51 percent. After all, Uncle Sam could do without my income taxes and it would be an insignificant part of the total but he still wants me to pay it and wants you to pay yours. Let us just keep it on that, if does amount, to an extent, of automatic escalation of costs, does it not?

Mr. BALL. Yes, Senator. I have said yes in going along with your example as you define it. But it seems to me unlikely, that that $400,000 building would have been appraised just a short time later with that large an increase in fair market value. If there were such an increase, you are right.

Senator WILLIAMS. The particular case I have in mind was a $600,000 home which was sold for a million and a quarter. There are other cases, and I will cite you some before we get through here, plenty of them. As you know, they have been escalating these prices. You and I discussed this several times.

Now, in establishing the rate of payment for this home—let us keep on this same nursing home—you would send out your auditors, either send them out or get material in, and then audit and establish the per diem rate which you would allow this home. Is that correct? You establish the depreciation base, whatever it may be, at the fair market value. You do that through what division of your department?

Mr. BALL. Through the intermediaries, Senator.

Senator WILLIAMS. And do they report to you?

Mr. BALL. Not necessarily on an individual home-by-home basis, until the final audit for the year is made and costs are settled. Then a copy of the audit is sent in.

LACK OF LIAISON BETWEEN MEDICARE AND MEDICAID AGENCIES

Senator WILLIAMS. How does this formula which you just described compare with the manner in which the medicare people do it, and when it goes to medicaid homes?

For example, this same nursing home applies to your department and Mr. Tierney's department indicating that they want to qualify for medicare and establish payment rates. Then they go to Dr. Land and want to find out what rates medicaid will pay and see which one gives them the best payment. What kind of liaison do you have between medicare and medicaid? Do you exchange information between the agencies automatically? Do you do it on request? Have there been any requests for it?

Mr. BALL. I do not believe it would take place automatically, Senator, at the time the home is purchased, except in the situations where the same intermediary was handling both medicare and medicaid; or where we share cost reports because medicaid is on a cost basis. An intermediary—for instance in California—the California Blue Shield handles both the medicare and the medicaid operation.

Senator WILLIAMS. The reason that I asked that question is because I tried to find out the formula under which you establish rates on these nursing homes which had had their value practically doubled through this type of sale. I was unable to find any liaison between Mr. Tierney's office and Dr. Land's. I notice they are both here today and I think it would be a good idea, at least if they have not been previously introduced, they be introduced and get acquainted with each other. I was told there was no liaison whatever between the agencies. They are both here and I wish they would straighten out whether they do use and whether they compare the formulas that you use to establish these payment rates between medicaid and medicare when you are setting up, and what depreciation schedules one program would allow and the other would allow. Do they differ? What do you do?

Mr. BALL. Senator, could I make a point on that and turn to them to complete the response from your earlier question?

For the clarity of the record, I want to say that in the hospital area——

Senator WILLIAMS. Let us keep it on nursing homes right now. Then we will go back to hospitals in a moment.

Mr. BALL. I just wanted to emphasize that in the ECF area, the basis of payment between the two programs is usually quite different. For hospitals it is the same.

In the ECF area, medicare pays on a cost reimbursement basis. The usual situation in title XIX, where the State decides what reimburse-

ment bases it will use, I believe, is based on negotiated fee basis. This might be their charge or a negotiated rate less than their charge. It is not really a cost reimbursement at all, so they approach it entirely differently.

Would that be right, Dr. Land?

Dr. LAND. That is correct.

Senator WILLIAMS. And come up with an entirely different answer?

Dr. LAND. Yes, sir. The ECF or nursing home in the State negotiates with a single State agency for their rates. As a rule, these rates are less than amounts paid under social security extended care facilities. This is a negotiated rate that is not required by statute to be a cost rate.

Senator WILLIAMS. The reason I ask this question is because it has been called to my attention that in certain areas, nursing homes can get a better deal under medicaid. They almost exclude medicare patients. In another, they get a better deal under medicare. They will exclude medicaid patients. It looks a little ridiculous to me that there is not more liaison between the two agencies. I cannot understand how, when you figure with somewhat the same formula, how you could come up with the different answers. Mr. Veneman, I would like your comment.

I wonder if we should not have a reestablishment of liaison between the agencies at least on the same nursing home so each agency would know exactly what the other agencies allow.

Mr. VENEMAN. I think it would be desirable to have the liaison, but again, it gets back to the point, Senator, where we do have 44 different programs under title XIX. I think in the State of California, the rate paid to the nursing home is something like $13.20 per day maximum charge, which is established by the Department of Finance. It is not even established legislatively. That is opposed to a title XVIII patient who is in the same facility. If my understanding is correct, the facility would be reimbursed for that service on a reasonable cost reimbursement basis, which is a national formula. We have two different approaches to it.

I think some States pay considerably less on the maximum daily charge for nursing home care than medicare pays some extended care facilities.

Senator WILLIAMS. I understand that Michigan may pay more under medicaid than they do under medicare. That is the problem we run into.

Mr. VENEMAN. There is also, I think, a fee schedule or a maximum schedule established by the State, if I am correct.

NURSING HOMES TRANSFERRED AT HIGHER VALUES

Senator WILLIAMS. Mr. Ball was talking earlier about a specific case I had in mind where these nursing homes were transferred at

higher values, I believe, in the name of a company we are interested in. I understand that you have checked that out. Do you understand that they are not engaged in medicare, or what was the information that you had on that?

Maybe Mr. Tierney would like to speak to that.

Mr. BALL. I think Mr. Tierney has the full facts on this.

Mr. TIERNEY. Senator, as we told you in a subsequent letter, that particular chain and institution have only purchased three homes, which are participating in the medicare program, within the last 2 weeks. I think they have six others, off the top of my head, which they are now operating, but which are not participating in the program. So we have not had as yet a submittal of any kind of a balance sheet or an asset valuation upon which to make a determination of whether or not there has been any change in valuations. But up to 2 weeks ago they were not participating in the medicare program.

Senator WILLIAMS. Really on that basis, there would be no reason why you should proceed to study what they should have done beyond what they have done; is that right?

Mr. TIERNEY. Yes, sir. The ones that are participating institutions have been purchased within the last week or 2 weeks, so that no new appraisal sheets, no new balance sheets have been submitted. But we will certainly be following up on that, Senator.

You see, we have to close out, Senator, the past period with the prior owners and have a final settlement with them and then set up a new approach.

Senator WILLIAMS. That would cover Dr. Land's part as far as you know, too? I am speaking of the Government as a whole, now, their interest in this.

Mr. TIERNEY. To the extent that these particular institutions may have been participating in medicare, the same thing will be true, Senator. We do have and have had now for some time—we have been working through Mr. Kelly's agency on the development of a common cost audit for title XVIII, title XIX and title V programs—a common cost form and a single audit.

We have also made available to the States at title XVIII expense all the cost information we have on participating institutions since February of last year. So those that are operating on a cost basis under medicaid have that information available to them.

Senator WILLIAMS. Well, that points up the problem we are having Mr. Veneman. I wonder if this does not point up lack of liaison between the agencies involved, because I was talking to Mr. Tierney and he has given me an accurate report.

But on the other hand, I would like to show you just what information we have here. This is from the company's records. I am quoting here:

"The company has not sought nor will it seek to qualify its present facilities under medicare."

That is correct. He just mentioned that.

"Except that medicare patients were admitted to the company's"—and I won't mention the two homes here—"but the two new facilities under which they do expect to participate."

So the assumption is we are not too much interested here, they are practically out.

But continuing further on another page, we find that it is contemplated that 27 of 107 beds in one facility it mentions here and 43 to 72 beds another facility, both under construction, will be set aside for medicare patients.

The continuing further, this is the significant point:

"For the fiscal year ended September 30, 1968, approximately 15 percent of the company's available beds"—that is, all the nursing homes it has now—"available beds have been utilized by patients who have been financially independent, private patients and the remainder have been utilized by patients under medicare or a program for which payment is made by the State."

In other words, 85 percent of their operations is medicaid, yet we are brushed off that this is an insignificant point. That is what I am talking about, the liaison. I was asking about this as a whole.

NURSING HOME VALUATIONS AND MEDICAID COSTS

Now, I would like to review just a little bit of what bothers me about this particular transaction. These five nursing homes were put together in a newly created package, and reading again from the Securities and Exchange record, the book value of the property transferred by this doctor to the company was $305,673. That is his net book value equity in these homes as of September 30, 1968. As a result of his sale of 90,000 shares of stock pursuant to the offer, he will have recovered the book value of his assets transferred to the company, realized a profit of approximately $458,000, and will still retain 630,000 shares, or 70 percent of the stock which, under this new setup, has a valuation of $1,322,000. Now, that is not bad for a $350,000 investment. What I have been trying to find out is how do you set up the new cost factors on that? Throughout this whole problem 85 percent of this was medicaid, and still planned to be medicaid.

Mr. VENEMAN. Senator, I think the key——

Senator WILLIAMS. That is the case which I asked them to follow through.

Now, I did not talk to Dr. Land on this matter, but I did talk to Mr. Ball in his office, and I thought we would get a report from both of them.

Mr. VENEMAN. Senator, I think we have to draw a distinction between the medicaid and the medicare programs. I would assume that at this stage, again the title XIX would be on a negotiated rate where a maximum could be paid, so it would not make any difference if

you were to reach that maximum whether he had a $100,000 nursing home or a million dollar nursing home. It does make a difference under title XVIII, where you reimburse the depreciation and reimburse the cost. But if 85 percent of the patients were title XIX patients, he would not gain much by having a high-priced home under title XIX.

Let me say again I do agree that there has to be closer liaison. As you will recall from my testimony this morning, we are suggesting that some of the social security people cooperate with the medical services people in trying to establish this.

$75,000 ANNUAL SALARY FOR A NURSING HOME ADMINISTRATOR

Senator WILLIAMS. At the same time this parent organization was formed, taking over this $305,000 equity for this one individual, at the same time, they entered into a contract with the head doctor of this operation on September 26, 1968, where he has a 5-year employment contract with the new company, taking over these five nursing homes, at $75,000 a year for the first 2 years, and $85,000 a year for the next 3 years. To what extent will that be included in the cost factors? He is going to be the administrator of these homes.

To what extent will that be allowed, because that is very close to $400,000 in 5 years' salary on a $305,000 investment. He already has $185,000 profit. He already has 70 percent of the stock left. Now he has a 5-year contract. And by the way, his wife also signed a 5-year contract for $15,000 a year in this same outfit.

Now, I am wondering. The assumption is that this is going to be mostly medicaid and medicare operations. Presumably, they are figuring on recovering enough in payments to make this a profitable investment. Otherwise, somebody is stuck; that is the new investors.

Now, are we going to absorb all of that in patient costs? I do not say this critically. I want to emphasize that you have been most cooperative in helping develop this. I do not think I would have developed many of these matters which I am asking about today without your cooperation.

But the point is, to what extent are we as a Government, in operating medicaid and medicare—and I am looking on this as a governmental whole—to what extent are we as the Government or the taxpayers of America, paying a wage tax, health insurance tax or income taxes, being asked to underwrite the pyramiding of valuation such as I have just outlined? I have any number of cases here like that.

Mr. VENEMAN. I would like to look into this specific case to determine just what portion of that $75,000 administration fee would be reimbursed under medicare. The medicare statute calls for reimbursement of reasonable costs. I would consider that a little bit unreasonable.

Mr. BALL. Nothing nearly that high in the salary of an ECF administrator would be recognized, Senator, as a legitimate part of the

cost. Under our rules a salary for a manager actually operating an ECF would be established at the going rate he would pay if he had to go out and hire such a person. That is all that would be included for the manager of an ECF as the medicare portion. As the Senator said, for the medicaid portion, it is a matter of negotiating of the rate for the care, and this type of thing is not too relevant.

Senator WILLIAMS. How much of that salary would you allow in this particular case?

Mr. BALL. I just do not know.

Mr. VENEMAN. I think we would have to check that one out.

Senator WILLIAMS. I think this has been checked out.

Mr. BALL. Since there are not any homes that were participating until 2 weeks ago, the issue had not arisen.

Mr. TIERNEY. We do not have it yet, Senator, but what will be allowed will be the going rate for the administrator of that size organization, either on an arms-length negotiation with the proprietor or the nonprofit institution in the area.

Senator WILLIAMS. Eighty percent of the home is medicaid now. To what extent is any of that even in the back of their minds when they negotiate?

Mr. VENEMAN. Senator, what State is it in?

Senator WILLIAMS. It covers about four States.

Mr. VENEMAN. Well, give me one of the States, and I think we can clear this up, any one.

Senator WILLIAMS. Massachusetts, New York, Wisconsin, Missouri, Florida.

RATES FOR HOSPITALS AND NURSING HOME CARE

Mr. VENEMAN. Massachusetts, under title 19, for rates paid for nursing home care by the State medicare program, would range from $9 to $15 a day.

I would assume from that that $15 is the maximum?

Dr. LAND. Maximum.

Mr. VENEMAN. So in no case could they be reimbursed under the title 19 program for more than $15 a day. If they are going to pay $75,000 for an administrator and pay $1 million for a facility, they had better have some other source of income.

Senator WILLIAMS. I was wrong. Most of these are in Massachusetts.

Mr. VENEMAN. The maximum there would be $15 a day under title 19, according to figures that are available here from Dr. Land.

Senator WILLIAMS. Do you automatically allow the maximum?

Mr. VENEMAN. No; it is not allowed automatically.

Senator WILLIAMS. In establishing the maximum, the point is that the expenses would be taken as a part of the factor, determining whether they would be $12 or $15, would they not?

Mr. VENEMAN. Yes; they would be. The level of care that is provided, the amount of staffing that is available, the type of facility that it is, whether it is a convalescent hospital type, nursing home type or an extended care facility, all of these would be considered in determining whether or not they were going to get somewhere between the $9 and the $15.

Senator WILLIAMS. And to a large extent, the carrier that is handling that is the one that would have a lot to do with establishing the rates——

Mr. VENEMAN. I do not think the carrier does that. I am not sure about Massachusetts, but in California in the title 19 program this rate for a facility is established by the health care services administrator.

Senator WILLIAMS. That is on medicare and medicaid?

Mr. KELLY. The State of Massachusetts has a board that is responsible for establishing all of the rates for both hospitals and nursing homes.

Senator WILLIAMS. That is on medicare and medicaid?

Mr. KELLY. Actually, it goes beyond that. They establish the rate for all hospital use in the State.

Senator WILLIAMS. To what extent, and what authority would a carrier have if they wished to be liberal or a little tight? Do they not have something to say about this at all?

Mr. VENEMAN. No; I do not think the carrier has that authority, Senator. I think under certain contracts——

Senator WILLIAMS. I meant allowing the doctors' fees and the various charges that could be made?

Mr. VENEMAN. The contract that the intermediary usually signs with either the Federal Government and/or the State, whatever the case may be includes the responsibility for assuring that the claim that has been submitted and for which he is making payment is reasonable.

Senator WILLIAMS. Mr. Ball, you are familiar with the case I am talking about, are you not?

Mr. BALL. Yes.

Senator WILLIAMS. And Mr. Tierney is, too.

If I recall correctly, there is a little problem of possible conflict of interest here, where one of the representatives of the carrier was also a stockholder in this company or a director.

Was that correct, and if so, was it proper?

Mr. TIERNEY. Senator Williams, when this company first put out its prospectus and its bulletin with the statement that they did not intend to get into the medicare field, it did carry the name as one of the directors of the company, a man who works for an intermediary of the title 18 program. We immediately called to his attention the impropriety of any such role, and he immediately resigned from the position. But you are right, he was named as one of the directors.

Senator WILLIAMS. Slight correction in that. The prospectus specifically stated that they did intend to get into medicare on their new facilities.

Mr. TIERNEY. As they are constructed in the future; yes, you are right.

Senator WILLIAMS. You did consider that that was a conflict of interest. What was done about it?

Mr. TIERNEY. He resigned.

Mr. BALL. We called it to his attention and he resigned.

Senator WILLIAMS. That is all that happens? That takes care of that case, does it? If you are caught with a conflict of interest and he resigns, that clears it?

Mr. TIERNEY. Well, there had not been any actual conflict to date, but it certainly would have been an improper role for future operation, Senator. We did not take any further action. There had been no money transactions.

I quite agree with you that it would be totally inappropriate for a representative of an intermediary to be sitting on the board of a provider whom he is representing. I just could not see letting that happen.

NURSING HOME SALES

Senator WILLIAMS. That is the point. I wish, Mr. Ball, that you would take this particular report and case just a little further and also check it out with Dr. Land's office as to possible rates and so forth, because this is just one example. There are any number of them, and I am not exaggerating on that. As you know, we discussed a whole series of these sales under similar circumstances when we were in Baltimore sometime back, where these prices have been inflated substantially. It is a matter of public record in the stock markets.

The question is, I want to know and I want to establish very clearly whether or not this return on the capital, which is approximately 8 to 9 percent now, is going to be 8 to 9 percent on the inflated value, the new value that is being established as they transfer this property, or whether on the old construction cost? Has it been depreciated down? Because it makes a big difference in the rates of payment we are going to allow, either under medicaid or medicare.

Mr. BALL. Senator, we would be very glad to take that particular case and supply the rates insofar as we can by working with title 19—as well as title 18—advise you of what is happening there and give you a complete story.

As a general answer to what medicare would do in that kind of a situation, Senator—it would ask for an apprasal of the fair market value of the depreciable assets, not what it had sold for, and then it would pay this roughly 8- to 9-percent reimbursement on the net equity that the individual had. If he borrowed money, of course, to pay the purchase price, he would not get a return on that. It is the equity in it, and a lot of this buildup, as you know, is in borrowed money rather than actual equity money.

Senator WILLIAMS. I understand the formula. I understand it exactly. But the question that is in my mind and the question I want answered at some point is what was recognized as the net equity upon which you are going to compute the 8- to 9-percent return. Now, at some point—and I understand your general formula—I want for a specific case exactly what in dollars, if it stayed around $300,000—5, 7, or 8—I want to know the rate in dollars, exactly. Because I am one of those thick-headed individuals that can understand figures better than I can theorize.

Mr. BALL. I will be happy to do that, Senator. As Mr. Tierney says, this operation has not yet had medicare patients.

Senator WILLIAMS. The operation did have some medicaid patients at the time, as I recall. They were 85 percent medicaid, and so 85 percent of their income is directly or indirectly from the Federal Government, including whatever may be the portion paid by the State. It is public money.

Mr. BALL. Let us furnish that to you.

Mr. VENEMAN. Senator, we will also have Dr. Land submit to you and to the committee the amount of payment that has been made to this facility through the title 19 program.

Senator WILLIAMS. I would appreciate that.

(The information referred to was supplied to Senator Williams.)

One other thing. I agree fully that with what was mentioned this morning, that the overwhelming percentage, whether it be doctors, nurses, nursing homes, or whatever, are trying to do a good job. I am not trying to make a blanket indictment out of this. We understand that. But nonetheless, we are trying to point up specific examples where they went wrong because it is the only way we are going to keep the programs operating soundly.

POSSIBLE OVER-UTILIZATION OF PHYSICAL THERAPY

Another thing occurred to me with respect to payment allowances of these intermediaries. This case happens to be the same intermediary involved in the other case—I am referring to another one now—but the same intermediary, which seems to be very lenient in allowing costs.

I am particularly concerned about the allowances for physical therapy and occupational therapy. Would you comment on that in general terms? Has that been a problem to you at any time?

Mr. BALL. Yes, it has, Senator; we have made several studies just recently of several extended care facilities where we feel that over-utilization of physical therapy has taken place to a very considerable degree, and we are very much concerned in that area. This has been called to the attention of the carriers involved very strongly, and I believe everyone is now alert to this particular problem. But you are absolutely right. It is an area of potential abuse in that the medical necessities of physical therapy may be problematical in many cases. The older person may feel somewhat relieved by having it, regardless of the medical necessity, and it is a very hard decision to make. But we have found quite a few instances, we believe, where services provided by nursing homes really went beyond the bounds.

Senator WILLIAMS. Well, I am referring to one of your own reports dated March 24, 1969. It involves nursing homes in the New England area.

Mr. BALL. Those are the reports I was thinking of, Senator.

Senator WILLIAMS. Yes. I just cite some of the examples here of what we have.

In this particular nursing home, they had 81 patients. According to this report, they examined the home's operations over a 20-day period. The billings covered 81 patients, who received 2,309 billable treatments at $9 each for a total of $20,781. That was physical therapy. Now, that meant that a daily average of 136 units of therapy were rendered every day, except Sunday. That is a pretty high average, is it not?

Was that not overcharging a little bit? They were charging $9 for each service.

Mr. BALL. I completely agree with you and this whole matter of physical therapy with that particular carrier was a matter of very

extended discussion. I am confident that the carrier agrees with us that they did not do a good job in that area.

Senator WILLIAMS. Here is another example where 58 patients were evaluated in one day and a separate charge was made for each therapist involved in the evaluation with a total of 218 visits for this one day. In addition, there were 142 units of therapy given that same day for a grand total of 3,216 billings, or 3,260 billings for one day. That is an average of a little over $60 a day per medicare patient for physical therapy.

Mr. BALL. Yes, sir; Senator, and in those reports that we furnished you on that, we came to exactly the same conclusions and related to that first home that you mentioned, not only has all this been discussed with the carrier, but payments have been stopped to that home.

Senator WILLIAMS. All payments have been stopped to the home?

Mr. BALL. Yes, all payments have been stopped to that home.

Senator WILLIAMS. How about to the other homes with which this group were affiliated? How much did you collect back? I noticed some of these patients got therapy on the day they entered the nursing home. They got physical therapy then and those who died during the interval got it on the day that they died.

Now, I wonder if they got it before or after? Seriously, though, did you collect any money back on this or——

Mr. BALL. Yes; collections have started on that particular home that you have in mind. There is $150,000 that we will be recouping.

Senator WILLIAMS. $150,000? How much had you paid them in 1 year?

Mr. BALL. Total?

Senator WILLIAMS. Total.

Mr. BALL. I would have to look that up, Senator.

Senator WILLIAMS. Maybe I can help you.

Mr. BALL. That particular figure is not in this report. I would have to——

Senator WILLIAMS. Yes, I am reading from the same report. You sent me a copy of it. In 1968, one year alone, in this one nursing home there were 41,387 visits by therapists of all types at $9 a visit, and they received a grand total of $372,483. That is broken down as follows:

Physical therapy, 12,026 visits for $108,234.

Occupational therapy, 15,432 visits for $138,188.

Speech therapy, 415 visits for $30,735.

Social services, 6,129 visits for $55,161, and then there were 385 visits for $49,465 for a total of $372,483, and this is just one year.

Now, how much do you say you are going to collect back or have collected?

Mr. BALL. It is over $150,000 that we are going to recoup.

Senator WILLIAMS. And how much has been paid of that and what are your terms of payment? I mean, is it a promissory note for some future time, or how is it paid back?

Mr. BALL. We are holding up Medicare payments to them, Senator, payments that they have coming to them until this amount is recouped.

Senator WILLIAMS. Well, they still have Medicare patients and you are just going to deduct that from their next payments?

Mr. BALL. No, not solely that. I believe also we will be seeking recovery at the same time.

Senator WILLIAMS. I understand that you are still handling patients under the medicare programs in these nursing homes?

Mr. BALL. Yes, sir. It has been——

Senator WILLIAMS. They are still qualified?

Mr. BALL. It has not been decertified.

Senator WILLIAMS. It has not been decertified?

Mr. BALL. They are not receiving any payments.

Senator WILLIAMS. They are still qualified and it has not been decertified.

Mr. BALL. Yes, but they are not getting any payments.

Senator WILLIAMS. Until they pay part of this back?

Mr. BALL. Yes, sir; that is correct.

Senator WILLIAMS. And then you will go on as usual?

Mr. BALL. Well, not as usual, Senator. If you mean by "usual" what they did in the past, I can assure you that that particular carrier is now very alert to this problem in this home and they will not continue in that way at all. These surveys that we made of these areas I think are extremely valuable and we get results from them.

Senator WILLIAMS. When did you start collection proceedings against this nursing home?

Mr. BALL. Immediately after the visit I spoke of, and that was the latter part of March.

Senator WILLIAMS. Just this year?

Mr. BALL. Yes, March the 24th I think was the visit date.

Senator WILLIAMS. There was an example here. Your man was in there and here is the note he made, "We saw about 20 people lined in the corridor receiving physical therapy. There was only one therapist present and people were moving their arms from one side of their bodies to another. All of the individuals were in wheel chairs and were billed $9 apiece for that service."

Now, would that—how would you classify that?

Mr. BALL. As outrageous.

Senator WILLIAMS. Outrageous. So outrageous that we are going to smack them on the hand but we are still going to continue to let them stay in the program?

LEGISLATION NEEDED TO EXCLUDE BAD PERFORMERS UNDER THE PROGRAM

Mr. BALL. Well, Senator, one of our proposals is for more authority to exclude from the program physicians and providers of service who have developed a record of bad performance under the program. At the present time if that home meets the standards that are in the law and provides the covered services and keeps proper records there is not as firm a basis for termination of future payments as we would like.

Senator WILLIAMS. You do not have any authority? Do you want additional authority, and if so, will you send us the legislation you need, so that you can cut off service from a home that has a record such as this?

Mr. VENEMAN. Yes, sir.

Mr. BALL. Yes, sir, we will certainly do that, and we want it to apply generally to providers and include those physicians that have proven consistently to have acted under the program in a way that constitutes an abuse.

Senator WILLIAMS. Do I understand that there is not a single record where you have ever stopped a single home from participating in the program as a result of abuses?

Mr. BALL. We have stopped many homes, Senator, but not on the basis of the sort of thing that you and I are talking about. This is a different matter. We have clear authority to remove homes when it is a question of the health and safety of the patients or other conditions of participation and the chairman was referring to a case that we had told him about earlier of a Florida hospital where after a long hearing we terminated that hospital from participation under the program because of the way they were operating the hospital.

We have authority for that. But on the question that if a home were meeting the standards of quality and the other provisions in the law, I do not believe we presently have clear authority to bar them from future participation solely on the grounds of previous abuse of the program. But, we would like that authority.

PHYSICAL THERAPY

Senator WILLIAMS. Now, take the case of one of these elderly patients receiving physical therapy the same day he died? Do you think that is reasonable service for them? I mean, if they did receive it. Do you not think it was injurious to the patient?

Mr. BALL. Well, I do not know whether I can make that generalization or not. Dr. Land here is the doctor, but I suppose someone could die of a heart attack on a particular day, and yet it was reasonable to have had physical therapy. I do not think——

Senator WILLIAMS. That is correct, but every one of those who died got physical therapy the day he died.

Mr. BALL. Senator, you know, I am in complete agreement with you.

Senator WILLIAMS. I am just quoting from your report.

Mr. BALL. I know, it is our report, and let me agree with you, it is a terrible situation, and it is not to be condoned at all.

Senator WILLIAMS. But it is being condoned. They are still operating.

Mr. BALL. They are not providing the therapies they did, and they are not receiving any money. They are not doing those things.

Senator WILLIAMS. There is no physical therapy or occupational therapy being allowed in this nursing home now?

Mr. BALL. Oh, I am sure there is some, but we have issued very strict instructions in the whole physical therapy area. Now, Senator, and particularly we discussed this area.

Senator WILLIAMS. Well, I appreciate the fact that you are well informed in this particular case because you know what we are talking about. Now, how many instances of physical therapy did they provide in the last 30 days?

Mr. BALL. Mr. Wolkstein informs me that there were very, very few in the last 30 days.

Senator WILLIAMS. Well, what is very, very few?

Mr. WOLKSTEIN. The situation that you are describing, Senator, was a situation in which an organization was providing physical therapy to two nursing homes in this area. This organization that provided that physical therapy is now out of business. The arrangement of that organization with the nursing home ended.

The organization took on its own physical therapy service subsequently, provided what seemed to be a questionable amount, the payment was stopped to that home—it was losing money on it, so it fired essentially all of the physical therapists that were on the staff. It has a very, very small staff now providing the service. It cannot provide much service with the staff available; therefore, the amount of money that must be flowing at the moment must be very small for this kind of service.

Senator WILLIAMS. What would you say, about a tenth of it or just——

Mr. WOLKSTEIN. With one physical therapist on duty, which might be in the order, the order of the situation there, you might be paying in the course of a year about $10,000 for physical therapy in the whole institution.

Senator WILLIAMS. For the whole year?

Well, now, where we are still allowing those to continue in the medicare area, do you think the patients are now getting proper and adequate treatment? I mean I am not questioning you, but do you think they are properly taking care of the patients now or do you think patients are suffering under this new arrangement?

Mr. WOLKSTEIN. Senator, the arrangements for determining what service a patient requires is that the doctor is asked to make out a form saying what services his patient requires. A form covering this information has been developed for review by the carrier. The carrier now has a very careful screening operation. It hired a physiatrist to develop rules, and apparently the service they have available is adequate, and as far as we can determine, no overpayment is being made.

Senator WILLIAMS. That is the point. I wasn't questioning it. I understand the rule, but you think that this $10,000 or $15,000 whatever it may be now on an annual basis is properly and adequately taking care of patients?

Mr. WOLKSTEIN. Apparently.

Senator WILLIAMS. Yes. Well, that means, we will say $15,000, make it $20,000 even. That allowance means we will overpay them $350,000 for the year before, because you paid them $372,482 12 months earlier. Your $10,000 or $15,000 or $20,000 would take care of them adequately now, and I accept your word for it, then that means that we paid at least $350,000 too much the year before.

If they were paid $350,000 too much the year before—and in many of those cases, as you know from your own report, it could not even be documented that patients had ever received physical therapy, there is no record of that—I am wondering why you settle a $350,000 claim for $150,000, smacked them on the hand and said "Go sit in the corner and keep right on calling."

Mr. WOLKSTEIN. Senator, perhaps I should——

Senator WILLIAMS. I would like Mr. Ball to answer that, because I think this is his.

Do you not think that was a very lenient settlement under the circumstances?

Mr. BALL. Senator, I do not think we are in a position really to say here that everything above $15,000 for physical therapy in that particular home is unwarranted and wasteful. What we directed be done was a review of each one of these bills for cases in the past, and it was arrived at that $150,000 worth was certainly not documented as one that should have been paid. Now, I would not want to say that a staff of one physical therapist can give completely adequate service. I do not think we are in a position to assess that.

Senator WILLIAMS. Well, I am not assessing it. I am just accepting your unofficial statement that they are being properly taken care of now, and I assume that they are. Surely you would not continue them if they were not, and if you can take care of them properly today with $15,000 or $20,000 I am just winding it up.

Mr. BALL. Senator, there is room in the requirements to allow different levels of physical therapy services here. We do not say that we would not have a nursing home in the program if it did not have the optimum level of physical therapy services. We could not do that.

CONNECTICUT SURVEY

Senator WILLIAMS. Mr. Chairman, I do not want to take up the whole time on this now, but I would like to discuss this physical therapy a little bit more and I will go over to another of the reports, a survey made in Connecticut between March 24 and March 28. You are familiar with that, Mr. Ball? I noticed that in summary you referred to the intermediary in this language: "The field office process is totally ineffective, and the team's impression is that this is the result of failure of the home office to furnish the field office with the proper personnel and equipment to do the job."

But, continuing on, in the same report Traveler's was—I mean the same intermediary was handling the—I will not make any corrections, but the same company was handling, was supervising the same cases, paying them right along, and I will go over to another nursing home. Here is one patient, patient No. 041-0309491B. Now, I do not know where you get the number; he was charged for 20 speech therapy sessions at $15 apiece, but the medical record revealed only six sessions. That was one nursing home and you continue on down and here is another nursing home with a women patient who at the time of admission was listed as "independent with respect to locomotion and was walking in the hallway 2 days after admission. However, the program paid for 100 days of service and fees including physical therapy for each day, whether or not she received it."

Now, what happened to those two nursing homes?

I notice that the auditors talked with the representative from the intermediary and said they had the impression that he was not overly concerned about the finding of your auditors.

Mr. BALL. Senator, as we have done in the area of physicians and hospitals, I think I should make quite clear for the record that the particular carrier that we are talking about here does have a very bad record in relation to this particular operation, and that is what

our reports show, and there is no question about it, but I would not want the record to cast a reflection on carriers generally.

Senator WILLIAMS. No, no, I do not want to either. I am not either, and it may be just as well that we do not.

Mr. BALL. I believe this particular company has now hired a physiatrist, a physician who specializes in this area and they now have corrected, I believe, this problem of guidelines from the central to the field office and are operating this now in a tight manner.

Now, I would have to get for the record what actually happened in each one of these homes. I just do not have that in my hand.

Senator WILLIAMS. By the way, this is the same company that has notified you, under date of June 20 that it would take 9 weeks for them to get a list of the payments to doctors and so forth. Have you had much cooperation from them?

Mr. BALL. Mr. Tierney has been in direct contact with them on the matter of cooperation and I think, Senator, it would be most useful if he could answer that.

Mr. TIERNEY. Senator, I met with the president and top management of this company. It is a very large company, and after these visits they admitted quite freely that they had not done a good job, that they had regarded medicare as a kind of a sideline operation. They gave us a full pledge of total devotion of their best management technique to the operation of the program from now on and they have done some very significant and I think very meaningful things since we laid all of these facts out to them. I think there is still a very basic problem as to whether or not they can quickly enough develop the capacity to really do as large a job as they have undertaken in the country, both as a carrier and as an intermediary. We are watching it very closely. We have not prepared a recommendation as yet, but I can tell you that the whole scene has changed very dramatically.

Senator WILLIAMS. I should think it was about time it changed.

Now, Mr. Tierney, when did you first approach the carrier and tell them that their work was not satisfactory?

Mr. TIERNEY. We have had more or less continuing dialog with them in some areas, claims processing, getting bills through the process on time. It was not until we started these program validation visits and got into the provider establishments, Senator, that we found out that the record was as bad as it is.

Senator WILLIAMS. That was around March of this year?

Mr. TIERNEY. On physical therapy and in the ECF, and this sort of thing, yes.

LITTLE CONCERN OVER THE MANNER IN WHICH CARRIERS OPERATE

Senator WILLIAMS. Is it not a fact, and I am not trying to take any credit for the committee and its work, but is it not a fact that there was very little if any concern or examination made about the manner in which these carriers were operating until the last few months, and if I am in error on that, I will renew the request I presented to you earlier, to show the record of where you have done something before? I am disappointed in the fact that if we hadn't gotten into this I do

not believe that you would have done anything, Mr. Tierney. I just wondered, would you have found this, would your auditors have been in there? I asked at a staff meeting with your group for a record of all audits that may have been made—a blanket request—and every audit report is dated in 1969, and I am just wondering.

What I referred to, these payments of three hundred and some thousands for physical therapy, four and five visits to an individual a day, occurred all throughout 1968, and it was not discovered until after we put a broad questionnaire out on these programs. I am just wondering, surely there ought to have been something done somewhere earlier.

Do you not have any records from 1967, part of 1968 where you examined this program? Was there not anything called to your attention which gave you concern prior to the initiation of this committee's activities?

Mr. TIERNEY. Yes. We have been carrying on this activity for sometime, Senator, and I am sure we would have uncovered this particular situation without the impetus of your interest. I think it is only fair to say this, Senator, that there has been an evolution of the program in I suppose you could say three stages.

During the very original operation of the program, the whole thrust was in establishing forms, establishing mechanisms, and getting the whole thing operating.

There was a second stage of perfecting that mechanism. I am sure you will recall and many members of the committee may recall that 2 years ago a major problem was backlogs of bills pleading for payment. We have perfected and streamlined those things and in the last year we have intensified our efforts a great deal, and I think Mr. Ball in his attachments to the testimony has listed the very significant steps we have now taken to assure the quality of the operation of the program. This we intend to continue to do.

Now, the audit situation, Senator, has been, as Mr. Kelly said this morning, slow, but we have a great number of audited cost reports on hand.

We now have the equipment to go out, and make assessments as to what is going on, to determine what is behind these costs, and we are doing it.

Senator WILLIAMS. To your knowledge, have you or anyone connected with the department ever recommended that any carrier be dropped from the program?

Mr. TIERNEY. We have, in effect, on a number of occasions not fully renewed carriers. We have some carriers now whose contracts are not fully renewed. They have been renewed conditionally, subject to termination upon a 90-day notice or contract limited to 6 months. We are going to continue that evaluation.

Senator WILLIAMS. Will you furnish this committee a record of the ones that have been dropped?

Mr. TIERNEY. Of the ones dropped?

Senator WILLIAMS. Yes.

Mr. TIERNEY. Yes, sir.

(Information supplied follows:)

MEDICARE CARRIER CONTRACTS TERMINATED OR MODIFIED

The only Part B carrier contract that was terminated was the one with the State of Nebraska Department of Public Welfare. This action was taken through mutual agreement although action was initiated by SSA because of inadequate performance. In addition, we have since the start of the program renewed contracts with carriers for limited periods or with short termination provisions to test whether needed improvements would be made. Contracts with Massachusetts Medical Service (B/S), New Hampshire-Vermont Physician Service (B/S), Illinois Medical Service (B/S), Medical Service of D.C. (B/S), and Blue Shield of Florida, Inc., were renewed for a six month period with further renewal contingent upon marked improvement in their Medicare claims processing performance and the effectuation of specific changes identified by SSA which were considered essential to their achieving a level of acceptable performance. In addition, the contract with Illinois Medical Service (B/S), was modified to provide that the contract could be terminated unilaterally by the Secretary at any time upon 90 days written notice of his intention to do so. The agreement with California Physicians' Service (B/S) was continued with the condition that the territorial jurisdiction of the carrier's operation could be modified if a satisfactory level of performance was not achieved by January 1, 1970.

Agreements with other carriers have, from time to time, been renewed with the warning in writing that no further renewal would be made unless specific areas of their performance, identified by SSA as being unsatisfactory, were brought up to acceptable levels. Such letters have been sent to the following carriers: Blue Cross-Blue Shield of Alabama, Iowa Medical Service (B/S), Michigan Medical Service (B/S), Blue Shield of Western New York, Inc., Blue Shield of South Carolina, Group Medical and Surgical Service (Texas B/S), John Hancock Mutual Life Insurance Company, Pan-American Life Insurance Company, Rhode Island Medical Society Physicians Service (B/S), Colorado Medical Service, Inc. (B/S), and Maryland Medical Service, Inc. (B/S).

Senator WILLIAMS. Has there been any recommendation with regard to the particular carrier involved here? Has that been discussed?

Mr. TIERNEY. Recommending termination?

Senator WILLIAMS. Yes.

Mr. TIERNEY. There has been no recommendation of termination, Senator.

Senator WILLIAMS. This has not been advised?

Mr. TIERNEY. No, sir, it has not.

IDENTIFICATION OF DOCTORS

The CHAIRMAN. Might I just ask a question at this point? I have been wanting to ask about this since it came up this morning, and Senator Byrd was asking some questions on it and it had to do with reporting payments under assignment and whether that might cause fewer assignments.

My question is, Why do you not simply call for reporting of payments made directly to the patients, as well? You require him to submit itemized bills, and we agree on that. That was one of the items in contest when we passed this particular legislation, that you require him to submit itemized bills to you before you pay, so you can certainly have identification of the doctor in both cases, and that way there would be no discrimination one way or the other.

Why can you not do it that way?

Mr. BALL. That would be very acceptable to us, Mr. Chairman. I believe you would have to inquire from the Treasury Department to be sure, but I believe that they think they need legislation to go that far on the indemnity part.

The CHAIRMAN. Well, if the man wants to be indemnified, he wants you to pay his doctor bills, it seems to me that you have every right to ask him, and I thought you did require him, to submit the bills so you can pay him.

Mr. BALL. Right.

The CHAIRMAN. All right, then you ought to know who the doctor was. If he submits the bill, it ought to have the doctor's name on it. If he is going to assign it, why not require the same information where he does not assign the bill. Here I have the man's assignment and I want to pay it, and here is his receipted bill and he was treated by Dr. Jones.

Mr. BALL. That is really what we originally thought would be best, if they were going to require it in one place, they ought to do it in both, and I believe Treasury had that under consideration, but whether they could require it without legislation I would have to leave up to them. As far as we are concerned, fine.

The CHAIRMAN. Why not do it in those cases, and if he wants to pay the doctor directly, fine. We can get it in either event, whether he assigns it or whether we are paying him directly.

Mr. BALL. We have no objection.

The CHAIRMAN. Now, if it requires any legislation, Mr. Ball, I would suggest that you recommend whatever legislation might be required. You have a legal staff and we have too, and if you think you need legislation to get that information, we will pass it for you.

Mr. BALL. Mr. Chairman, on that I am sure you recognize that it is a Treasury issue of whether or not they are going to require an information return for income tax reporting, and I have to defer to them on both the need for legislation and what it would be.

I am just saying that from the standpoint of the operation of this program I certainly would have no objection.

The CHAIRMAN. Well, now, they are going to be here tomorrow, and if they need that information and they want it, and if you cannot get it any other way, I know how to get it. You can apply a tax retroactively. If we have to do it, we can just tax all of these carriers back to the day they started medicare and deny them any deduction for any of these payments unless they tell us who they paid the money to. I think they will report the information or go broke, one way or the other.

There is also a question of securing the names of doctors who received large payments which involves several carriers. They seem to be Blue Shield plans. Some of them have refused to give the names to you. Is that correct?

Mr. BALL. I really do not know. Is that correct?

Mr. TIERNEY. You mean the names that you requested, Mr. Chairman?

The CHAIRMAN. Well, now, here is a good example. We ask you to request information of your carriers. Then you send this form out indicating the information we want. Here is question No. 8; "enter below the physician or supplier's name and address." "If more than one physician billed medicare under this number, show the name of all physicians using the number. If the number represents a clinic or a group practice enter the name and address."

All right, here is the number 002–50–2521. Now, that is just not a social security number. That does not identify anything. Here is a letter, but I will not name the carrier. You may have it and I will be glad to give it to you. Just to make the point, here is a carrier response to Mr. Tierney's letter of June 16, 1969, requesting information we are seeking.

"We did not respond to question 8 of section A because," and I underline this, "no authorization exists from those designated persons to reveal names and addresses. The remainder of the questions are answered completely."

Now, no authorization exists? Who is paying?

Mr. TIERNEY. I am not familiar with this reply, Mr. Chairman. We will certainly get to it. I do not know of any carrier that said they would not give you——

The CHAIRMAN. Well, here is the letter.

Mr. BALL. I think what we would say, Mr. Chairman, was that we disagree with them. We think they should, that we would have authorization.

The CHAIRMAN. Right.

Senator BENNETT. Do you follow them up and insist?

Mr. BALL. I have not seen it.

The CHAIRMAN. This illustrates the degree of control that you have over your own carriers, if you cannot find out who they are paying the money to. They will not even tell you.

Mr. TIERNEY. Mr. Chairman, the only time it has ever come to our attention, one carrier told us that they would not tell us and we called them up and we got that straightened out real fast, and we will get this straightened out real fast.

Senator WILLIAMS. This is dated June 26, this last one which said they were not going to furnish names.

Mr. TIERNEY. I beg your pardon?

Mr. BALL. June 26.

The CHAIRMAN. One carrier responding on June 26. That identifies Rochester, N.Y. "We have not been authorized to release this information on question 8."

Mr. TIERNEY. I do not know. Authorized by whom, Mr. Chairman? But we will get the information.

The CHAIRMAN. Well, if you are paying, I suggest that either you do not pay them or we tax them, one way or the other. If you are the one paying, I suggest that you find out who you are paying or else we just deny the deduction for what they claim they paid that fellow where they do not want to identify him. It just seems to me that working together, and mind you, you are the ones paying the money out, if you cannot get the information we think necessary, we think we can get it through the tax laws. We believe that if they are working for you, that you ought to be able to get it. They are your agents, you hired them.

Mr. BALL. We will get it.

The CHAIRMAN. I am happy to know that because we think that information would be very useful in improving the program. If I do say it, Mr. Ball, I think in some respects we will help you with this program because it is kind of tough for you to have to be the mean

guy all of the time and try to make these people tell you what the facts are, and straighten up and fly right, and put pressure on them.

Mr. BALL. I think you are being very helpful, Mr. Chairman.

Senator ANDERSON. Well, I have an article from the Scripps-Howard papers indicating you wouldn't give me a list of payments to doctors.

Mr. BALL. Senator, we have taken the position that to release publicly, on a wholesale basis, the names of physicians who just received a certain amount of money under the program might easily be misunderstood as if there were an assumption that all that the individual doctors were guilty of some wrongdoing. It has been brought out here many times that a gross payment of a given amount may or may not be indicative of a problem. The physician may have many employees and his actual net income may be relatively low. Or, he may have the kind of a practice that is almost entirely a medicare practice. The position that we have taken is that when we have established the fact and moved to prosecute for fraud, obviously, as soon as the information can be released without damaging the case, it should get the widest possible publicity in order to prevent that kind of action. We have furnished the committee information on people who have grossed $25,000 a year or more, but we have taken the position that we would not on our own initiative release that for the newspapers.

Senator ANDERSON. I have a letter here which reads:

> On August 17, 1966, I entered Las Cruces Memorial Hospital for a prostate operation. My doctor was D. L. Dugan. Dr. T. B. Williams had warned me this doctor was in the habit of overcharging—and he became angry with me when I questioned him about charges.
>
> He promised to give me a local anesthetic when I explained I was subject to a number of allergies. Instead he knocked me completely out, which ruined my vision and I still stagger from the allergies he triggered.

I received this letter on Thursday.

Mr. BALL. Could I take a look at that letter, Senator?

Senator ANDERSON. Sure. I will even let you answer it. We get all kinds of letters from these people, and you get tired of writing these fellows and saying it is being corrected. He paid for two prostate operations and he never had an operation.

Mr. BALL. I think his request to please investigate the case is a very valid one and we would like to do it.

Senator ANDERSON. Well, that is all you are trying to do. Many people have died due to things like this.

Mr. BALL. Senator, we will be very happy to put our investigators on it.

Senator ANDERSON. Thank you.

The CHAIRMAN. Senator Bennett?

INCREASED COSTS OF MEDICAID

Senator BENNETT. Well, gentlemen, I have been looking at this blue book, and you have one before you, each of you, and the chart on page 3 intriques me and I think that it represents the heart of the problem we are talking about.

In the last 2 years the cost for medicaid has increased 57 percent in 2 years. The number of people served have increased 19 percent,

which is exactly one-third as fast, and the population increased 3 percent. So, the cost of medicaid applied against the population increased 18 times in 2 years.

Now, where are we going to stop? What do you look forward to for the next 5 years? If you look on page 1, chart No. 1 you will see that the rate of increase projected to 1970 is at an ever-climbing scale. From 1968 to 1969 the rate was $0.6 billion and the rate projected from 1969 to 1970 was $1.2 billion an increase of twice as much money in this second year.

Do you have any hope that you can level it off or are we going to increase at that rate from now on?

Mr. VENEMAN. Well, Senator, I do not anticipate that rapid rate of increase from now on. I am not going to be optimistic and say that is going to level off totally. I think there is going to be a rising cost of medical care, but not to that degree.

I think there are two or three factors that have to be considered here as we look at this thing overall. No. 1, when we initiate title XIX, for one thing we did extend a great many benefits that were not previously covered to a larger segment of the population.

Secondly, I think that a lot of medical costs that previously were not seen in any Federal budgetary figures are now beginning to appear in Federal budgetary figures. For example, a good many of our low-income persons, particularly those that were not on public assistance, have had their medical needs taken care of in facilities that were financed by local government. At the present time these same persons can go to that same county hospital and we pay, we match the cost. They are eligible under either group 1 or group 2.

As I mentioned this morning, a great many people in mental institutions were being compensated for and cared for as State patients and these figures were not reflected. So, I think that much of this is reflected in the high increase in cost as it relates to a relatively lower number of people coming into the program. We are paying in Federal dollars a good share of the medical costs now that were being paid for by State and local governments previously.

They are all going to get into the program.

Senator BENNETT. When did the medicaid program start?

Mr. VENEMAN. The first one began in January of 1966.

Senator BENNETT. So we have had——

Mr. VENEMAN. Eight States, I believe, went in in January of 1966.

Senator BENNETT. We have had 1966, 1967, 1968, and we are halfway through 1969.

Mr. VENEMAN. Well, I think we have to recognize also, Senator, that during these 3 years, three and a half years, additional States have been coming into the program, so that is being reflected also as time goes on. We have now 44 of the 50 States, and still about a half a dozen of them are out. But, you know, I think this gap is going to close is really what I am saying. You know, we are participating, and that is what we—that was the intent of the legislation, really, that is what title XIX says, that you maintain your effort, those of you in the State and local governments, you maintain your effort, we will match you and we will have a more comprehensive health care program for the low-income and public assistance recipients. Had we not had this program, we would have still seen rising costs in health care.

I think that under our public assistance medical care covering some of our public assistance recipients and under the medical aid to the aged program also we have seen rising costs, but the proportion of the Federal dollars has not been as great.

Senator BENNETT. Well, assume that the costs have been rising in part because it was a new program. How soon will we reach the point where we can assume that proportion of the population, we can expect will be served by this particular program will have leveled off?

Mr. VENEMAN. Well, I would say that when all States come in we will see some leveling off. We will not see a total leveling off until, well, even 1975 or 1978, it depends upon whether or not your bill relevant to section 1903(e) goes through which extends it for 2 years. We may see some leveling off if this bill goes through, for the next 2 years, too.

Senator BENNETT. Would you care to hazard a guess as to how much more increase we will have before we should approach a leveling off?

Mr. VENEMAN. I would be afraid to hazard a guess, but perhaps Mr. Kelly would not, or Dr. Land.

Mr. KELLY. Well, I think that what we have already seen, Senator Bennett, is that States are now exercising a more constrained series of decisions than they did at the beginning of the program.

The program has been expensive to them, as well as to the Federal Government and, therefore, they are tending to be more conservative in the people that they make eligible and the level of services that they provide. But, I think it is very clear that when you reach the objective of the legislation, and that is that you will provide comprehensive care by 1975 to people who are medically indigent, that if the States adopt definitions of medical indigency similar to the definitions that have been adopted in the two most populous States, New York and California, then the total cost of the program will be substantially greater than it now is.

Senator BENNETT. Well, we discovered, of course, when we were considering recently section 1903(e) that many of those States are already crying that they cannot maintain their present program and they are having to cut them back.

Mr. VENEMAN. I think that is true, Senator, but I think I can cite an example that points out there are two sides to this coin. You know, we expressed concern, and I think rightfully so, over the estimating problems that have been made in both title XVIII and title XIX programs from the time that you were deliberating over the bill until today.

But, we have a reverse situation actually in California where in 1967 we budgeted about $307 million of State dollars for the program, which means about a $650 million program. In August of that year the administration said that the program was running away with itself and it was going to cost $75 million more. That means that they anticipated in August of 1967 that we would expend about $380 million for the State's share. We closed out that fiscal year spending $230 million, so they were $150 million off the other way. So, I simply point out that estimates can go both ways.

Senator BENNETT. Well, I am looking at a report from my own State of Utah that says that they missed their 1969 costs by $2,400,000. They were greater by that amount than they had anticipated.

Mr. VENEMAN. Out of a total program of how much?

Senator BENNETT. $10 million, 25 percent off. And there is another interesting comment in the reply, particularly in view of what we have been talking about. Medicare patients for payment for hospital, nursing home and doctor bills had affected our programs by the providers encouraging us to reimburse at the same level.

By the same token, they all accuse medicare of increasing their costs unnecessarily and, therefore, they have to pass some of this on to us.

The part A of medicare has relieved the State from covering inpatient cost to those individuals more than age 65 and our contribution is $44 deductible.

Under part B the medicare program has set the stage for reimbursement on a usual, customary and reasonable basis yet the program only pays 80 percent of the usual, customary and reasonable charge.

This concept has skyrocketed physicians' fees out of proportion, and doctors are failing to take into consideration the word "reasonable". It is doubtful that we will ever be able to meet the usual and customary fee schedule set forth by the medicare program.

Somewhere between medicare and our program there is a level of reasonableness.

Now, reasonableness then has been used in my State to hike up the burden on the State, and they do not like it. Well, I am concerned. It was assumed that the estimates that were presented to us when the bill was passed have all been greatly exceeded and they are now being exceeded at an increasingly rapid rate.

I am not sure whether we can continue to fund a program that increases at the rate of 57 percent every 2 years.

Mr. VENEMAN. We cannot, Senator. Some of the persons in the Secretary's office held a meeting with our primary health people trying to look at priorities in the health field, and probably the one greatest restriction that we have is that we attempt to meet the needs of the many other programs, that we have to service in the health, education, and welfare, and particularly in the health field, is the question of where is title XIX taking us, because if it continues at the rate that it has, as has been expressed by the staff, and at the rate that has been expressed in your own concern, the dollars that are available are not going to be available for increasing our manpower, for increasing our neighborhood health centers, for increasing our child health programs, or for NIH and some of the other programs that also maintain a high priority.

So, I am just simply saying that unless collectively we do something about it, if this rate continues at this projected rate, the present rate, it is going to supersede any other programs that we have because we just will not have the resources available to fund the others.

Therefore, I do not think it is going to continue to grow, at the rate of a 57 percent increase in 2 years. I do not think that will continue, but I think every kind of control possible has to be placed on it because we are dealing with only x number of resources and they have to be distributed properly.

Senator BENNETT. I hope you can suggest to the committee maybe some changes in the law that will help bring this under control.

Mr. VENEMAN. Yes, Senator. We suggested some in my testimony this morning, and I think one of them goes right to the point that Senator Williams mentioned when he referred to certain practices in a nursing home, where under title XVIII there is no clear authority to refuse to permit licensed persons to participate under the statute, I mean under the program as it presently exists.

You cannot exclude them. That is one of them.

We also suggested that we limit the States and the amount of payment that we will participate in in institutional care. There are three or four primary things legislatively that we have recommended, and we have made several administrative changes and we are open to any suggestions you can come up with to go forward.

Senator BENNETT. I think the committee will probably have some for you as a result of this investigation.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Byrd?

ESTIMATED COSTS OF MEDICAID AND MEDICARE FOR FISCAL YEAR 1970

Senator BYRD. Thank you, Mr. Chairman. First I would like to ask a couple of elementary questions:

Mr. Secretary, what is the estimated cost of medicare for fiscal year 1970; and, secondly, the estimated cost of medicaid for 1970?

Mr. VENEMAN. I will yield to Mr. Ball for the medicare and Dr. Land for the medicaid.

Dr. LAND. $2.7 billion is the Feedral share for medicaid for 1970.

The CHAIRMAN. How much?

Dr. LAND. $2.7 billion.

Senator BYRD. $2.7 billion for medicaid?

Dr. LAND. Yes, sir.

Mr. BALL. For the Hospital Insurance Fund for fiscal 1970, the estimate is $5,044 million. That is for part A.

Senator BYRD. Dr. Land, that $2.7 billion, is that not—is that an increase over the April estimate?

Dr. LAND. Senator, I apologize. I gave you incorrect figures. $2.55 billion is the correct figure if the Congress approves the program limitations that are being proposed.

ESTIMATED AND ACTUAL COSTS FOR MEDICARE AND MEDICAID FOR FISCAL YEAR 1969

Senator BYRD. Well, that is what confused me. I thank you.

Now, I would like two additional figures. What did HEW estimate the cost of fiscal year 1969 to be when it submitted the budget a year ago, and what was the actual cost, first for medicare and then for medicaid?

Mr. KELLY. Let me give you the medicaid figure, if I may, Senator Byrd. The President's Budget was submitted at $2,118 million and there was subsequently, a supplemental appropriation of $278 million. The final expenditure figure is $2,384 million, so that the original budget was only 89.4 percent of what we actually experienced.

Senator BYRD. Well, now, let me see if I understand this. The actual cost of fiscal year 1969 was $2,384 million—you might say $2,400 million?

Mr. KELLY. Close, yes, sir.

Senator BYRD. Now, you estimate that the fiscal year 1970 would be 2 billion and 5, $2,500 million, virtually the same?

Mr. KELLY. That is correct, but there is a major change that occurs. There is $238 million worth of costs that have heretofore been borne under medicaid which the States now estimate that they will cover under public assistance for the aged, and this relates to the intermediate care facilities rather than nursing home care.

Senator BYRD. Well, that is a paper transaction?

Mr. KELLY. It is a different appropriation it is charged to, but the cost is still being borne by the public assistance and medical assistance program, that is correct.

Senator BYRD. Well, then, what about the medicare part of it?

Mr. BALL. On the Hospital Insurance Fund, Senator, for fiscal 1969 benefit and administrative cost is around $4 billion.

Senator BYRD. That was the estimate a year ago?

Mr. BALL. This was the estimate at the time of the Trustees Report that is, the 1968, Annual Trustees Report, March 27, 1968, so approximately a year ago.

Senator BYRD. And that was $4 billion?

Mr. BALL. Yes, sir.

Senator BYRD. And what was the actual cost of 1969?

Mr. BALL. It is very close for fiscal 1968, Senator, because of course that was in March of 1968 and we had most of the information. This seems to be total disbursement 4.4.

Senator BYRD. 4.4?

Mr. BALL. 4.4—it may need a slight correction, but that is approximate.[1]

Senator BYRD. That is on the cash basis you are speaking of?

Mr. BALL. Yes, sir.

Senator BYRD. Well, now, do you have an estimate of the—well, do you have the actual cost of 1969 on an accrual basis?

Mr. BALL. I do not believe we do, Senator. We have one of the actuaries—we have someone in the audience, but I do not believe we have done that on an accrual basis.

In the hospital insurance program it is not substantially different because the payments flow pretty rapidly.

Senator BYRD. Well, then, the estimated cost for fiscal year 1970 of $5 billion, is that on a cash basis? You are still speaking of the cash basis, I assume?

Mr. BALL. Yes, sir.

Senator BYRD. So your estimated cost, you estimate the cost will go up?

Mr. BALL. The actuary is confirming the fact that in the hospital insurance the accrued and the actual cash basis is very close together.

Senator BYRD. Well, then, you could estimate the cost for fiscal year 1970 at $5 billion and it would be only $600 million more than the actual cost of fiscal year 1969?

Mr. BALL. That is correct, Senator.

Senator BYRD. Were there any bookkeeping transactions involved in that?

[1] See p. 155 for a correction of this figure.

Mr. BALL. I do not know of any, Senator.

Senator BYRD. Now, I wanted to ask the Secretary a couple of questions, but I guess I will have to wait until be gets back.

Mr. BALL. I might just point out that was about the same increase between 1968 and 1969, and about the same $600 million.

Senator BYRD. Mr. Chairman, I might have to filibuster a few moments until the Secretary gets back.

Mr. BALL. The Secretary had to take an urgent phone call, Mr. Chairman.

The CHAIRMAN. If you want, I will call on Senator Curtis and then come back to you.

Senator BYRD. Why do you not just do that.

The CHAIRMAN. Senator Curtis?

NEW YORK STATE MEDICAID BENEFITS

Senator CURTIS. I would like to know what medicaid benefits are paid in the State of New York. What do you do for the people up there?

Dr. LAND. Do I know what the scope of the program is, Senator?

Senator CURTIS. Yes. Not necessarily dollars, I want it in the types of services.

Dr. LAND. Yes, sir.

Senator CURTIS. Well, you provide hospital care?

Dr. LAND. Yes, sir. I do not have the list. I was trying to provide the complete list.

Senator CURTIS. Is there a limit on the number of days of hospital benefits?

Dr. LAND. The State legislature in New York recently placed a limit on the number of days in a nursing home.

Senator CURTIS. Do you know what the limit was?

Dr. LAND. No, sir. I would have to submit that for the record. (See p. 145.)

Senator CURTIS. No Federal limitation?

Dr. LAND. No, sir.

Senator CURTIS. Does New York provide the outpatient hospital service; do they provide that?

Dr. LAND. Outpatient hospital services, laboratory——

Senator CURTIS. Do you know what the extent of those are?

Dr. LAND. They are generally supplied all over the State, yes, sir.

Senator CURTIS. Is there any limit on the amount of out-patient services that an individual or family can receive in year?

Dr. LAND. I do not believe so. No, sir.

Senator CURTIS. And just recently there is a limit as to how much nursing home care?

Dr. LAND. Yes, sir.

Senator CURTIS. Do they provide laboratory and X-ray services?

Dr. LAND. Laboratory and X-ray, physician services wherever performed.

Senator CURTIS. Is there any limit on the amount of laboratory and X-ray services?

Dr. LAND. No, sir.

Senator CURTIS. They also have in their medicaid program skilled nursing home services?

Dr. LAND. Yes, sir. They recently placed a limit on the skilled nursing home services.

Senator CURTIS. And you would have to supply that?

Dr. LAND. Yes, sir, I will. (See p. 145.)

Senator CURTIS. They provide physicians services?

Dr. LAND. Yes, sir.

Senator CURTIS. In an office?

Dr. LAND. Wherever supplied, office, hopsital, clinic, outpatient.

Senator CURTIS. Home calls or in a nursing home?

Dr. LAND. Home calls.

Senator CURTIS. And it covers the services of an optometrist?

Dr. LAND. I am sure it does.

Senator CURTIS. Is there any limit on how many times a year?

Dr. LAND. I do not know of any limit.

Senator CURTIS. How about a podiatrist?

Dr. LAND. I am sure podiatrists are covered.

Senator CURTIS. There is no limit on any of these?

Dr. LAND. Pardon?

Senator CURTIS. There is no limit on any of these?

Dr. LAND. Not as far as I know.

Senator CURTIS. And the Federal Government is paying what portion of medicaid costs?

Dr. LAND. Fifty percent.

Senator CURTIS. And there is absolutely no limit on how many physician calls or anything else?

Dr. LAND. No, sir.

Senator CURTIS. And on top of that the State determines who is eligible?

Dr. LAND. Correct, sir. They did make one change—another change in the program. They had a very broad, comprehensive coverage dental program, and they have now eliminated as of today, this comprehensive coverage dental program, and only allow emergency dental service.

Senator CURTIS. They have cut that one down?

Dr. LAND. Yes.

Senator CURTIS. But they had no limit on that before?

Dr. LAND. No, sir. It was very comprehensive.

Senator CURTIS. You take out complete dental service. Was there any limit as to what kind of materials were used for bridges or what else?

Dr. LAND. There were some limits, but not many.

Senator CURTIS. They also provide drugs and related items?

Dr. LAND. Yes, sir.

Senator CURTIS. Is that limited to prescription drugs?

Dr. LAND. No, it is not limited to prescription drugs. For example, insulin would not be a prescription drug and it could be purchased across the counter. They also allow other across-the-counter purchases.

Senator BENNETT. Like Alka-Seltzer?

Dr. LAND. Like Alka-Seltzer, aspirin.

Senator CURTIS. Now, insulin is a category by itself?

Dr. LAND. Yes, sir.

Senator CURTIS. It is about the one medicine that may be necessary to continue or to sustain life. But, there is no limit on the amount of drugs to be provided to an individual or a family under medicaid in New York, is there?

Dr. LAND. Not as far as we are aware of.

Senator CURTIS. How about home health care services, do they provide that under medicaid in New York?

Dr. LAND. I am practically certain they do, yes, sir.

Senator CURTIS. Do you know of any limit on it?

Dr. LAND. No, I do not.

Senator CURTIS. Do they provide under medicaid in New York private duty nurse services?

Dr. LAND. Yes, sir.

Senator CURTIS. Is there any limit on how many days you can have a private nurse?

Dr. LAND. Not as far as I know.

Senator CURTIS. Could it be 365 days?

Dr. LAND. I think so.

Senator CURTIS. Do they provide clinical services?

Dr. LAND. Yes, sir.

Senator CURTIS. Is there any limit on that?

Dr. LAND. Not as far as I know.

Senator CURTIS. They provide eyeglasses and other eye aids, do they not?

Dr. LAND. Yes, sir.

Senator CURTIS. Any limit on that?

Dr. LAND. I think there are in some of these a requirement of some prior approval, but I do not have my list of the state characteristics here. For example, I think there may be some prior approval for purchase of glasses.

Senator CURTIS. Do they provide rehabilitation therapists under the medicaid program in New York?

Dr. LAND. I am certain they do, calling it physical therapy.

Senator CURTIS. And it includes occupational and speech and the various kinds?

Dr. LAND. Yes.

Senator CURTIS. Any limit?

Dr. LAND. Not as far as I know.

Senator CURTIS. Do they provide psychological testing under medicaid in New York?

Dr. LAND. I am not certain of that, Senator.

Senator CURTIS. I think they do. Do they provide psychiatric day care and night care services?

Dr. LAND. I am sure they provide psychiatric care.

Senator CURTIS. Is there any limit on the number of calls that an individual or family can have from a psychiatrist, being borne by the medicaid program in New York?

Dr. LAND. I will have to furnish that for the record, Senator.

(The following information was subsequently supplied for the record:)

NEW YORK STATE MEDICAID PROGRAM

The New York State Medicaid Program, as of July 1, 1969, is still a very broad one. Limitations have been placed on three services while other changes in the program affect the number of eligibles and reimbursement to providers.

Limitations on services:

Skilled Nursing Home Care is limited to one hundred days but extension beyond this period is possible with prior authorization.

Dental Services are limited to preventive prophylactic and other routine care. Prosthetic and orthodontic supplies may be furnished with prior approval.

Transportation is limited to emergency only except with prior approval.

The number of eligibles should be reduced as a result of reductions in the income levels for financial eligibility.

The number of participating providers may be adversely affected by a reduction in fee schedules for non-institutional items of medical care and the freezing, until December 31, 1969 Hospital and Nursing Home rates.

More detailed characteristics of the State's Medicaid program are attached herewith.

NEW YORK TITLE XIX PROGRAM—JULY 1, 1969

I. FINANCIAL ELIGIBILITY

1. All individuals receiving assistance under the State's plan under titles IV and XIV of the Social Security Act.

2. Medically needy individuals whose income and resources equal or exceed those established for the programs under 1, above, but are insufficient to meet their costs of medical care and who meet the other eligibility requirements of these programs.

The following are the Eligibility Standards for Group 2.

Persons: One; Two; Three; Four; Five; Six; Seven.

Yearly Net Income: $2,200; $3,100; $4,000; $5,000; $5,700; $6,400; $7,200.

Allowable Resources: Savings equal to one half of annual net income. $500.00 burial per person to a maximum of $2,000.00 per family.

II. SCOPE OF CARE

(Categorically Needy Persons and Medically Needy Persons), (No limitations except, effective 7-1-69, on Nursing Home and Dental care and Transportation).

1. Inpatient hospital services, including care for patients 65 years of age and over in institutions for mental diseases and tuberculosis.
2. Outpatient hospital services.
3. Other laboratory and X-ray services.
4. Skilled nursing home services (other than services in an institution for tuberculosis or mental diseases). Limited to 100 days with prior authorization required for any extension.
5. Physicians' services, in office, patient's home, a skilled nursing home or elsewhere.
6. Practitioners' services (podiatrist and optometrist).
7. Dental services, limited to preventive prophylactic and other routine care. Prosthetic and orthodontic supplies may be furnished with prior approval.
8. Drugs, biologicals, blood, blood products and sickroom supplies.
9. Services provided by a home health agency.
10. Private duty nursing services.
11. Clinic services.
12. Prosthetic devices.
13. Other:
    A. eyeglasses and other eye aids;
    B. all rehabilitation therapies including physical, occupational and speech therapy or orthoptic training;
    C. psychological testing;
    D. psychiatric day care and night care services;
    E. care in a public home infirmary and infirmary section of a private home for the aged;
    F. any other diagnostic, screening, preventive and rehabilitative services when properly prescribed and recommended;
    G. transportation: Emergency only except with prior approval;
    H. home aide services.

III. PAYMENT

Effective June 1, 1969, state maximum reimbursable fee schedules for all outpatient medical services and supplies, other than orthodontic services were reduced 20%.

On July 1, 1969, a further 80% limitation was imposed on the above care and services furnished the medically needy. This limitation becomes inapplicable if obligations for medical care have reduced the individual's income and resources to an amount equal to the most liberal money payment standard.

Hospital and Nursing Home rates are frozen through 12-31-69.

Senator CURTIS. Now, does it also include care in a public home, infirmary or an infirmary in a private home for the aged?

Dr. LAND. I am certain that it does.

Senator CURTIS. Does it include diagnostic screening, if any, and rehabilitative services when prescribed?

Dr. LAND. I would imagine so, yes, Senator.

Senator CURTIS. Does it include supplying of blood to medicaid persons?

Dr. LAND. Yes, three pints per admission in the case of an aged person covered by Medicare.

Senator CURTIS. Three pints?

Dr. LAND. Yes, sir.

Senator CURTIS. For what period of time?

Dr. LAND. Per admission.

Senator CURTIS. Per admission? How does that compare with medicare?

Dr. LAND. It is a complementary regulation.

Mr. BAIL. Senator, under medicare there is a blood deductible, but then beyond that what is necessary, medically necessary, would be paid for under medicare. There is no maximum.

Senator CURTIS. What are blood products?

Dr. LAND. Those are where the elements of the blood have been separated into the separate elements and used to treat specific disease conditions.

Senator CURTIS. Now, in the medicaid program in New York do they provide transportation for medical care and food services and attendants required?

Dr. LAND. They just recently, beginning July 1, changed their transportation law so that only when essential and upon prior approval, except in an emergency.

Senator CURTIS. And they also provide home aid services. Can you think of anything that the medicaid program does not provide in New York?

Dr. LAND. No. I have always considered that it probably provides more than any other program in the country as far as the scope of services.

Senator CURTIS. Well, when medicaid was presented to this committee there was no such scope of program presented to this committee. It was presented in a very sketchy manner, and without any indication that a State could have a free rein for the most part without limit, and in fact it is without limit so far as the Federal Government is concerned.

Now, did you recently have a Federal regulation with regard to transportation issued?

Dr. LAND. Yes, sir.

Senator CURTIS. For all States?
Dr. LAND. Yes, sir.
Senator CURTIS. You did?
Dr. LAND. Yes, sir.
Senator CURTIS. What would that provide?
Dr. LAND. It provided that effective July 1, 1970, a State would be required to furnish transportation.
Senator CURTIS. Would be required to furnish it?
Dr. LAND. Yes.
Senator CURTIS. Did you have authority in the law to do that?
Dr. LAND. We were so advised; yes, sir.
Senator CURTIS. Now, it is said that this is for people of low income, but medical care is not the only Federal program that they are given. They get subsidies in housing.

They are inaugurating a gigantic food stamp program, they are being relieved of taxation in many instances by the Federal Government, and while I would condemn as vigorously as anyone here that fraud and the abuses in the program, the point is, if you got all of that out, got rid of all of that, everybody was honest, everyone was careful, we still have a program that is going to cost a tremendous amount of money. And, it seems to me that before the program gets any older, before all of the States broaden it to the point where that one, or two or three have, that it would be just good housekeeping and honesty with the people if some priorities were established and we zero in on a few of the services most necessary and eliminate some of the rest of them, because unless that is done these programs will continue to grow and grow.

FISCAL AGENTS UNDER MEDICAID

I would like to ask when an entity is appointed as an intermediary, what power do they have? You used a carrier, or in medicaid what did you use?
Dr. LAND. In medicaid they are fiscal agents.
Senator CURTIS. Fiscal agents.
Dr. LAND. They do not and they are not allowed to assume the responsibilities that the carriers under title XVIII assume. By statute, the responsibility for the program under title XIX, belongs to the State agency, they might have someone else do the work for them, but they cannot get rid of the responsibility, so the responsibility is back to the State agency even if they do use a fiscal agent.
Senator CURTIS. Now, can a fiscal agent bind the Federal Government?
Dr. LAND. No, sir.
Senator CURTIS. The fact that a fiscal agent approves an unnecessary, wasteful and extravagant claim say for physical therapy, which has been discussed here, that brings no obligation on the Federal Government to pay it, does it?
Dr. LAND. I would not think so, Senator, under the title XIX because the responsibility is the State agency.
Senator CURTIS. Do you have a written contract?

Dr. LAND. The State agency has a written contract with their fiscal agent. Not Federal.

Senator CURTIS. Does that conform to any particular requirements of the Federal Government?

Dr. LAND. Yes. There are handbook regulations concerning these contracts with the fiscal agent.

Senator CURTIS. They are just handbook guidelines?

Dr. LAND. Well, they are regulations, as a matter of fact. It so happens that the regulations are in a handbook form.

Senator CURTIS. The Federal Government does not approve of the contract or the delegation of power that is executed?

Dr. LAND. The contract is approved in the regional office.

Senator CURTIS. Which office?

Dr. LAND. In the regional offices.

Senator CURTIS. Well, now, I would like to ask something about medicare. Does a carrier have a written contract with the Government?

Mr. BALL. Yes, Senator.

Senator CURTIS. Are they all alike; is it a standard form?

Mr. BALL. Essentially.

Senator CURTIS. Could you supply one here for our record, one in blank? So that we might know what authority is vested in the carrier.

Mr. BALL. Certainly, Senator.

Senator CURTIS. Now, an intermediary is designated by the hospital—and that is how they come into being?

Mr. BALL. Not quite, Senator. They are nominated by the hospital or an association of hospitals or extended care facilities, but we have to accept the nomination as being consistent with efficient and economical administration. In other words, they nominate, but do not actually select.

Senator CURTIS. Yes. Now, do you have a written contract with intermediaries?

Mr. BALL. Yes.

Senator CURTIS. Is it more or less a standard form?

Mr. BALL. Yes, Senator.

Senator CURTIS. Could you supply one of those?

Mr. BALL. Yes, Senator.

(Extensive information supplied for the record at this point was made a part of the official files of the committee.)

REIMBURSEMENT OF CARRIERS

Senator CURTIS. What is the basis on which you make payment for the services of a carrier?

Mr. BALL. On the basis of cost, Senator. They are reimbursed solely for their cost of the work they do under that contract. There is no element of profit in it.

Senator CURTIS. So the more claims they approve the more costs they have and the more they draw, is that right?

Mr. BALL. I would not say so, Senator. I think it is probably just as expensive to disapprove claims as to approve them. Actually, it might be more related to the work that they need to go through, the

number of claims they handle, I think, but not necessarily the number they approve.

Senator CURTIS. Well, with this physical therapy case that Senator Williams was discussing, was that in medicare?

Mr. BALL. That was in medicare, Senator, and I think there the problem was that they were not putting enough money and effort into the review of that type of operation. It was not that they just were letting them go through and thus had higher administrative costs—they were not actually working at it hard enough.

Senator CURTIS. Well, but certainly a carrier would be paid more for servicing six physical therapy treatments for the same patient in one day, would he not, than one?

Mr. BALL. I do not believe so, necessarily, Senator. I think he might actually be doing more work to do a good job for us and to reduce the number of physical therapy claims by expanding his professional relations with that home and explaining what was allowable and by working at getting the thing set up in the right way.

I do not really believe there is too much correlation between more expensive administration of this program and just letting a large volume of claims be handled. It may be good to keep down the volume by spending more administrative money.

Senator CURTIS. Of course, it may be well if there was. I cannot see that a carrier would have any financial incentive for doing a good job. If he is paid just for the cost of shuffling papers.

Senator WILLIAMS. If the Senator will yield, is it not a financial incentive to do a bad job because the amount that the carrier receives, to a certain extent, is based on the amount of payment——

Mr. BALL. No, it is the cost of doing the work, Senator.

Senator WILLIAMS. I mean, it relates to his total business if he pays on a per patient basis or if he paid on a dollar basis as it relates to his total operation. Would you assume——

Mr. BALL. No, there is a cost finding process to determine what he actually has spent to run a medicare program, and that payment is made to him. The point I was making with Senator Curtis is that you may have a fairly high rate of expense to claims and have quite a lot of money going into a very careful claims operation, and it may save a lot of program money; that was the point I was making. On the other hand, you might have a relatively low-cost ratio to the amount of claims that you pay and the problem there is although the cost of administration is low, a great many claims might be paid that perhaps should not be. That was the only point I was making.

Am I being responsive to your question?

RENEWING BENEFIT PAYMENTS BY CARRIERS

Senator CURTIS. I think so. Now, the way you run this, do you turn some money over to a carrier and they go ahead and make disbursements to individuals or do they make disbursements first and then are reimbursed?

Mr. BALL. No, they are able to draw on an allowance, on an advance.

Senator CURTIS. Now, if they paid under medicare either part A or part B an unreasonable or unjust indefensible payment, in due course

when would a representative of the Government have a chance to catch it, if ever?

Mr. BALL. Senator, there are a variety of checks that we have been discussing and they really come at different times. One type of thing that we were referring to earlier is that we are sometimes alerted and sometimes the carrier is alerted to incorrect payments by reason of a patient himself saying that the service was never given him. We have sent him a notice that the carrier or intermediary has made a payment.

Another sort of situation that the chairman referred to earlier today concerned one of the hospitals that we removed from the program. There the matter was first brought to our attention by a former employee of the hospital.

Now, we are developing various kinds of alerts in the computer system that are much more comprehensive, things such as tying together the length of stay in a hospital and the diagnosis and highlighting, therefore, differences among hospitals in terms of how long people stay in for certain procedures and see if we can find difficult and bad situations that way.

Many carriers are set up—and we are pressing for it to be more universal—to be alerted automatically to unusual numbers of physicians visits with a given diagnosis. And, as I indicated earlier, too, Senator, our regional officers visit the carriers and are in touch with them frequently, and we have central office people that go out and examine the carriers, and now recently, as Senator Williams has brought out we are going behind that and looking at the way providers operate who are within the jurisdiction of that carrier, and in that way flushing out problems.

One other method that you might be interested in is that we send through dummy claims to the carrier and follow them through and see what happens, and in that way we are alerted to some of their problems and we then can work with them on correcting them. There are quite a long list of other actions that I was going to submit for the record.

Senator CURTIS. Well, in reference to intermediaries I have a report here coming from a place in Pennsylvania. It says, "Our review of travel costs disclosed that intermediary claimed reimbursement for meals and alcoholic beverages at a medicare conference held on April 12, 1966, invoice No. 182515 supporting this charge shows that the cost of alcoholic beverages served at this conference was $212."

Mr. BALL. Is this an audit report or what is it?

Senator CURTIS. Yes, and then it has this rather interesting——

Mr. BALL. We disallowed that.

Senator CURTIS. Yes, but the language used is quite interesting. It says, "No provisions made for reimbursement of cost for alcoholic beverages. Further, the Social Security Administration, Bureau of Health Insurance, has taken the position that since alocholic beverages are not considered stimulants of production and do not help disseminate technical information, it cannot be considered allowable cost of the medicare program."

Mr. BALL. It just proves, Senator, that even auditors have a sense of humor.

Senator CURTIS. Well, the point I am getting at, and I will be glad

to look at those, is that this is a very broad delegation of authority to carriers and fiscal agents and intermediaries, is it not?

Mr. BALL. Well, Senator, one of the provisions in the contracts, as you will see when you look into these, is an agreement to abide by the rules, regulations and instructions and so on that are issued by the Bureau of Health Insurance, of the Social Security Administration. Although there is some friction from time to time on whether we are excessive in the amount of direction that we give them, by and large, most carriers have been very willing to take directions, what you might want to have as an addition to those agreements, Senator Curtis, is at least a few examples of what we call the intermediary and carrier letters that in great detail, in many instances, direct the administration of the program.

It is not just a broad grant of authority and then they are left alone. There is case after case after case in area after area of a great deal of instructional material asking them to perform in this way and that way and so on.

Senator CURTIS. About how many claims under part A did you handle last year?

Mr. BALL. Last year under part A——

Senator CURTIS. Just roughly about how many million?

Mr. BALL. Well, there were inpatient hospital claims last year amounting to six and a half million.

Senator CURTIS. And about how many claims did they handle under part B?

Mr. BALL. 27.8 million, Senator. This is really, as you brought out, a very, very large program, involving the services of a great variety of people and needing the understanding of a great variety of people. There is a tremendous volume, and some of the illustrations of difficulty that we have had during the day I think are understandable, given the tremendous volume of this program and the newness of it. I would like to say again that I think on the whole the carriers and the intermediaries have performed creditably and are continuing to improve.

Senator CURTIS. I am sure that is correct.

FREEZE ON CERTAIN CHARGES

On a different subject, Mr. Secretary, I thought I understood you this morning, in referring to some of the steps you have taken to reduce costs, I thought you had used an expression that indicated a freeze on certain charges?

Mr. VENEMAN. Yes. Well, what was published in the Federal Register today, Senator, was a provision which would limit the payment to individual providers, which could be doctors, dentists, and other providers, to the amount that they received on January 1, 1969.

This amount cannot exceed the 75th percentile—in other words, what 75 percent of the doctors receive as usual and customary, doing business in that particular region.

Senator CURTIS. So, in a given area as soon as this program went in they hiked up the prices and got them raised before January 1, they are in; those who just suffered along and had not raised their prices are still frozen at the lower level?

Mr. VENEMAN. I do not think they would have anticipated this action prior to January 1, 1969.

Senator CURTIS. I beg your pardon?

Mr. VENEMAN. I do not think they would have anticipated this action for that purpose prior to January 1, 1969, and they cannot go to the 75th percentile without an approval by the medicaid State agency and/or without the approval of the Secretary.

Senator CURTIS. Well, I still think that it rewards those who have not only raised but maybe raised several times and raised in a substantial amount prior to January 1 of 1969, and it might severely penalize providers that have faced their own increased costs of doing business, but had not raised their prices until January 10, or maybe not at all.

Mr. VENEMAN. Well, if this were the case, Senator, there are those providers who are—well, in an area that is down below the 75th percentile then there is an opportunity for them to increase.

We have essentially said that you cannot go above the 75th percentile of usual and customary in a particular area, but if you are below that you can get up to it with approval, I think it requires State approval and the Secretary's approval. California, for example, is now paying at the 60th percentile. Now, by this regulation this does not mean that they can automatically jump to the 75th. It means that there is a 15th percentile tolerance there, but they are going to have to get approval of the State agency as well as the approval of the Secretary before they can go up.

Senator CURTIS. In the case I am about to cite I am unclear just what programs were involved because my informant was not too clear.

There is no doubt it was in the medicaid program. In a country county seat in Nebraska that is a fairly good size and has good medical facilities and a good many doctors, if the welfare office referred a patient to a general practitioner the general practitioner was allowed $3.75 for the call. If the general practitioner felt that the patient ought to return for another call, he had to go through a cumbersome job of filling out papers and showing the necessity.

Mr. VENEMAN. Prior authorization.

Senator CURTIS. Yes; but, if the welfare worker sent the same patient to a specialist, the doctor could charge his usual and customary charge and the doctor was the judge of whether or not the patient returned for an additional call.

Mr. VENEMAN. Senator, that decision was made either by the legislature or the administration of the State of Nebraska. We had nothing to do with that decision.

Senator CURTIS. Well, I am glad to hear that, and I told you I was unclear as to the details.

Mr. VENEMAN. You see, under title XIX there are some States that have put doctors on a fee schedule; others pay on the basis of the usual and customary, and others pay on the basis of usual and customary on a percentile basis. Some States have doctors on usual and customary and everybody else on a fee schedule, but these are decisions that are made within the State agency that administers the plan. If the plan is one that meets the criteria that has been established by Medical Services Administration, Dr. Land's office, which

criteria attempts to fulfill the intent of Congress when they passed the legislation, and then we will accept the State's plan.

Senator CURTIS. Well, I doubt if you can successfully run a program on a nationwide basis of 200 million people and reimburse hospitals, particularly on the basis of their costs. It seems to me that in the rural areas we have some excellent hospitals that probably charge maybe $37 a day; they are run by dedicated people and somehow the patients get well. Yet, those people that charge medicare $37 a day are faced with all of the trials and tribulations and the forms and harassments and urging to lower as the provider of hospial beds, a hospital bed in the State where maybe their average is $80 a day.

Mr. VENEMAN. There are two or three things——

Senator CURTIS. And it is all paid out through the same common fund of all taxpayers.

Mr. VENEMAN. Well, there are several things that affect, of course, the daily rate of the hospital. I think one thing is we talk about the direction that we are attempting to take in providing services and facilities, but I do not think any of us should be left with the impression that the daily rate will go down, because if we are successful in utilizing extended care facilities and neighborhood health centers and others, then the hospital beds will undoubtedly be filled with short-term patients, or shorter-term patients. If you cut down on the patient days you then increase the daily cost.

Presumably you are getting more for your money, but you know, if you get a patient in there for 5 days instead of 10 days at $40 or $80 a day, you can put them in the extended care facility, for example, in Massachusetts for $15, at a much less cost than leaving them there. But, I am simply saying that if we start utilizing other kinds of facilities the per day cost per hospital for the acute bed care cost I am inclined to believe would go up.

Senator CURTIS. I have taken more time than I should, Senator.

Senator BYRD. I will yield to the Senator from Arizona, Senator Fannin.

Senator FANNIN. Thank you, Mr. Chairman.

VOLUNTARY HEALTH INSURANCE AS AN ALTERNATIVE TO MEDICAID

Mr. Secretary, Mr. Commissioner, you and your associates have been very patient, I just want to cover one subject on page 2 of your statement. You give the reasons for medicare which, of course, we all understand, but then you say that senior citizens cannot afford to pay a premium high enough to cover the cost of care.

Now, I recognize this certainly is a problem. But, then on page 6 you say 20 million older people—just about all those over age 65—are covered automatically under the hospital care program.

Of these people 96 percent have also signed up for the voluntary part of medicare and pay $4 a month to get additional coverage for physicians' bills, and you bring out how many people have been involved, and what has happened. I am just wondering whether or not you feel that a voluntary health insurance program, not affecting the medicare program, could be an alternative to the present method of handling the medicaid program?

Mr. VENEMAN. Senator, the testimony that you allude to is the testimony of Mr. Ball.

Senator FANNIN. Yes.

Mr. VENEMAN. I think I will let him respond.

Senator FANNIN. Fine. Thank you, Mr. Ball. Do you understand—I know you have seen the programs that have been recommended, the tax deductions for individuals and handling the ones that could not pay the premium by some other method.

Mr. BALL. Senator, just speaking for myself, there is no administration position on the question that you raise, my own belief is that down through the years ahead it would be highly desirable for a combination of voluntary insurance and Government programs on a prepayment basis to cut down on the need for medicaid.

I think that such an approach with people who are at work, making this premium payment is highly desirable. I was limiting my testimony to the unusual situation of the aged, where most of the group is retired, has a very low income, consequently and where the need for care is so great that the premium rate is very high.

Now, that same set of circumstances does not apply across the board to the average person below 65, and I think that voluntary programs have a much better chance of full success there.

Senator FANNIN. Yes; well, I understood what you were referring to, but in your statement I was trying to discover what might be done to overcome the turmoil that we seem to be in now with many of the States and also the problem we are having with the alternatives being offered now as far as we were concerned.

Mr. VENEMAN. Well, Senator, I am one who believes that we are going to have to start moving in the direction of prepaid care for those persons who are now eligible for title XIX.

Now, yon know, granted it does not make very much sense to suggest that we have prepaid insurance in the aid to disabled category, but it does make sense to me to try to make it work in the aid to families with children category.

Now, I have done a little bit of dividing and by taking case load against total cost for family groups in some of the areas and find that we are making average expenditures of some $400 and $500 per person.

Well, now, for a family of five that would be $2,000 a year. Now, we can buy an awful lot of insurance for that. So, I am saying that the case load is not too much different from many average families. The only difference is their low income and you assume they are going to have perhaps a little higher risk of the need for medical attention because of their environment, and perhaps because they have not been exposed to good health care and good preventive medicine, but it should not be that much higher and I would like to really seriously see some good demonstration programs going on in certain areas to see whether or not we cannot let out a bid for prepaid insurance for certain segments of the case load.

Senator FANNIN. Do you not have a program now in one of the States where you are experimenting?

Mr. VENEMAN. We do. We have two of them, actually. We have one California foundation program which is on a prepaid principle and the other one is in Oregon.

Dr. LAND. We have been following along and studying this and we have in Texas what can become a prepayment program. The greatest difficulty in development of prepayment for this particular group is a lack of statistics, of knowing what the needs of the population are.

In other words, you would have to have 2 or 3 years of experience before any insurance company would be willing to accept a risk by accepting premiums, for example, from the State agency, and we are developing in one of those States, particularly Texas, some statistical data that can be used in this respect, and other States are showing a great deal of interest in attempting to work out this, and the State of Pennsylvania is quite interested in developing premium payment for a portion of the caseload.

As the Under Secretary said, I do not think a prepayment for the entire four categories would be feasible and the best way to start would be to have one category, and that would be AFDC because we have more data on that group than we have on others.

Senator FANNIN. Well, there is a tremendous amount of information being developed through the social security activity. Won't that be available?

Mr. VENEMAN. It should be, it should be before long, Senator. This is always the excuse you get when you start discussing out the possibility of starting this and they say, well, you know, how do we actuarily base a premium payment. But, I think, you know, we have been with it long enough, and we are never going to find out unless we do a few pilot programs and we might as well see if it is going to work.

Senator FANNIN. Well, thank you very much.

The CHAIRMAN. Senator Byrd, do you want to ask some questions?

Senator BYRD. Thank you, Mr. Chairman.

Mr. BALL. Senator Byrd, I wonder if before you question the Under Secretary I could correct a figure that I gave earlier in the discussion that we had? We were giving you figures from the trustees report here and I find that there has been the updating. A current revision on hospital insurance would make about $100 million more for 1969 and about $200 million more for 1970 than the figures that I gave you earlier.

Senator BYRD. Well, now, let's see if I have those clear now. That would make 1970, $5,200 million?

Mr. BALL. $5.3 billion in round figures.

Senator BYRD. Right, $5,300 million?

Mr. BALL. Yes, sir.

Senator BYRD. All right, and then it will make 1969 what?

Mr. BALL. $4.6.

Senator BYRD. That is actual cost, $4.6?

Mr. BALL. Yes.

Senator BYRD. Thank you.

NEW YORK STATE MEDICAID PROGRAM

Dr. Land, you have a very detailed knowledge of New York State laws and requirements and you answered very forthrightly a great multitude of questions put to you by Senator Curtis. My question is this: You say that is the most comprehensive and the most liberal law in the country in this regard. Do you favor the New York law?

Dr. LAND. Well, I have to say, Senator, that the New York law is certainly within, completely within the realm of this statute. It is perfectly permissible within the statute.

Senator BYRD. Well, I am aware of that.

Dr. LAND. If you are asking me for my personal feelings——

Senator BYRD. Yes.

Dr. LAND. It has been my attitude as Commissioner of Medical Services that a State should start with a minimum, as minimum a program as possible, and then proceed to develop a program in an orderly fashion and gear up for the program, develop the administrative structure to run the program, and then go into the program, but start with what is the minimum requirement, rather than the maximum requirement.

In effect, we might say that New York now has a 1975 program. Our advice to the States has been to start with a program which they can handle and have enough planning to be ready to develop a program similar to the one that was started today in Virginia which they have been about 2½ years getting ready for it and it just went into effect as of today.

Senator BYRD. Then you would not recommend that other States adopt the New York law?

Dr. LAND. No, sir.

Mr. VENEMAN. Senator, I think there is one factor that when a State implements title XIX, and Dr. Land can correct me because this goes back a few years in memory, I think one of the requirements was that a State could not reduce the scope of services below what they had at the time that they implemented the title XIX amendments.

So, if a State was providing psychiatric care or was providing many of these other medical services, they have to continue.

Am I correct?

Dr. LAND. That is correct.

Senator BYRD. But you agree with Dr. Land, Mr. Veneman, that New York has proceeded too rapidly and you would not recommend——

Mr. VENEMAN. I would absolutely not recommend it. New York got in over their head right from the beginning. I think they set their income eligibility standard at about $6,000 which, you know, is just almost unrealistic.

Senator BYRD. I assume that is one reason why Governor Rockefeller wants the Federal Government to take over the welfare program, and I will not ask you to answer that.

POSSIBLE CHANGES IN MEDICAID REIMBURSEMENT

But, Mr. Kelly mentioning that the States have taken a more conservative attitude, and in that respect, Mr. Secretary, are you considering any changes in the present regulation which requires, which regulation now requires the hospitals under the medicaid program be reimbursed under the same formula as applies to medicare?

Mr. VENEMAN. I believe that—well, I think maybe Dr. Land will have to answer this. I think our reimbursement schedule is essentially the same as the medicare reimbursement schedule at the present time.

Senator BYRD. It is the same now, but do you plan to recommend any changes in that?

Mr. VENEMAN. Well, we recommended the one change that eliminated the 2 percent. I know of no other that is being contemplated at the present time, Senator. Mr. Ball may wish to add something.

Mr. BALL. I might mention at this point that the statute requires that hospitals be reimbursed on the basis of cost in the medicaid program, and it also says "cost" in the medicare program.

Senator BYRD. Now, you mention in the statute—would you indicate where in the statute or legislative history that you find that?

Mr. BALL. Where it says "cost" in both instances?

Senator BYRD. Where in the medicaid statute or legislation history you find references to payments to hospitals required to be the same as under medicare.

Mr. BALL. No, Senator: I did not mean to say that. What I was saying was that the statute requires reimbursement of hospitals in medicaid on the basis of costs and it also requires in the medicare statute reimbursement of hospitals on the basis of cost. It seemed logical if words are used more than once in the same statute to interpret them the same, but the statute itself does not say they have——

Senator BYRD. Well, that is what I wanted to get clear, the statute does not say it?

Mr. BALL. It does not say it has to be the same, it says they both have to be on the basis of cost.

Senator BYRD. Now, the Governors have recommended that the Federal Government, the Governors of the individual States have recommended that the Federal Government help hold down rising hospital costs by abandoning the mandated cost-plus formula now used in the medicaid and medicare payments and any provisions relating to nursing homes.

Is there any—does the Department plan to make any changes in that?

Mr. BALL. Senator Byrd, when they speak of a cost-plus formula, I believe they must be referring to that 2 percent which has been eliminated. I do not personally accept that description of it, but I am sure that is what they are referring to. In other words, that 2 percent is what some people refer to as the plus.

Mr. KELLY. There is some work that we are doing that really relates to making many more of the programs more comparable, Senator Byrd. We are working in the State of Massachusetts on an experimental plan to see if we can develop with the State hospital association and with the State insurance carriers, both Blue Cross and Blue Shield and several of the insurance companies with the State of Massachusetts one cost report that would satisfy the requirements of all users and one audit of that cost report that would validate the accuracy of it so that the hospitals and the providers were not faced with the problem of preparing different kinds of cost analyses for different third-party payers and having different auditors coming in to validate whether or not they were accurate statements.

Senator BYRD. Well, speaking of different auditors, I want to mention a hospital in Virginia that I happen to know about. It is audited and the hospital pays for the audit, and then the medicare program

requires another audit and it is audited by the same accountant and the medicare people pay the same accountant to reaudit what he has already audited. I do not say you ought not do it, but I just bring that out since you have mentioned auditing.

Mr. KELLY. Our purpose is to avoid that.

Senator BYRD. Your purpose is to avoid that?

Mr. KELLY. Yes, sir.

Senator BYRD. I see.

Mr. VENEMAN. Senator, I think I can clarify one of your questions. The statute does require that the State plan provide, and if I am incorrect, Dr. Land can correct me, for payment of the reasonable costs, as determined in accordance with standards approved by the Secretary, of in-patient hospital services provided under the plan.

Now, that does not apply to nursing homes and, therefore, I said in my earlier response to Senator Curtis, I believe it was, when he raised the question about nursing-home rates under medicaid, these rates are variable depending upon the maximum range established by the States.

But, in-patient hospital care must be reimbursed on reasonable costs.

Senator BYRD. I see. Thank you, sir.

Now, Dr. Land, in an interview with Medical Economics magazine you were reported as saying that the only logical way to pay doctors under medicaid is on the basis of "usual and customary charges," a basis that is more generous than the medicare formula.

Now, is that the policy of the Department?

Dr. LAND. No, sir; and I do not think that is an exact quote.

What I was trying to say in that article was that because of the law under title 18 requiring that a payment of usual and customary charges to physicians, that it had caused a great deal of pressure on title 19 and many of the State agencies had complained that because of the requirement under title 18, therefore, they were under great pressure to do the same thing under title 19, and in order to urge that we have the proper number of physicians participating in the program so that the recipients could receive care, then it was an urging on my part that we try to approach as closely as possible those fees that were being paid under the title 18 provision, but not above it.

REPORTING MEDICARE PAYMENTS TO THE INTERNAL REVENUE SERVICE

Senator BYRD. Now, this next question, Mr. Secretary, is a matter of trying to ascertain the philosophy of the Department.

Now, every company and every bank in the United States when it pays a dividend in excess of $10 is required to report that fact to the Internal Revenue Service, and IRS will be here tomorrow, and I thought it would be well if we could have an expression from the Department, and my question is this: in your judgment, it is logical or appropriate that insurance carriers should be exempt from reporting hundreds of dollars and in some cases thousands of dollars paid in fees to various individuals?

Mr. VENEMAN. We have indicated earlier today in testimony, Senator Byrd, that there would be no objection as far as HEW is concerned to a provision which would require submission of payments by carriers or by providers to IRS.

Senator BYRD. In other words, your views that if IRS required the carriers to do as the companies and banks are now required to do in regard to dividends that would be satisfactory with HEW?

Mr. VENEMAN. We would have no objection.

Senator BYRD. You would have no objection.

Now, one final question, Mr. Secretary, and this is a very brief question, and you will not have to answer now, but if one of your associates wouldn't mind taking the stand——

Mr. VENEMAN. Why do we not all take it down and see how many answers we come up with?

Senator BYRD. Now, this is a little bit beside the exact matter we are speaking of today, but I have had some difficulty in getting facts from your Department so I thought maybe this might be a good opportunity to ask you if you would be so kind as to look into it for me.

CLOSING OF CHARLOTTESVILLE OFFICE OF HEALTH, EDUCATION, AND WELFARE

Now, on March 27 I communicated with the Secretary in regard to this matter, and he very kindly and nicely replied on May 19 saying that the information was not available but it was being compiled, and this is July, so I assume it is probably available, and the question is this: in regard to the closing of the Charlottesville office of Health, Education, and Welfare and moving that office to Philadelphia—now, I do not in any way condemn that being done, I ask a question. All I want is some facts, and my question is this: will the proposed move result in a saving to the Government, question No. 1.

Question No. 2: If so, how much, and in what areas will the savings accrue?

Now, I have been trying to get an answer to that question since March 27, and I would be very gratified if the gentleman from California could get that answer.

Mr. VENEMAN. I am sure Mr. Kelly would be most happy to respond.

Senator BYRD. Thank you very much, Mr. Chairman.

STAFF STUDY OF MEDICARE AND MEDICAID

The CHAIRMAN. Thank you.

The staff will give you a copy of the questions that they have been sending out so that you can see what we are talking about and what the staff approach has been. I would suggest, Mr. Secretary, that you and Commissioner Ball take a look at that. This is how our staff has been proceeding. We asked you to provide us with the names of doctors who were paid more than $25,000 in 1968. You provided us with information from those carriers who could provide it, but many of them could not and they provided us only with identification numbers. These are not social security numbers in most instances, but various physician identification numbers for 5,000 doctors. We also asked for certain basic, certain very simple information about those doctors which then gave us a basis upon which to ask for additional information on 1,181 of the 5,000. We came across the sort of thing that would make us ask further questions.

For example, look at page 2 of the report on this particular doctor I showed you which we asked the carrier to provide.

On page 2 is the profile of medicare reimbursement. It shows, total allowed charges $95,942.49; number of patients, 201.

Now, right off that set us to wondering how this fellow could justify charging $95,000 for 201 medicare patients.

Then we asked for a further breakdown and you go on down to nursing-home visits, $22,605 in payments; number of patients, 54: number of visits, 4,560.

That volume of visits immediately makes you suspicious that either the doctor owns that nursing home or he has a sweetheart to deal with. Then you come down to item No. 8, injectable drugs, and under A, injection only, you look at that, $42,293.05 for injections to 149 patients.

Now, that is a lot of injections.

That is 149 people. Number of services, I assume the number of times he gave injections, 8,275. Well, now, right off, that makes us suspicious of that particular situation.

Mr. VENEMAN. Senator, I have one question. I am not familiar with the name of the town, but what is the population in that community?

The CHAIRMAN. That is a small community. I am very familiar with it. I am not going to identify that doctor for the very simple reason that I think somebody ought to look into it and go by and pay him a call and see what this deal is all about.

May I say, he might get an injection while he is there!

Mr. BALL. Senator, as you know, the staff of the Social Security Administration, worked with the staff of the Senate Finance Committee in designing this questionaire to flush up this kind of information, and it looks to me like they are doing a good job.

The CHAIRMAN. Well, mind you, we have uncovered a lot with just three people. You have 50,000 of them over there. I would not want you to show the diligence with your 50,000 that we show with our three, because we would have an awful lot of complaints from the doctors and the nursing homes and everybody else. But, these carriers, mind you now, Mr. Secretary, every one of these carriers ought to be able to provide you with that information, and most of them cannot do it. We have got it from some, and others cannot provide it.

Now, here is another form filled out on the same basis.

Nursing-home visits reimbursed $25,666.55. He wanted to make sure that this was not an even figure. The number of patients, 110; number of visits, 4,844.

That would immediately make you wonder why all of those nursing-home visits, particularly in view of the fact that we paid him a total of $32,449.49.

Then you go back to the back part of the form, in remarks, and here the carrier says, "Because no definitive response was received from the Bureau of Health Insurance with regard to this inquiry, Dr. K's claims were returned to be processed for payment June 6, 1968."

That ought to put you on notice. This does not look right to the carrier. Somebody in Social Security ought to be moving on that. You ought to find out what the thing is all about.

Here is another doctor.

Now, this fellow, I suppose, is doing business with Dr. K. because he had a similar situation. In this case he had $14,765 paid for nursing-home visits to 102 patients. A lot of money there for 102 people. It is $140 per patient for nursing-home visits. On the form it says, "no reply was received from the Bureau of Health Insurance relative to inquiry regarding Dr. K's claim. Dr. D's claims were also returned for processing." They referred these to your people, and apparently they got no response about that.

Possibly these two doctors are working together. It looks like gang visits to us, where they have a nursing home and they just kind of walk through and say "hello" to all of the patients and ask them how they are feeling and bill each one for $8 or $10 as the case may be. It looks to us like a situation which should be examined.

Our staff then proceeded then to ask you, Dr. Land, and your people, to provide us with the names and amounts paid to people who were getting large payments under medicaid. I am not going to put those lists from Louisiana in the record because these are very prominent people in Louisiana. I know some of them. Some of them have been very good supporters of mine.

But I am pleased to say that there are only ten of them from Louisiana. I notice that out of the ten, four come from two small communities. One is in the largest community—perhaps the county seat of that particular parish, but there are four of them in one county, four in two small cities. Let us see. About the biggest you could find here is one fellow, and if I do say so, he provides service, no doubt about that. I notice $46,000 under title 19 and then $38,000 under title 18 and that works out to that one fellow collecting $84,000 from medicare and medicaid. That is just a lot of money to be collecting off of these old and poor people.

Mr. VENEMAN. Is that a single practitioner, Senator?

The CHAIRMAN. Unless he is in partners with this other fellow from the same city. I am informed that they are both single practitioners in the same town, but apparently one of them found out how the other one was doing business because I note that they both come in with high payments. This other doctor received $46,000 and $12,000 so he got $58,000 out of the two programs.

You might think that some of us folks in Louisiana have really found a way to charge high against medicaid and medicare, but if you think we are high you ought to take a look at Oklahoma.

The same type of inquiry directed toward Oklahoma comes in with 69 doctors in these cross comparisons, and look at some of their 69. About the highest we could get in Louisiana was $84,000. Some of these fellows in Oklahoma are collecting over $100,000 each. Some of these people are coming in with almost $100,000 apiece in small towns that I never heard of out in Oklahoma, and I have been around in Oklahoma and I know something about that State.

Now, these would all justify somebody taking a look at the situation and seeing just what justification there was for these payments.

May I say, Oklahoma comes in with more doctors, apparently, that meet the high-fee test than does the State of Texas, and Texas has a way of going first class on things, as you know.

But if I do say it, while it is true that Oklahoma manages to show up

with more doctors charging high fees, Texas, qualitywise has them beat.

Turning to some of the high payments in Texas.

How about this fellow in a little town.

Well, this doctor got $52,000 under title 19 and $97,000 under title 18—medicare. Apparently, qualitywise, he has got them all beat. Some of these are clinics, so some of them would include more than one doctor. It would seem to me that the two agencies, Mr. Veneman, and after all, both of them work under your direction, it seems to me that the two agencies ought to get together and compare notes on these payments. And that identification number at the top should be the social security number.

Mr. VENEMAN. Senator, let me just reemphasize what I pointed out this morning, that the responsibility for the administration and investigation under title 19 is up to the State. I think I mentioned the total staff. We have 100 people now working in the Medical Services Administration in this field, and we are asking for 150 more. We would catch this guy. The State and the intermediary has to get to these people. That is where we have to have the controls.

And I mentioned also that in California we had two investigators for the State of California.

The CHAIRMAN. Well, I used to be with the State government and we did a lot of things—some good and some bad—because we were told by Washington that we had to do that. It seems to me that you have the power to say, "all right, now, this must be done; you must take a look at this situation". Then I would hope, Mr. Secretary, that by the time we get through with all of this investigating your shop would have all of this information so you could look and run right on down through and see who was getting a great deal of money.

Senator WILLIAMS. Would the Senator yield at that point?

The CHAIRMAN. Yes.

Senator WILLIAMS. While you are looking these over you may be interested in payments in another area in another State, Dade County in Florida.

The first doctor drew $277,378.66; the second one $178,258.27; the third one $154,890.31; the fourth one $137,864.64; the next one $112,349.37; and the last one $102,771.16. It is a healthy area in which to live, and people there must be getting a lot of medical attention.

Mr. VENEMAN. Senator, I am not sure that is even the total figure. Is that just title 18 you are talking about?

Senators WILLIAMS. That is correct. We have not been able to get the other figures. We have asked for that, which might bring the total up to a reasonable living allowance.

Mr. VENEMAN. Even in Florida.

Senator WILLIAMS. Yes. I have the names of the doctors here if you are interested in them.

The CHAIRMAN. Now, I am satisfied that a lot of this can be worked out and I am sure that you are feeling growing pains that will subside in considerable degree as you have more experience with the programs, just as Commissioner Ball has stated. Some of this

can be worked out best while the top pressure is on you, where you don't have to be the mean fellow who insists on everybody's cost and everybody's expenses being right and disallowing things. A good time to do it is when Congress is raising the very devil with you about the matter and what must be done. In my home State, for example, in New Orleans where I lived for a while, is the Ochsner Foundation Hospital, one of the finest hospitals in the country, would you not agree with that?

Mr. BALL. Oh, yes; yes, indeed, Senator. That is a point we can certainly wholeheartedly agree with.

The CHAIRMAN. John Williams said you had better agree with that.

What is this HIBAC committee?

Mr. BALL. Health Insurance Benefits Advisory Council.

OCHSNER FOUNDATION HOSPITAL

The CHAIRMAN. The Health Insurance Benefits Advisory Council; all right, now.

One of the best doctors at Ochsner Hospital, one of those who runs it, is on that committee: is he not? Do you recall his name?

Mr. BALL. Dr. Merrill Hines.

The CHAIRMAN. Yes.

Dr. Ochsner, who founded that hospital, used to be one of the chief physicians at New Orleans Charity Hospital.

Now, the per patient stay at Charity greatly exceeds the average number of days at Ochsner. Mind you, at Charity you are at Government expense, and at Ochsner you pay for it whether under medicaid, medicare, or whatever. Notwithstanding all of that, they will not let you stay at Ochsner nearly as long as you stay at Charity. It seems to me that somebody like Dr. Ochsner, who served for a long time at Charity before he founded his own hospital, as well as Dr. Hines, who has helped to do much of the work, ought to be able to show you how you could find some way of getting the same kind of proper utilization you find at Ochsner.

At Ochsner, their board is very strict about who can be admitted. My understanding, for example, is that you cannot get a bed at Ochsner for a checkup. You can rent a hotel room somewhere nearby and you can go to the clinic and they will run tests on you, but then you go back where you came from; you just cannot have a bed at Ochsner for that purpose.

The patient-days might not show up accurately for comparison, because they perform so many serious operations. For example, they will remove more cancerous larynxes than they do tonsilectomies in that hospital. It might look like they have long patient stays until you analyze by diagnosis. If you look at what they are doing for people there, their utilization committee is enormously efficient and they are very tough about putting you out of there the moment that you are able to take care of yourself.

They are also very tough about who they will take. Most people would prefer to go to Ochsner rather than Charity—the Government is going to pay for it in either event—so they have adopted a policy that within a 50-mile area of New Orleans you cannot go into Ochsner unless you meet one of two criteria. Either you have to have an unusual case or else you would have to have been one of their patients previously to go in there under medicare or medicaid because they cannot take all of the medicaid and medicare people who would like to go in there.

UNIFORM FEE SCHEDULE

They use a uniform fee schedule. I think it is the hospital where Clint Murchison passed away—and don't blame the hospital—he lived a very long and useful life. They charged him the same standard fees, charged Clint Murchison the same thing they charge medicare or medicaid patients. I understand that more and more better hospitals are coming to that uniform fee schedule practice. Is that correct?

Mr. BALL. I believe so, Senator. Yes. I think that is the public charge that applies to everyone for accommodations they have.

The CHAIRMAN. The better hospitals are moving toward a practice so that, whether you are a workingman who can ill afford to pay, or whether you are a millionaire, they will still charge the same fee for an operation, and by doing that, then proceed to charge the medicare and medicaid on exactly the same basis.

Ochsner does it that way.

Mr. BALL. Yes. The only thing I am hesitating about is the distinction between paying for an operation, which is a part B provision, where you may get quite a lot of variation from one fee to another as against hospital charges. I was not quarreling with you on the hospital charges. The usual practice is to pay the same whatever the charge is at the hospital for a private room or semiprivate and so on, without regard to your income, but I believe, too, that even in the area of fee services there is much less varying of charge by income than there used to be.

The CHAIRMAN. And actually it would seem to me that it would ease your burden as the hospitals moved toward that procedure, whereby the charge to everybody was the same.

It was one thing back in the days when you did not charge the poor man who could not pay, and tried to make it back on the rich man who could. But if you want to protect the fee system, it seems best that we get it down to a similar basis for the same operation, where everybody pays the same. That way, if somebody needs some help, we would either provide it at the State level or the Federal level without worrying about whether the State was paying for it or the man was paying for it himself, and whether he is rich or poor. That being the case, we can then talk about realistic fees and stop all this flimflam about giving some services away and instead just talk about what a fair fee would be.

Mr. BALL. Yes.

The CHAIRMAN. I think if you check those hospitals, I think you will find that they have the finest doctors in America, and by the time they get through, the doctors earn about $9,000 a year. They keep their operating rooms fully busy and try to see that they keep every room they have got filled. But they do not put people in and keep people longer just because they have empty beds. If they have empty beds, they still discharge patients because they see no point in keeping people in a hospital any longer than necessary.

I have read where the American Medical Association has come out against doctors overcharging for laboratory work which they do not do themselves. For example, laboratory tests may cost him 50 cents apiece and the doctor may ask a $5 fee and tack it on in addition to the regular fee.

Now, with the support of the American Medical Association, would you find any difficulty in writing a regulation or something to say that you cannot charge more than 50 cents under medicaid and medicare if that is all it will cost you to have that laboratory work done?

Mr. BALL. Well, Mr. Chairman, we have already done that in the medicare program.

In one of the recent changes that we have made—and this is either in the December or the February series of actions—we undertook to direct the carriers to hold down generally recognition of fee increases, and certain other things. One of them was to say that the reasonable charge for a laboratory service that was not performed by the doctor but by someone else for him should be based upon that laboratory charge to him, and that the doctors markup on that ought to be very slight indeed.

The CHAIRMAN. All right.

I want to make it clear again to all of you in the Department that while it may sound as though we have spent our time throwing darts at the doctors, this just happens to be one area that strikes the eye. It does appear to me that over-all savings in the program will be greater in other areas if we can do a good job in administering this program with respect to hospitals and nursing homes.

As much as I would want to honor and respect the medical fraternity, there have been some abuses that are just striking and they should be corrected. But I really do think that the biggest savings in this program is going to come in better utilization and in fair billing and fair charging for what hospitals and nursing homes provide.

Mr. BALL. I agree with you completely, sir.

Senator WILLIAMS. Mr. Chairman, I know the hour is late, and I have just one question. But first in connection with Senator Long's inquiry to you concerning the IIIBAC committee; if I understand correctly, one of the members of that committee was found to be engaging in questionable practices himself, and I understand is under indictment now.

Has he been removed and replaced?

Mr. BALL. He was removed and his services on the committee were terminated. I have forgotten the exact date, but it was 2 or 3 years

ago, Senator. He was on the original group. That case is with the U.S. attorney.

Senator WILLIAMS. Yes. I notice that he showed up on this list that we had. I was just wondering, and wanted to be sure.

Now, I want to ask this one question, and I will not ask it as a question now, but I would like to have this information, and perhaps you would supply it to us tomorrow.

The CHAIRMAN. If I could just interrupt, I thought Mr. Ball was going to add something to his answer.

Mr. BALL. I merely wanted to take the opportunity, Senator, to say that the Health Insurance Benefit Advisory Council, as a whole, has been an extremely capable and very helpful organization in the program, and it has very high-quality membership. I would not want that one incident to cast a reflection on the group as a whole, and I am sure you did not want to.

Senator WILLIAMS. No, not at all; not at all. I agree with you completely about the high caliber of the men, and an incident such as that can happen, but I just wanted to make sure that it was taken care of, because it would be embarrassing.

Mr. BALL. Yes, sir.

Senator WILLIAMS. Now, I would like for you to bring with you in the morning a list showing all of the funds that have been paid to each of the carriers or intermediaries and to the subcontractors for administration expenses for each of the last 3 years, and that is to cover from the time of the beginning of the program. I think there was some payment or arrangement made in the initial stages before the effective date of the program.

Could you get all of those lists for us and have them for us tomorrow?

Mr. TIERNEY. Senator, could that be late tomorrow?

Senator WILLIAMS. Well, if that would be better, yes.

Mr. TIERNEY. I am sure that we can, Senator.

(The material referred to follows:)

ADMINISTRATIVE COSTS OF PART A INTERMEDIARIES, FISCAL YEARS 1967 AND 1968, AND FIRST 9 MONTHS OF FISCAL YEAR 1969

Intermediary	Fiscal year 1967	Fiscal year 1968	1st 9 months, fiscal year 1969
BLUE CROSS			
Birmingham, Ala	$279,162	$750,145	$578,053
Phoenix, Ariz	211,779	438,959	340,434
Little Rock, Ark	277,208	465,171	359,579
Los Angeles, Calif	1,424,626	2,233,600	2,695,392
Oakland, Calif	630,047	1,350,000	1,593,801
Denver, Colo	469,672	841,666	783,440
New Haven, Conn	227,435	328,726	279,215
Wilmington, Del	160,300	258,921	141,779
Washington, D.C	238,153	400,730	362,976
Jacksonville, Fla	941,838	1,553,109	1,379,708
Atlanta, Ga	162,095	263,347	230,020
Columbus, Ga	262,596	579,873	504,244
Rockford, Ill	34,854	53,974	46,282
Boise, Idaho	122,941	241,717	296,533
Chicago, Ill	1,633,131	2,916,900	3,347,282
Indianapolis, Ind	727,305	1,195,773	1,038,602
Des Moines, Iowa	406,417	533,770	484,607
Sioux City, Iowa	160,258	226,615	362,712
Topeka, Kans	313,190	501,693	401,930
Louisville, Ky	490,320	958,770	868,406

ADMINISTRATIVE COSTS OF PART A INTERMEDIARIES, FISCAL YEARS 1967 AND 1968, AND FIRST 9 MONTHS OF FISCAL YEAR 1969—Continued

Intermediary	Fiscal year 1967	Fiscal year 1968	1st 9 months, fiscal year 1969
BLUE CROSS—Continued			
Baton Rouge, La	$274,696	$500,092	$528,759
New Orelans, La	154,805	312,535	325,754
Portland, Maine	139,374	254,821	195,341
Baltimore, Md	527,300	811,700	743,600
Boston, Mass	1,460,284	2,312,254	2,350,000
Detroit, Mich	976,203	1,354,571	1,746,882
St. Paul, Minn	744,306	1,243,452	1,172,080
Jackson, Miss	164,181	296,668	355,206
Kansas City, Mo	302,260	515,418	447,725
St. Louis, Mo	478,182	882,474	1,007,467
Great Falls, Mont	115,858	245,967	200,839
Omaha, Nebr	182,694	328,043	271,363
Concord, N.H	233,143	412,397	366,830
Newark, N.J	767,145	1,595,100	1,254,600
Albuquerque, N. Mex	107,375	214,095	222,192
Albany, N.Y	171,070	318,992	288,837
Buffalo, N.Y	311,697	532,136	497,395
Jamestown, N.Y	33,728	40,920	45,737
New York City, N.Y	1,551,304	2,657,909	2,796,544
Rochester, N.Y	168,750	265,044	282,842
Syracuse, N.Y	152,308	270,596	238,289
Utica, N.Y	121,675	180,001	156,937
Watertown, N.Y	22,053	23,204	18,669
Chapel Hill, N.C	571,472	1,096,478	1,106,015
Fargo, N. Dak	109,575	223,163	202,945
Canton, Ohio	73,793	135,000	102,173
Cincinnati, Ohio	435,117	727,847	530,966
Cleveland, Ohio	346,093	699,918	591,735
Columbus, Ohio	239,097	333,777	317,131
Lima, Ohio	42,887	66,107	50,763
Toledo, Ohio	132,020	204,732	163,220
Youngstown, Ohio	114,478	166,150	168,308
Tulsa, Okla	376,379	608,683	784,779
Portland, Oreg	340,855	594,635	565,471
Allentown, Pa	73,108	109,195	86,954
Harrisburg, Pa	210,500	384,040	369,882
Philadelphia, Pa	320,162	601,268	528,799
Pittsburgh, Pa	684,620	1,118,083	996,578
Wilkes-Barre, Pa	157,448	225,586	198,898
Providence, R.I	209,756	360,417	324,511
Columbia, S.C	329,828	493,184	534,962
Chattanooga, Tenn	443,703	958,370	900,745
Memphis, Tenn	156,548	288,690	292,487
Dallas, Tex	1,696,516	2,460,203	1,848,920
Salt Lake City, Utah	104,202	193,636	188,589
Richmond, Va	461,809	611,021	641,500
Roanoke, Va	61,415	111,091	124,671
Seattle, Wash	384,510	528,708	517,486
Charleston, W. Va	149,167	274,036	192,601
Parkersburg, W. Va	48,661	71,227	61,997
Wheeling, W. Va	264,286	269,464	203,102
Milwaukee, Wis	786,796	1,063,399	950,000
Cheyenne, Wyo	57,944	119,146	70,756
San Juan, P.R	69,182	97,628	98,545
Blue Cross Association	1,314,016	1,875,557	2,186,350
Total Blue Cross	29,099,661	48,732,887	47,510,062
COMMERCIALS			
Aetna Life	744,412	1,459,480	1,319,717
Community Health	11,432	15,898	14,324
Cooperativa, Puerto Rico	37,492	39,297	47,064
Hamilton Life	93,093	127,409	
Hawaii Medical	67,113	127,484	84,280
Inter-County	375,626	580,316	505,587
Kaiser	93,637	134,260	82,173
Mutual of Omaha	627,890	1,227,400	1,768,700
Nationwide	236,442	301,570	265,906
New York Department of Health	92,707	134,095	136,964
Prudential	488,429	673,390	714,230
The Travelers	1,133,803	1,894,477	2,037,390
Total commercials	4,002,076	6,715,076	6,976,335
Total part A	33,101,737	55,447,963	54,486,397

ADMINISTRATIVE COSTS OF PART B CARRIERS, FISCAL YEARS 1967 AND 1968 AND FIRST 9 MONTHS OF FISCAL YEAR 1969

Carrier	Fiscal year 1967	Fiscal year 1968	1st 9 months, fiscal year 1969
BLUE SHIELD			
Birmingham, Ala	$490,012	$855,643	$744,994
Little Rock, Ark	451,064	576,105	492,628
San Francisco, Calif	4,968,429	8,431,615	8,715,991
Denver, Colo	827,907	1,443,173	1,249,892
Wilmington, Del	167,900	391,761	288,762
Washington, D.C	574,389	919,381	811,518
Jacksonville, Fla	1,943,555	4,491,934	3,927,375
Chicago, Ill	1,587,077	2,859,000	2,810,543
Indianapolis, Ind	1,012,955	1,725,525	1,456,255
Des Moines, Iowa	813,529	1,495,721	1,234,791
Topeka, Kans	513,544	845,491	1,079,545
Baltimore, Md	550,200	1,124,000	982,300
Boston, Mass	1,922,959	3,699,730	3,152,200
Detroit, Mich	2,366,194	3,782,419	3,282,654
Minneapolis, Minn	530,582	814,342	551,551
Kansas City, Mo	524,555	1,079,205	934,834
Helena, Mont	229,539	340,100	285,000
Concord, N.H	324,542	727,112	831,796
Buffalo, N.Y	491,628	1,002,989	775,130
New York, N.Y	4,359,737	7,568,909	6,641,609
Rochester, N.Y	333,215	495,604	454,157
Fargo, N. Dak	217,044	323,404	245,827
Cleveland, Ohio	530,222	974,345	762,986
Camp Hill, Pa	2,381,192	4,058,600	3,999,900
Hato Rey, P.R	161,230	240,522	248,507
Providence, R.I	341,482	523,543	454,702
Columbia, S.C	368,019	493,669	477,748
Sioux Falls, S. Dak	173,253	277,148	263,974
Dallas, Tex	2,685,433	5,361,041	4,109,001
Salt Lake City, Utah	185,464	310,597	309,598
Seattle, Wash	1,559,516	2,154,240	1,742,761
Madison, Wis	834,971	1,527,431	1,193,153
Milwaukee, Wis	393,600	702,531	525,119
Total Blue Shield	34,806,888	61,716,830	55,036,301
COMMERCIALS			
Aetna Life	2,196,504	3,126,026	2,240,789
Connecticut General	763,520	1,145,444	901,494
Continental Casualty	1,269,494	1,517,232	1,279,047
Equitable Life	1,528,748	1,953,700	1,683,500
General American	808,563	1,458,683	1,415,687
Group Health Insurance	912,315	1,427,246	1,198,619
John Hancock	1,147,591	1,964,980	1,342,929
Metropolitan Life	2,117,369	3,119,727	2,547,164
Mutual of Omaha	477,173	657,900	583,200
Nationwide Mutual	2,473,501	3,525,089	2,980,323
Occidental Life	3,174,019	4,480,405	4,140,943
Pan American Life	805,449	1,364,332	1,272,534
Pilot Life	819,025	1,279,368	1,419,078
Prudential	1,983,094	2,964,780	2,576,370
The Travelers	2,045,995	2,416,272	1,815,260
Union Mutual	402,348	527,941	390,787
Oklahoma Department of Public Welfare		620,894	485,790
Nebraska State	43,628		
Total commercials	22,968,336	33,550,019	28,273,514
Travelers (RRB)	2,836,069	4,179,310	3,339,585
Total Blue Shield	34,806,886	61,716,830	55,036,301
Total part B	60,611,293	99,446,159	86,649,400

THE HIBAC COMMITTEE

The CHAIRMAN. Would you let me ask one more thing about the HIBAC committee? Is that a utilization committee, or is it broader than that?

Mr. BALL. It is very broad, Senator. Originally, the statute provided for two committees. In the 1967 amendment, you combined them. Originally you had a separate provision, a separate committee for utiliza-

tion. Now, that function is a HIBAC function, but they have a broader function of examining all of the policies in the program. They pass on policy and regulations. I do not mean that the Secretary is directed by them, but they advise him on all proposed regulations. It is a group that has looked into all parts of the medicare program. I commend to you the annual report that they have submitted to the Congress. They have made several very constructive suggestions in administration and in legislation, and it is a very comprehensive report on the operation of the program.

NEED FOR CAREFUL REVIEW OF UTILIZATION BY STATES

The CHAIRMAN. It seems to me that you ought to have a committee just on utilization and put somebody as the chairman of that committee who knows how to run a tight ship and then see if you cannot put some people on that committee who have similar reputations, with the understanding that the man who runs the most efficient hospital will be the one who calls the signals on that committee. When you do that I think you might get the same kind of performance out of some of these other hospitals that you are getting out of the best hospitals in the country.

Mr. VENEMAN. This is exactly what we anticipate in this short-term committee that I referred to this morning. They would look into the utilization procedures in title XIX. We have already said that the State plan has to incorporate a utilization procedure, as well as review of charges and other features of the program, but I do not think we can have an effective utilization review committee in Washington. We are going to have to have it broken down so that the States have good utilization review procedures, and even down to the localities, because it would be virtually impossible to handle the 30 or 40 million claims that originate nationally. But you can do it on a regional, State, and local basis.

The CHAIRMAN. Yes; but it seems to me, though, that you after all come here from the State of California where you have had a lot of contact with the California welfare program but now you are doing business with 50 States. It seems to me that you ought to have competence, and after all, some of the best people in HEW were trained in State government, or at least have had State government experience and do business with State Government, and you ought to have a little task force in your shop somewhere that can go into any State where they have fouled up and take them by the hand and get matters straightened out. They could sit down with them, and take each one of them by the hand and say, here is how you should do this, and here is how you should run that.

Mr. VENEMAN. Yes; this is exactly what we anticipate doing.

The CHAIRMAN. For example, we started out in the unemployment insurance program with our program modeled after the Wisconsin statute. It looked like Wisconsin was doing the best job, and we brought someone from Wisconsin who could suggest how to run the unemployment insurance program, and they patterned the program after that. It seems to me that you ought to get yourself a group so that when a State program seems not to be going right, you could

send somebody down to sit with them, and suggest how they might improve.

Mr. VENEMAN. That is exactly what the States need; and you see what happened with this program that was adopted in late 1965 to become effective in January 1966, and to have all of the States in the program by 1970, and we had 35 people working on the whole program. You know, the States got themselves into programs without any counsel from us except a lot of correspondence going back and forth, and if you would read through some of that you would need a staff in itself to interpret it, but nobody was available for technical assistance.

We would hope that we would have that available plus the guidelines in the basic criteria for establishment and utilization and review and development by this group.

The CHAIRMAN. Now, Secretary Veneman, frankly, I have had some thoughts about putting something in the law. We are saying that here is something that the States ought to do, and if this is the right way to do this thing, it seems to us that you could insist they do something properly, and if the State thinks that is wrong, you could reduce the matching formula and that State would be digging itself into a deeper and deeper hole, paying more and more for less and less. But when we do that I think that you ought to have people available who could go to that State and say, "look, old friend, if you do not start straightening things up and handling your program better it is going to cost you a lot of money, and here is how we think it could be done," otherwise——

Mr. VENEMAN. We found ourselves in this position two or three times. We sent a task force or small group of people in where a system——

The CHAIRMAN. Well, oftentimes after Governors are elected they appoint some fellow who was a prime campaign supporter to be the welfare man. While he might be the best campaign orator, that fellow has no experience in what he is supposed to do at all. Then the Governor appoints some people to the welfare board—he wants to honor this prominent man here or that prominent man there—and the ignorance on the board exceeds the competence. Then that fellow goes and picks a few other people that he kind of likes in the department, and the next thing you know some other fellow who has great competence gets disgusted and quits, and then they are short on know-how.

If States are ever going to get straightened out, especially with a new program, someone is going to have to show them how. It is fine for a State to sit there and issue press releases blaming Washington, saying nobody can run a program with Washington dictating all of it, but as a practical matter I just think that we ought to have available in Washington, and that means you, a team of experts to go down there and show them how to straighten the program out and how to make it work.

Now, I have been on the other end. We have come from down there up here, and said, "Look, it appears to us you might not want to give us matching funds and you might not want to go along with this, and here is what we want to do, but we regret that sometimes it does not

work out very well because by the time we get back home we have forgotten everything you told us or he has forgotten everything you told him, or he has got it all fouled up."

I think you ought to go to him and say: "Here is how this thing could be run and straightened out, and if you do not straighten it out it is going to cost you something."

ADVISORY GROUPS IN THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Senator WILLIAMS. Mr. Chairman, on this point—I think that we may need this task force. Before we get to expending too much for it, I want to call attention to the fact that the Department of Health, Education, and Welfare testified before the Appropriations Committee that we already have 407 advisory groups in Health, Education, and Welfare advising us at a cost of $7.23 million a year. Maybe you need just one task force to find out what these advisory committees are doing. Maybe we have done here at the national level what the Senator from Louisiana has just described was so often done and is so often done at State levels, and maybe we need to do some housecleaning here.

Mr. Chairman, I would like to insert at this point in the record a table showing the budget for these advisory groups:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—ADVISORY GROUPS

Agency summary	Fiscal year 1969			Fiscal year 1970		
	Number of groups	Gross membership[1]	Cost	Number of groups	Gross membership[1]	Cost
Consumer Protection and Environmental Health Service	48	499	$551,866	60	618	$662,966
Health Services and Mental Health Administration	69	935	1,340,570	72	960	1,355,210
National Institutes of Health	196	2,188	3,838,937	202	2,252	3,688,059
Subtotal, health agencies	313	3,622	5,731,373	334	3,830	5,706,235
Office of Education	21	274	363,000	23	323	652,900
Social and Rehabilitation Service	40	1,227	335,082	41	1,225	479,792
Social Security Administration	5	78	157,835	5	78	196,560
Office of the Secretary	7	107	506,000	4	58	190,000
Total, Department of Health, Education, and Welfare	386	5,308	7,093,290	407	5,514	7,225,487

[1] Some individuals serve on more than 1 group.

The CHAIRMAN. Maybe you could get by without some of those committees. I think that we could get by without a lot of people that we have got on the State payrolls—I should think that we could get by with a lot less—and maybe you could do the same thing.

Mr. VENEMAN. That is the thing that I emphasized this morning, the point this morning we mentioned in connection with this particular group, that it was a short-term group looking at short-term problems with a termination date and it is not going to be another continuing one.

Senator WILLIAMS. I was not questioning that point. I realize that, but the mathematics of your advisory groups could put 500 individuals

at $15,000 a year in full-time salaries as advisers. That is what we have now, and I wonder if we can afford that much advice.

So, I just pass that along.

The CHAIRMAN. No; the kind of thing that I had in mind should not require an increase in budget. I am surprised to know that you have 407 advisory groups. I cannot figure out the 407 groups. I cannot figure it out.

Mr. VENEMAN. I have not been able to figure it out either, Senator.

The CHAIRMAN. It would seem to me that you might be able to find about five people who understand the various programs that you conduct at the State level, who can go and spend a week with a State and can straighten the situation out and show them how to operate effectively.

Frankly, seeing how some of these things get fouled up I would just like to have somebody to call on rather than take the only man we have got and send him down there and straighten them up. I would like for you to have somebody to go down there. But, if you have 407 advisory groups, it seems to me that you ought to consider seeing whether you can cut down on that; I might note that it took 108 pages in hearings to list the names of those groups.

Mr. VENEMAN. I think you have the only compiled list. I would like to see it.

The CHAIRMAN. Well, that is news to me; I did not know that there were 407 advisory groups.

We will meet again at 10 o'clock tomorrow.

Thank you very much, gentlemen.

(Whereupon, at 4:55 p.m., the hearing was recessed to reconvene at 10:00 a.m., Wednesday, July 2, 1969.)

MEDICARE AND MEDICAID

WEDNESDAY, JULY 2, 1969

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to recess, at 10:10 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present Senators Long, Anderson, Gore, Talmadge, Harris, Byrd, Jr., of Virginia, Williams, Bennett, Curtis, Miller, Jordan, and Fannin.

The CHAIRMAN. We will open the hearing this morning with Commissioner Thrower of the Internal Revenue Service to discuss some of the tax problems related to medicare and medicaid.

Mr. Thrower, I think you are familiar with our discussions here yesterday. Is the tax collector able to collect taxes on all the money that is being paid out under medicare and medicaid particularly insofar as these payments are made to doctors? What is your reaction to that situation?

STATEMENT OF RANDOLPH W. THROWER, COMMISSIONER, INTERNAL REVENUE SERVICE; ACCOMPANIED BY WILLIAM H. SMITH, DEPUTY COMMISSIONER AND JOHN S. NOLAN, DEPUTY ASSISTANT SECRETARY FOR TAX POLICY

Mr. THROWER. Well, Mr. Chairman, let me say we appreciate very much having word yesterday of the opportunity to appear here before you. We are very much interested in having this information in usable form. W have been in communication with the other interested agencies, and we believe that accords are being worked out where we can get it in the fashion and in the form that will be immediately usable in our automatic data processing system. The Deputy Commissioner, William Smith, has been in communication with others in this respect, and I would like to ask him to review the details for you of the accords being reached at this present time.

REPORTING OF MEDICARE AND MEDICAID PAYMENTS TO PHYSICIANS

Mr. SMITH. Mr. Chairman, we have been looking into this matter for a period of the past 2 years, and we are convinced that we now have an understanding with the officials of the Social Security Administration. We see no systemic problems, no problems of any kind that

32-108—69——12

would interfere with information-reporting by Social Security, by intermediaries, by others who make payments to doctors and people similarly circumstanced.

Indeed I suspect given the state of automation today that there should be no reason why most of this information cannot be supplied to us in magnetic tape mode which would simplify life for everyone concerned, and would make it possible to match the payments with other information being reported to us. If not that, it would at least be usable in the audit process when we select tax returns for examination.

The CHAIRMAN. Well, if we can get that information, we might get the rest of what we would like to know. For example, we have the right to ask to see someone's tax returns up here, and I do not think we will abuse that right. I have tried to protect the rights of citizens not to have their tax returns published unless we find something that looks wrong where we think perhaps it deserves the glare of public exposure. But if there is nothing wrong with the taxpayer's return, we do not care to expose it or make it known. But I do think we are entitled to know what is going on.

With regard to some of these documents I think it is fair to know how much doctors are making to begin with; how much they get from Medicare and Medicaid. It would help us in pursuing an intelligent course.

Now, does this action assure you that insurance companies are going to give you the information as to what they are paying doctors under their private insurance policies?

Mr. SMITH. The change that I understand has been proposed by Senator Williams would certainly provide the basis for that kind of information reporting, too. And certainly that gap would have to be closed in my opinion.

The CHAIRMAN. Some of the insurance carriers indicated to me that they were hopeful that they could get by with settling for reporting of their government payments.

It seems to me that while we are on this issue we might as well go ahead and settle as to whether we are entitled to know the rest of that information. I am sure, Commissioner Thrower, you were a lawyer before you came here, were you not, and you know that the doctor-patient relationship is parallel and similar to the attorney-client relationship. That protects you against telling what you advised your patient or what your client said to you if you were his lawyer, and the same thing applies to a doctor if you are his doctor. I do not think it was ever intended to protect you from telling the tax collector how much money you made out of that relationship. If those people would like to contend that it does, then it seems to me that we could find a way to get at that. But do you see any problem involved as far as confidential relationships between doctor and patient are concerned?

Mr. THROWER. I see none whatsoever. And I think with this Committee's continuing interest we will have no difficulty in getting this information. I think it should be made available to us in usable form. And as I say, I feel with your continuing interest we will soon have it.

The CHAIRMAN. It seems to me that we have a job to do in more

respects than one. We have a job to do in the one instance to see that the old people are not cheated and that people who are paying for health services for those fine old people are not cheated. Then we have a second duty to see to it that people who may have been improperly finding ways through these insurance programs to avoid taxes they owe this Government are prevented from doing so. If we can do both, I think we would be just a little bit more successful than if we only did one.

Mr. THROWER. Well, I would probably want to add that I do not know that we have any basis for making any prejudgment on any broad scale as to whether these earnings have been reported or not. But we do feel strongly that it is appropriate for the information to be available to us in usable form and to be taken into account in our investigations, and we are looking forward to that.

The CHAIRMAN. I am not going to name anybody, even though I might be entitled to an informer's fee if I did, but I know a fellow who graduated the same year I did from law school. He used to keep a cash box in his office. When someone would come in and ask him to notarize a piece of paper and pay him a $5 fee he would just take that fee and put it in his cash box, tap it and say, "That's $5 Uncle Sam won't take away from me."

Doctors may be doing some of that, too. There is not much we can do about that type of thing as far as I know, but I would assume insofar as they are receiving payments from insurance companies we are entitled to that information.

Mr. THROWER. We agree with you certainly.

The CHAIRMAN. Senator Anderson.

Senator ANDERSON. I just want to make sure they do get that information. You say you are finally becoming interested in the matter.

Mr. THROWER. You can rest assured we are interested in having this information in usable form and would expect to use it in the performance of our responsibilities under the Internal Revenue Code.

Senator ANDERSON. Well; I am not a lawyer. What do you mean "in usable form"? Do you have the information or do you not have the information?

Mr. THROWER. Well; to have the information related to social security numbers is much more meaningful than having it without the——

The CHAIRMAN. Previously you had it only by Swiss code number, did you not, about the same thing as that? I mean that previously you had it identified by code numbers which did not identify the man that got the money. In fact, I am informed by our staff that you were not getting it even by way of the Swiss code.

Mr. SMITH. We have not been receiving information returns on this kind of payment, but we have in hand right now information with respect to payments made under Medicare and Medicaid in 1966–67, at least Medicare where the aggregate amount has been in excess of $50,000. We intend to audit the returns of these doctors who have received this money. We have also received information returns that we have in our Detroit data center and we are in the process of aggregating this information now, and we expect to examine these returns which appear to need audit as soon as we possibly can.

CONSCIENCE PAYMENTS BY PHYSICIANS

The CHAIRMAN. You might also get some conscience payments just like HEW has been getting some payments. A story they tell on the Committee is that some fellow wrote in and sent the collector of Internal Revenue a check for $2,500. He said, "Dear Mr. Collector: After having thought about my income tax return, I just cannot sleep at night, so I am sending you a check for $2,500 which I failed to pay. If I still cannot sleep at night, I will send you a check for the rest of it." (Laughter.)

The CHAIRMAN. Go ahead Senator.

INTERNAL REVENUE SERVICE USE OF PAYMENT INFORMATION

Senator ANDERSON. I merely want to know if you are going to make these changes. You can decide can you not?

Mr. THROWER. Upon receiving this information our initial step, as Mr. Smith indicated, would be to pull the returns of those doctors on whom we have information that they received more than $25,000 a year and determine which require examination.

Senator ANDERSON. Do you plan to release that information?

Mr. THROWER. We do not have any plans to release information with respect to the audit.

Mr. SMITH. We could release information to this committee, of course, but in addition to that we could also compile statistical data which might be of some value on a broader basis.

Senator ANDERSON. It would be interesting to know whether a doctor has been paid $90,000. Could you not check that?

Mr. SMITH. Know whether doctors have been paid $90,000?

Senator ANDERSON. We had a doctor in here the other day who had $92,000 in fees. Would that excite you at all?

Mr. SMITH. Yes; it interests us.

Senator ANDERSON. What would you do?

Mr. SMITH. Beg your pardon?

Senator ANDERSON. What would you do?

Mr. SMITH. Well, we would do with that as we would with any information covering payments of this kind. It would be—match it with the information, similar information reported on the doctor's tax return to determine whether or not it had all been reported for tax purposes. Now, Social Security, of course, medicare, and medicaid might have a different interest in payments of that kind. Our interests would be entirely for tax purposes.

Senator ANDERSON. Do you have an interest in each individual case?

Mr. SMITH. In each individual case.

SOCIAL SECURITY ADMINISTRATION RELUCTANCE TO FURNISH INFORMATION TO INTERNAL REVENUE SERVICE

Senator WILLIAMS. Mr. Thrower, prior to this time has the Social Security Administration been making the information readily available to your Department that they are accumulating about payments to these doctors?

Mr. THROWER. I understand not. I think that Mr. Smith can develop the history of that more fully, the background, if you would like. We are sure at the present time that for the future we will have the information.

Senator WILLIAMS. I understand that they have given that assurance for the future, but it was my understanding that heretofore they have refused to turn that information over to your Department, and while they were relaying it to this Committee they questioned the wisdom or the propriety of their turning it over to you. Is that correct?

Mr. THROWER. We have sought it and not gotten it.

Mr. SMITH. The two agencies have debated the matter for the past few years. We knew that it would involve substantial systemic changes for Social Security, in a difficult budgetary period a considerably outlay of money; it would require adjustment in our own procedures. And what we have been doing in the interim is securing information with the cooperation of Social Security that has led, for example, to the accumulation of these 45,000 information documents that we have in Detroit that we propose to use as a basis for selecting doctors tax returns for audit.

Senator WILLIAMS. But if in the future arrangements were made to use the Social Security tax number of the individual, do you think we will solve this problem to a large extent?

Mr. THROWER. To a large extent if we could secure it on tape it would facilitate our utilization of it that much more.

Senator WILLIAMS. Sure; now, the question was made by, I believe Commissioner Ball, that he was not sure that he would have the authority or that he would want to file these with W-2 forms which I suppose means make this information available. Have you worked out any arrangements where this will be furnished to you in that form or will you need legislation, or will they need legislation directing them to make this available to you either on tape or the W-2 form the same as any other employer?

Mr. THROWER. I understand they are prepared to make it available to us. As to the resolution of their legal problems, Mr. Smith will discuss that.

Mr. SMITH. Senator Williams, I believe it would be well to clarify the statute. We have believed for some time that section 6041 provides the legal authority to require information returns from the private carriers and from Social Security. However, there have been lawyers who have debated the other side of this question and who have taken the other point of view. I think it would be well to clarify the statute. I think also that in the process of clarifying the statute, whether it is done as an amendment to 6041 or we add a new section, provision ought to be made for aggregation of these payments, and there ought to be the basis for reporting by the person who was not necessarily the beneficiary but the recipient of the money in the final analysis. In short, a form 1087 procedure, in the same way that we use a form 1087 for dividend reporting today where nominees are the ones who supply it.

Senator WILLIAMS. Yes; well, I agree and felt that the statute was adequate, but rather than debate that point perhaps we can clarify it and make it more specific. And, will you submit to this Committee

your recommendation for whatever legislation may be necessary to completely clear this point up so that they will not only be using the Social Security tax numbers in all these payments for both Medicare and Medicaid but also that the information will be made readily available to your Department——

Mr. THROWER. We will undertake to provide that promptly.

Senator WILLIAMS (continuing). In the proper form that you need it?

Mr. SMITH. Including a statement to the payee?

Senator WILLIAMS. That is correct. Include whatever authority and directions that you think may be necessary. And we will be glad to pursue it further and I think we can get it cleared.

The CHAIRMAN. Senator Gore.

INTERNAL REVENUE SERVICE INTEREST IN MEDICARE INFORMATION

Senator GORE. Mr. Commissioner, I would not like to see the Internal Revenue Commissioner have any responsibility to the Medicare program. I am not sure that I agree with some implications that show we are going to use the tax return as a means of policing the Medicare program. I understand your legal responsibility, it is confined to the collection of taxes.

Mr. THROWER. That is the way I understand it also, Senator.

Senator GORE. Is that the extent of your interest in obtaining reporting of fees paid to doctors?

Mr. THROWER. That is the extent of our interest which I think we undertook to make clear, that the limit of our concern is the proper reporting of this information under the Internal Revenue Code.

Senator GORE. And the purpose of reporting is to facilitate the proper and adequate levying of taxes and collection of revenue.

Mr. THROWER. So that we may secure the maximum compliance with the law, the income tax law.

Senator GORE. The failure in reporting thus far would in no way so far as I know—I do not ask you to affirm this since this is again not a revenue question—justify any defalcation in either the carriers or the Government administrators in supervising these programs. As I say, I do not ask you to affirm that. That is my opinion.

I would like to ask how this moratorium began and when—that is, the moratorium on reporting on payments to doctors. Are you aware of that?

Mr. THROWER. I would like to ask Deputy Commissioner Smith to develop the history of that in response to your question.

Mr. SMITH. Senator Gore, the ruling that brought about the moratorium that you refer to was issued in 1963. At that time, if you recall, this committee had just previously enacted into law the requirements with respect to dividend and interest reporting.

At that particular time we were receiving something in the neighborhood of about 100 million information documents a year, all of which were largely dividend-information returns, only about 500,000 of which were interest-information returns. At that time the requirement on interest reporting was set at $600. This committee in making the change in the statute reduced that level to $10. This changed the

mix of information returns and brought a whole host of new types of information reporting to the surface, with a consequent substantial adjustment in our procedures and our system for dealing with information of this kind. In fact, today we received and did, shortly after the enactment of the statute, begin to receive something in the neighborhood of about 200 million information returns. While we were in the process of digesting all of these new volumes and all that it implied with respect to that change in the statute, this question of information reporting on payments made by insurance companies to doctors came up. And in part we felt that we needed time to digest what it was we were getting. And I think the events indicate that we did need a period to adjust to that changeover.

In addition to that, there were some questions as to whether or not the legal right existed to insist upon these payments.

Senator GORE. Well, I have just reread the section, and I do not wish to express a legal opinion on it. I must say it would appear to be a close question.

Mr. SMITH. Yes, sir, I guess it is a close question. But the Chief Counsel's Office in the Internal Revenue Service finally decided that the information returns could be required. We decided not to require them at that time for all of the reasons that I indicated. And we were also at that time, as you may recall, in the process of installing a series of service centers throughout the United States. And that installation has only been completed as of a few years ago and these are the sites at which all these papers would have been received, a substantial volume of paper.

Very simply, we just decided that we had more to chew on than we could handle and that some postponement might be in our interest and in the interest of the Government so that we could do a more effective job with the other responsibilities.

Senator GORE. But, Commissioner, you have now reversed that order and you are now to require information returns; is that correct?

Mr. THROWER. That is correct, with such assistance as may be necessary from this committee.

Senator GORE. Well, thank you. Now, what assistance do you need from this committee? Do you need any amendment in the law?

Mr. THROWER. Well, we are now studying that, and we would like to make a presentation to the committee very shortly when our suggestions have been developed.

Senator GORE. But at this point you have no request for additional assistance?

Mr. THROWER. At this point we do not.

Mr. SMITH. I just might make one point, though. There are some 1,800 carriers as I understand it and some 200,000 doctors and a substantial number of payments being made every day, and I have indicated we received 200 million information documents—most of them covering dividends and interest. The Forms W–2 raise this total to about 350 million. And the reason that I alluded to the need for aggregation earlier is that somehow this volume has got to be cut down if it is to be kept within manageable proportion for us.

Senator GORE. Well, the statistics you have just given illustrate, however, that statistically the information return with respect to pay-

ment to doctors is a small item as compared to the total volume of information returns. And now with the ruling that the Commissioner has given, there is no longer any excuse for not requiring these information returns.

Mr. SMITH. No, sir.

Senator GORE. So this problem should be cured. If you need additional assistance, Mr. Commissioner, I will be sympathetic to it.

Mr. THROWER. Thank you.

Senator GORE. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Bennett.

Senator BENNETT. Thank you, Mr. Chairman.

OTHER FEDERAL PAYMENTS REQUIRING REPORTING

Are there any other areas in which the payment of Federal money is involved which you cannot now reach for any particular reason?

In other words, if we are going to consider legislation to make it possible for us to get information about the doctors under this program, should the legislation be broadened to include any other similar problems?

Mr. THROWER. Senator, I think we would be happy to reflect upon that and incorporate our responses to that suggestion within our presentation.

(Additional information supplied at this point follows:)

The Service has undertaken a comprehensive and systematic review of the various Federal programs in order to (1) identify any under which payments constituting taxable income are being made which are not now reported on information returns; and (2) establish which, if any, cannot be required under provisions of existing law. The Service will also explore with any agencies making such payments the changes necessary in their systems to accommodate information reporting. The Service will furnish the Committee on Finance the results of this review.

(CLERK'S NOTE: At the time of printing the results of the review referred to had not been received by the committee.)

Senator BENNETT. You do not know of any offhand?

Mr. THROWER. I certainly could not cover it fully offhand. I do not know whether Mr. Smith is in a position to undertake it.

Mr. SMITH. The other large area would be payments that are made by the Department of Agriculture. And currently, so far as I can recall, most of the payments made by the Department are now being received by us, in magnetic tape mode.

The Department of Agriculture, at our request, some 3 or 4 years ago secured social security numbers from all farmers who are the recipients of payments under any of the programs administered by the Department of Agriculture.

Mr. THROWER. I think—pursuing your suggestion, I believe we would like to undertake a comprehensive analysis and see if there are other areas where we are not getting this kind of information.

Senator BENNETT. If we are going to cure the problem, we might as well cure the whole problem while we are at it.

I have no other questions, Mr. Chairman.

The CHAIRMAN. Senator Talmadge.

Senator TALMADGE. Thank you, Mr. Chairman.

I thought the law, Commissioner, required that all payments that might be considered income payments had to be reported as a matter of law to the Commissioner of Internal Revenue. Is that not true? What is the law on reporting income, as it now exists?

Mr. SMITH. Section 6041 requires that an information return be supplied to the Commissioner of Internal Revenue for payments that are made in the ordinary course of business where those payments exceed $600 per year.

Senator BENNETT. Does that include matters of payments to doctors whether it be by the Government or whether it be from a private carrier under a private contract.

Mr. SMITH. We believe that the statute as it is presently drawn does require that; yes, sir.

Senator BENNETT. It does require it.

Mr. SMITH. That is our——

Senator BENNETT. Why did the Department not institute reporting prior to this time?

Mr. SMITH. As I indicated to Senator Gore, the dramatic changes that were made in the information return system in the early portion of this decade gave a tremendous amount of administrative problems to us in adjusting to change and making provision for how we would handle all of the information that has been supplied to us on dividends and interests. And this was one area that we decided to postpone action on until such time as we were ready to go ahead.

Senator TALMADGE. Did you think the cause was doubtful or that there was not any necessity for postponing action?

Mr. SMITH. In our opinion, the law is not doubtful, but there were many lawyers outside the organization that believed otherwise and that is why I, in response to Senator Williams, indicated that I think that some clarification of the statute would be welcome.

Senator TALMADGE. Do you have the computer system set up nationwide now?

Mr. SMITH. Yes, sir. Our computer system is installed nationwide.

Senator TALMADGE. All over the country. That is on magnetic tapes, and when information is obtained on these forms, is that automatically fed into the computer system?

Mr. SMITH. Yes, sir. As a matter of fact, we still get a great deal of information in paper form, but my recollection is that, in the case of dividends, interest, and wages, currently we are receiving the equivalent of about 50 million information documents on magnetic tape.

Senator TALMADGE. And that is geared to each individual social security number, I assume?

Mr. SMITH. Yes, sir; that is correct.

Senator TALMADGE. And unless the information that you received is based on the social security number of the payee, it is of little or no value, I would assume.

Mr. SMITH. There is absolutely no way that we can access the magnetic tape file that we maintain except with the social security number.

Senator TALMADGE. So these information returns must be filed with the social security number of the payee?

Mr. SMITH. Yes, sir.

Senator TALMADGE. Let me ask you something further now. You have already issued a regulation changing, insisting on information returns on these payments on medicare and medicaid; have you not?

Mr. SMITH. A regulation has not been issued as yet. With respect to medicare and medicaid we are in consultation with the Social Security Administration, and it is the joint opinion of both agencies, that within a very short period of time we can make the necessary adjustments.

Senator TALMADGE. When do you anticipate that regulation to be issued?

Mr. SMITH. I see no reason why something cannot be drafted and issued within a month.

Senator TALMADGE. I presume it will be retroactive for the calendar year 1969?

Mr. SMITH. I suppose that would turn upon whether or not the records of the intermediaries and Social Security Administration would be in such a condition that the information for the early part of calendar 1969 could be picked up. I am just not certain about it. That is something to which they could better testify.

REPORTING PAYMENTS TO PHYSICIANS UNDER PRIVATE INSURANCE

Senator TALMADGE. Now, will that also include information on private hospitalization insurance policies?

Mr. SMITH. No; it will not.

Senator TALMADGE. Just those where the Government makes payment.

Mr. SMITH. We have, as the Commissioner has indicated, plans underway to deal with those payments the same way we would deal with medicare and medicaid.

Senator TALMADGE. Don't you think it would be advisable to do so in order that your system might be more accurate and brought up to date fully?

Mr. SMITH. In my opinion, if you do not do that, you only have a partial system.

Senator TALMADGE. That is my thinking. I think that you must have it not only for payments that are made by Government but also payments that are made by private insurance companies, otherwise you have a loophole in your reporting system that would make it impossible for you to tell with accuracy what the total payments were.

Mr. SMITH. Yes, sir; that is correct. The only way we could ascertain it then would be in the way which we do it now and that would mean auditing their books and records, and this can be a very complicated process.

Senator TALMADGE. Thank you, Mr. Chairman. I have no further questions.

The CHAIRMAN. Senator Curtis?

Senator CURTIS. Thank you, Mr. Chairman.

REPORTING PAYMENTS MADE BY PRIVATE INDIVIDUAL

Following the line of Senator Talmadge's questions, I would like to know what the law is in reference to a private individual, if he makes payments to the family doctor, to a lawyer, to the yardman, or

to anyone else. What responsibility or what duty is required in regard to filing the form 1099.

Mr. THROWER. Excuse me. I was going to note that section 6041—the basic section—is applicable to all persons engaged in a trade or business and making payments in the course of such trade or business to another person of rents, salaries, wages, premiums, annuities, and so forth. So that——

Senator CURTIS. It relates to payments——

Mr. THROWER. It does not relate to a payment by an individual for medical services, not in the course of trade or business.

Senator CURTIS. In other words, if a businessman in the course of his business employed an attorney and paid him more than the amount specified in the statute, it would be incumbent upon many to file a form 1099, but if an individual employed an attorney for his personal and family matters, it would not; is that correct?

Mr. THROWER. The latter would not be covered by the statute; I am sure that would be correct, yes, sir.

Senator CURTIS. Now, I find that as a matter of practice tax-exempt organizations file forms 1099 for payments they make. I receive once in a while a form 1099 for a tax-exempt farm organization that they have made payments to me. I had occasion once to receive a 1099 from a religious organization. My question is this. Are labor organizations required to file a 1099 form for payments of money they make to individuals?

Mr. THROWER. They would be covered, yes.

Senator CURTIS. Now, the payment of money does not have to be compensation; is that correct?

Mr. THROWER. Well, rent, salaries, wages, premiums, annuities, compensation, remuneration, emoluments or other fixed or determinable gains, profits and income, which is, of course, very broad.

Senator CURTIS. So that if the Congress decided that tax-exempt organizations should file—should be required to file—1099 forms with respect to gifts or political contributions, the statute would have to be amended.

Mr. THROWER. This is with respect to gifts or political contributions——

Senator CURTIS. Yes, that is right.

Mr. THROWER. (Continuing). Made by the exempt organization?

Senator CURTIS. Yes, or by anybody else.

Mr. THROWER. Yes, that would seem so.

Senator CURTIS. Now, with respect to the filing of these forms in behalf of, or concerning physicians and surgeons, my information is that the American Medical Society has no objection to this, that they welcome it as an orderly procedure. I want to ask you, have you met with any objection on the part of organized medicine to extending the requirements on the filing of informational returns?

Mr. THROWER. We are not aware of any, no.

Senator CURTIS. Well, I am sure you have not.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Senator Miller?

Senator MILLER. No questions, Mr. Chairman.

The CHAIRMAN. Senator Harris?

Senator HARRIS. I have no additional questions.
The CHAIRMAN. Senator Jordan?
Senator JORDAN. Thank you, Mr. Chairman.

INCREASED INTERNAL REVENUE SERVICE WORKLOAD RELEASED TO REPORTING OF MEDICARE PAYMENTS TO PHYSICIANS

I am interested in developing a little more the volume of extra work that would be required if these 1,800 carriers having to do with some 200,000 doctors were required to file information returns. Have you made an estimate of the volume that would be thus developed by this additional work?

Mr. THROWER. If it came to us in usable form as indicated, I do not think that absorbing it into the system and utilizing it would present any significant problem, workload or otherwise.

Senator JORDAN. You have already testified you are already processing from 200 million to 350 million information returns now. The addition of the extra information returns occasioned by this new requirement would not be excessive?

Mr. SMITH. Well, there is a third multiplier, Senator. You have not only the 1,800 and the 200,000 doctors, but you also have to consider the number of payments that may be made by each one of those carriers to each one of those doctors, and that multiplier could run the total up substantially. And that to the extent that an intermediary or the Social Security Administration or a carrier, can aggregate [all] payments made to any individual doctor during the course of the year, it would be advisable in our opinion to require aggregation in order to lessen the burden on us, which is already substantial.

Senator CURTIS. Would the Senator yield just very very briefly?

Senator JORDAN. I yield.

Senator CURTIS. Does not one comply with the statute if they file it once a year? You do not have to file an estimate every time you write a check.

Mr. SMITH. Oh, no. Once a year. That is correct.

Senator CURTIS. Thank you, Senator Jordan.

Mr. SMITH. Something else I might add. The principle of aggregation is already embedded in the statute for dividend and interest payments.

Senator JORDAN. Of course it is, and that is why I wondered why you bring up the point that a great number of payments will be made; because it is not a factor, is it?

Mr. SMITH. Well, section 6041 as distinguished from sections 6042 and 6049 does not provide for aggregation.

Senator JORDAN. I see.

Mr. SMITH. We would like to be sure that in this clarification that aggregation be provided for in order to reduce the volume of paper.

Senator JORDAN. This is one point then that we want to clear up in the new legislation——

Mr. SMITH. Yes, sir; in my opinion you should.

Senator JORDAN (continuing). That you are talking about?

Mr. SMITH. Yes, sir.

Senator JORDAN. And you are prepared to include it in the corrective legislation you will submit to us?

Mr. SMITH. Yes, sir.

The CHAIRMAN. Senator Byrd?

Senator BYRD. Thank you, Mr. Chairman.

PREVIOUS INTERNAL REVENUE SERVICE MORATORIUM ON REPORTING

I want to explore further the so-called moratorium—I think that is the word that Senator Gore used in his discussion with Mr. Smith—a moratorium on the requirement of the fees being reported by the carriers. And that goes back, as I recall, Mr. Smith, to 1963, did you say?

Mr. SMITH. Yes, Senator.

Senator BYRD. Do you need more time to digest the matter?

Mr. SMITH. Sir?

Senator BYRD. Now, this is 1969. Has the department initiated anything between 1963 and 1969 to clarify this?

Mr. SMITH. We have not rescinded that ruling that resulted in the so-called moratorium as you have referred to it.

Senator BYRD. And there was a ruling?

Mr. SMITH. Yes, sir.

Senator BYRD. I asked that, because yesterday I explored this matter with the officials of HEW, and the answers indicate that there probably was not, but there was a ruling.

Mr. SMITH. Well, the rulings that required such information reporting under section 6041 were placed in suspension in 1963. This had the net effect of not requiring information reporting from insurance companies for whatever temporary period of time might be necessary. And temporary in this case is now 6 years.

Senator BYRD. Temporary has been 6 years?

Mr. SMITH. Yes, sir.

Senator BYRD. Well, now, let me ask you this. Did the IRS initiate that ruling or was it requested by the Department of HEW?

Mr. SMITH. So far as HEW is concerned, the existing arrangement—the absence of reporting on the part of intermediaries and the Social Security Administration—is of much more recent date. The period from 1963 is the period for which we granted relief with respect to the private insurance companies.

Senator BYRD. Now, I put this question yesteday to Mr. Ball: Did HEW request IRS to go slow on initiating a ruling, that is, to change the moratorium? Mr. Ball replied that, "Well, I think for the exact wording of that I will ask Mr. Hess to reply."

Now, Mr. Hess says, his deputy, "I do not think there was a request in this sense. There were staff discussions back and forth in which we translated to Internal Revenue our concerns that many of the plans said they were not going to be able to meet the requirement at that time through their computer operations." Yet all companies have to meet that requirement in regard to dividends, dividend payments. I am correct in that, am I not?

Mr. SMITH. Yes, sir.

Senator BYRD. Then Mr. Hess goes on: "We pointed out that this could have a very inhibiting effect on physicians taking an assign-

ment, which was a delicate matter at the moment, and we continued in discussion with them." That is IRS. "The question has been raised several times in the last couple of years and they have continued to tell us they have it under advisement."

And that is the status now I assume—it is still under advisement.

Mr. SMITH. As of today the ruling is being reexamined with the intention of republication of a rule which would require information reporting on the part of the private insurance companies.

Senator BYRD. And that is the ruling which was a temporary ruling in 1963?

Mr. SMITH. Yes, sir.

Senator BYRD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. As I understood your answer, you said that for the future, looking from this point forward, that payments of more than $600 by insurance companies to doctors will be reported on information returns; is that correct?

Mr. SMITH. That will be our requirement. Now, you realize, of course, that most insurance companies are going to have to completely regear their systems. How long it will take for this to be accomplished and for the information to be reportable to us after the systems have been regeared, I have not the slightest idea. Obviously, also, they will have to secure social security numbers from all the doctors.

The CHAIRMAN. Right. I understand that. So as to give it to you on magnetic tape form which is the most usable and practical way. That is how you would get it.

INTERNAL REVENUE SERVICE USE OF INFORMATION OBTAINED BY COMMITTEE STAFF

Now, we have here the names and the amounts paid to doctors who each received more than $25,000 from medicare or medicaid. Do you have that information?

Mr. THROWER. I have asked for it.

The CHAIRMAN. We are going to provide you with that. You will have the information as to doctors who last year received $25,000 or more from medicaid and medicare. You will have available the same list I was looking over yesterday, for example, of some of the very high payment cases.

Now, what do you propose to do with that information when we give it to you?

Mr. THROWER. We plan to pull the tax returns for the doctors involved and determine whether or not there is a basis for audit.

The CHAIRMAN. In the event that you find a large number of cases where taxes were not paid on this money, what do you propose to do about it?

Mr. THROWER. Well, of course, the tax mechanism will take over to some extent. If taxes have not been paid on the income, obviously the machinery that is provided under the Internal Revenue Code would be automatically set in motion to the fullest extent.

The CHAIRMAN. Would that result in prosecutions—could that result in prosecutions for fraud?

Mr. THROWER. It could.

The CHAIRMAN. If you find a sizable number or a considerable percentage of cases among those doctors who did not pay taxes on the money, would you then seek to obtain information about doctors who received less than $25,000 in income?

Mr. THROWER. I am sure it would be of interest to us, yes. Certainly for the future we will be receiving information on all payments over $600.

The CHAIRMAN. Well, now——

Mr. THROWER. If you are referring to the past, in audits that we make we would certainly be interested in all cases of practitioners receiving payments under the system. We would want to take into account the total relation, whether above or below $25,000.

IRS AUDIT OF CONGRESSIONAL TAX RETURNS

The CHAIRMAN. Let us just take an example. As I understand it, your general procedure with regard to those of us in Congress is that—and this is something that we agreed upon with you—you just draw out of the hat about 20 percent of our names every year and check our tax returns. Is that about the way you do it?

Mr. THROWER. We are now undertaking to make those selections on a scientific basis in order that we do stress the returns which more probably have error. And we have systems of determining these probabilities. And progressively we are increasing the utilization of this—what we refer to as a discriminate function—in the selection of returns for audit. A return is graded, for example, as to its probability for error based upon information we received.

The CHAIRMAN. I thought that you were still going under the old system where you would just pull 20 percent of the returns and run a sample and see what you found. And if there was some discrepancy in the taxes, you would settle up with those. You tell me that now in testing and sampling the returns from Congressmen and Senators, you try to pick out the returns that you think are most likely to be from someone who might owe you some money and you check those rather than simply a 20-percent sample.

Mr. THROWER. It is a more scientific selection of that sample, yes.

The CHAIRMAN. So you try to pick the ones where you stand the best chance of winning?

Mr. THROWER. Right. We try to pick those that we think are more in need of investigation. We try to relieve from investigation those taxpayers that more probably are filing accurate returns and where investigations are not needed. Our manpower as you gentlemen well know is severely limited and we are undertaking to apply it in a way that will be productive both with respect to the correction of error in specific returns and in securing acceptable levels of compliance throughout the total populace.

Mr. SMITH. We also know, Mr. Chairman, that the adoption of an information return system and our enforcement of that system ordinarily brings a significant improvement in voluntary compliance.

The CHAIRMAN. In other words, if people know that if they do not pay their taxes they are liable to be checked on and investigated and

made to pay with penalty, the probabilities are they will pay rather than try to get by with not paying.

Now—and I see you are nodding at that.

RATIO OF TAX COLLECTIONS TO COST OF COLLECTION

I am curious to know where you have to actually go out and find somebody and collect the money from him, how does the amount that you bring in compare with the cost of your Enforcement Division?

Mr. SMITH. The revenue receipts that are the result of enforcement action by Internal Revenue Service multiply by several times the cost of collection of that money. It will range, depending upon categories of income or various characteristics of the taxpayers, from several times to one, to 10 to 1, or more in some instances.

The CHAIRMAN. In other words, you would say at least 6 to 1 on what you receive, after you pick out someone that you think did not pay his taxes and seek to collect it.

Mr. SMITH. At the very least that, Senator, because as a matter of fact we do not request funds of the Congress for additional manpower unless at the margin we believe we can secure $6 for each additional dollar of cost.

Mr. THROWER. This is in the application of manpower. Of course there is no prejudgment with respect to individual returns or any group of returns. But in the decisions as to the application of manpower, this return is contemplated in order to apply the manpower in the most efficient way.

The CHAIRMAN. Well, now, if you are getting 6 to 1 for every dollar requested for additional enforcement activities, that would undoubtedly mean that you are making a lot more than that, maybe 12 or 20 to 1 by virtue of the fact that people know if they do not pay their taxes the Enforcement Division is likely to be on them and they might even be prosecuted criminally if they do not pay up.

Mr. SMITH. Well, my recollection is that the rough figures would be something like this. The compliance appropriation, which is the appropriation you are discussing, runs about $400 million—and the revenue resulting from enforcement action amounts to about $3½ billion annually.

The CHAIRMAN. Yes. That is a lot of money.

Mr. THROWER. We would add to that the thought that even more significant and of greater impact is the effect upon voluntary compliance through giving assurance to the people that those who do not comply are having their returns checked, and where they are in wilful violation they are being properly penalized.

The CHAIRMAN. Well now, if you should find a large percentage of violations—and I would hope that it is not the case—would you then be interested in obtaining further information, going back another year to see what happened the year before?

Mr. THROWER. Well, certainly in our planning for the application of manpower we undertake to determine areas of noncompliance and give them priority attention.

The CHAIRMAN. In other words, you would propose to treat a doctor the same way you would treat a Senator. If he is a real furtive

prospect, you would go after him and go back a few years, and on the other hand, if he seems to have paid his taxes, why you would lose interest in that matter.

Mr. THROWER. That certainly would be so.

The CHAIRMAN. Incidentally, I think it might be well to have some understanding that the Department might ask these carriers not to destroy any records until we find out just exactly where we stand on this. I see Mr. Ball nodding.

TAX TREATMENT OF KICKBACKS

Now, we have evidence of kickbacks between nursing homes and doctors and nursing homes and pharmaceutical suppliers. What do you propose to do about that?

Mr. THROWER. That would be taxable income and we would propose to cover that within our audits. We would be very much interested in having the maximum amount of information that may be available on the subject.

The CHAIRMAN. I am not telling you how to administer the medicare program, but if somebody is giving or getting systematic kickbacks from a nursing home or a doctor or a medical supplier, he owes us some taxes on it and it is your duty to collect it, is it not?

Mr. THROWER. That is true.

Senator MILLER. Would the Senator yield at that point for a brief question——

The CHAIRMAN. Yes.

Senator MILLER (continuing). About the other side of the coin on that?

What about the deductions for the kickback?

Mr. THROWER. That would be a matter of interest to us, also, as to whether by reason of the aspects of public policy involved or perhaps even violation of the laws, whether that would be deductible. Without any prejudgment, of course, we would be interested.

Senator MILLER. You do have some law on that subject which permits you to disallow a kickback deduction, do you not?

Mr. THROWER. Yes; under the circumstances, yes.

The CHAIRMAN. A kickback falls into somewhat the same category as a bribe, does it not? So if it takes on the aspect of a bribe, it would not be deductible, would it?

Mr. THROWER. If it was in violation of evident public policy or was in violation of law, it would not be deductible. I would not want to undertake to give a broad prejudgment of what may be involved. I have not examined them. But I would say we would certainly be very much interested——

The CHAIRMAN. Well, you are a lawyer, but I really do not think that you have explored that subject in the same depth as Senator Williams over here who is not a lawyer. He has belabored that point for hours on end, and I think that he has achieved an expertise which probably would come to that of a good lawyer. [Laughter.]

Mr. THROWER. I think the Senator has made a great contribution and I certainly would accept what you say.

The CHAIRMAN. Senator Anderson?

SOCIAL SECURITY ADMINISTRATION REFUSAL TO FURNISH INFORMATION TO SENATOR ANDERSON

Senator ANDERSON. I tried to find this piece earlier from a Scripps-Howard newspaper entitled: "Won't Give Anderson Doctors' List."

I am interested in why Social Security is providing all these lists but they refused it to me. And down here it says: "Ball granted administrative exception to section 11-06 which allows public information disclosure of doctors' names."

Has there been any change in that at all? Are you still refusing to give the doctors' names?

The CHAIRMAN. I suggest that that article be printed in the record in connection with the Senator's inquiry. I believe you are familiar with this. Mr. Ball?

Mr. BALL. Yes; I am.

(The article referred to follows:)

[From the Albuquerque Tribune, June 25, 1969]

WON'T GIVE ANDERSON DOCTORS LIST

(Seth Kantor, Tribune Washington Correspondent)

WASHINGTON—Social Security Administration (SSA) Commissioner Robert M. Ball has rejected a request by Sen. Clinton P. Anderson, D-N.M., that the names of doctors involved in the Medicare program in New Mexico, and the fees they received in 1968, be made public.

But the senator is likely to have the names anyway because the Finance Committee on which he is the ranking Democrat is securing names in preparation for hearings on possible Medicare-Medicaid abuse.

Anderson, father of the Medicare program, asked Ball on May 20 to make an exemption to the SSA's 33-year-old "secrecy regulation," which keeps the public from finding out how public money is being spent on physicians' fees.

Anderson made public today the answer written June 19 by Ball. The commissioner told him that information on some 4,700 medical doctors in the nation who made at least $25,000 apiece through Medicare in 1968 was being made available for study by the Senate Finance Committee.

NOT TO INDIVIDUALS

"I might say that we have not made available to any individual senator or congressman," said Ball, "the names of physicians and amounts of payments."

But the situation regarding what Ball and Health, Education and Welfare Secretary Robert H. Finch have been willing to furnish the Finance Committee has undergone vital change in the past month.

In May, the SSA was submitting information on doctors by computerized, coded numbers—not by names—to the Finance Committee.

Now, actual names are being made available. A committee source said today the last of thousands of the names are expected next week, and Senate hearings on the nation's soaring Medicare costs, with examples of program abuses by doctors, will get under way next month.

Anderson is ranking majority member of the committee and will have the names of the highest-paid New Mexico doctors, osteopaths and dentists available to him through the committee.

SECRECY REGULATION

Meanwhile, Ball is standing firm on a decision to employ the "secrecy regulation," otherwise known as Sec. 1106 of the Social Security act.

Ball can grant an administrative exception to Sec. 1106, which would allow public disclosure of doctors' names. He told the Tribune Washington Bureau that public disclosure of fees would not reveal the extent of overhead costs to the doctor, and would be "unfair to the overwhelming majority" of them who "have done nothing wrong."

LUJAN AGREES

Rep. Manuel Lujan, Jr., R-N.M., said today he agreed with Anderson that "there should be public disclosure of the names of doctors being paid from public funds.

"I have no objection to public disclosure on anything that belongs to the public, including the full activities and incomes of congressmen.

"In the case of the medical profession, public disclosure would lead to more efficient self-policing by the profession."

Mr. BALL. Senator, as far as furnishing physicians' names and amounts paid to them to the Internal Revenue Service is concerned, there is no bar at all in the regulations and of course not to the——

Senator ANDERSON. You are the bar. You have raised that.

Mr. BALL. No, not with regard to what has been under discussion here—the furnishing of information to Internal Revenue. We have taken the position, Senator, that as far as publication is concerned for internal use—making the information public—that we believe that it might be unfair to some of the doctors on the list, because it might be interpreted that merely receiving, say, more than $25,000 from medicare was evidence of wrongdoing. And I would not want there to be any such implication.

First of all, these are gross payments and typically the expenses of operating a practice might take 30 or 40 percent of that. There is great differences among practices. Some are very concentrated among older people and a very high portion of their income might be from medicare. And on the other hand some of the physicians on the list will be currently under investigation where we certainly do think there is wrongdoing. The position that we thought was the better public policy position, Senator, would be to have publicity on the wrongdoers but not associate them with the others as would occur on a blanket list merely based on the amount of gross income received from medicare.

I have discussed this with the chairman as well. It is true that I do have under the regulations the authority to make an ad hoc release on this. We feel that if we were going to do this on a regular basis for the public, that I probably ought not to use that ad hoc authority but rather actually amend the regulations and put them out for 30 days and get comments.

The CHAIRMAN. Well, could we have this understanding? Could we have this understanding, Mr. Ball, that as far as Senator Anderson is concerned he can see any information you have on that subject and he can use his own discretion if he wants to publish something with regard to any individual case which he might feel was improper? Is that all right with you?

Mr. BALL. Yes, Mr. Chairman. Yes.

The CHAIRMAN. In other words, as I understand it you do not want to make a blanket release because you do not want it inferred that because you paid somebody a large amount of money, that that was necessarily wrong. You do not want that inference drawn. But as far as getting the information, he can have it?

Mr. BALL. Yes, Mr. Chairman. Did I make it clear—

Senator ANDERSON. Pretty clear.

Mr. BALL. Did I make it clear that as far as the Internal Revenue Service is concerned all of this information is available at any time? There is no barrier in the regulations to that.

REFUSAL BY MEDICARE CARRIERS TO PROVIDE INFORMATION REQUESTED BY COMMITTEE

The CHAIRMAN. Well, let us just get one other point straight.

Yesterday we brought out the fact that several carriers have refused to provide the names of the doctors. Mind you, I make the point that they refused to give the names, but so far as I know you have withheld nothing from this committee. As a matter of fact, we have information that you do not have because we have taken some of the information you made available to us and put the pieces together before you had a chance to do the same thing with it, which I think represents the utmost in cooperation with us. You gave us raw information from which we drew our own conclusions without prior screening by you, which I think is about as much cooperation as one could expect.

But there are carriers who have refused to give you the information with the result that we cannot get it, the names and addresses of physicians about whom we made inquiry. I would like to know whether you have been in touch with those carriers and are they still telling you that they will not provide this information.

Mr. BALL. Mr. Chairman, when I learned yesterday that there were three such carriers—I had not known that before—we immediately got in touch with them. We told you that we were sure that we would get the information, and they have agreed to give it.

The CHAIRMAN. I want to thank you, Mr. Ball, and may I say as far as you are concerned you have provided complete cooperation. We have no complaint about that whatsoever.

Mr. BALL. Mr. Chairman, we have considered this right along as a joint inquiry into the subject and one in which the administrators of the program of course have a vital interest and out of which we expect improvement to arise. And as you know the discussions of many of the individual cases, the development of questionnaire forms and so on have been done very largely jointly by the two staffs.

The CHAIRMAN. That is how it ought to work and thank you very much.

Senator ANDERSON. I merely want to be sure that we are getting this information. I am told they found a law on that thing, section 1106, so they had to turn my request down. Is there a new law that you can count on now for stopping this for sure? I think you ought to give the information out, and if we find violation we ought to be criticizing it. I certainly have not had any information on that at all.

Mr. BALL. Senator, we have agreed to furnish you with what ever lists you would like.

Senator ANDERSON. Precisely. But nothing comes, nothing happens. Have you furnished one piece of paper at all for the last 3 years, 2 years?

Mr. BALL. Oh, I believe we have furnished quite a few, Senator. Regarding the matter of doctors' names and amounts of money paid to them we furnished the committee a list with respect to the $25,000 level, and I replied to your inquiry by asking whether it would be sufficient for your purposes to secure from the committee the information which we had furnished at the $25,000 level. I understand you are now asking again that we do it at the $10,000 level for your State, and I would be glad to comply with that.

Senator ANDERSON. I appreciate that.

I have high regard for Mr. Ball.

The CHAIRMAN. Well, I am going to instruct the staff to get for Senator Anderson what he wants and turn it over to him and he can use it however he wants to use it.

Senator ANDERSON. If I use it improperly, I expect I am to answer for it. But I would not use it improperly.

The CHAIRMAN. Senator Williams.

Senator WILLIAMS. No questions.

The CHAIRMAN. Senator Bennett.

EFFECTIVE DATE OF NEW REPORTING REQUIREMENTS

Senator BENNETT. With respect to this program on which you are about to embark hopefully to get information about these doctors and the whole program we have been talking about today, are you going to seek the information on the basis that you will have it for the calendar year 1969, or are you going to ask the carriers to give it to you prospectively so that you will only be able to check for portions of the year 1969?

Mr. THROWER. We will undertake to get it for the full calendar year 1969.

Senator BENNETT. Thank you.

Mr. THROWER. I think, as Mr. Smith indicated, we simply do not know the availability of it for prior periods, but we would certainly like to have it for the full year 1969, and I think with the expression being indicated by this committe, we all make every effort to see that it is available for that period if that is at all feasible.

Senator BENNETT. Thank you.

The CHAIRMAN. Senator Curtis.

Senator CURTIS. No questions.

The CHAIRMAN. Senator Fannin.

Senator FANNIN. Yes, Mr. Chairman.

ALTERNATIVES TO MEDICAID THROUGH TAX CREDITS

Mr. Commissioner, gentlemen, we have been, as you know. looking for alternatives to the medicaid program because of the great controversy that presently exists especially in some of the States that just do not feel that they can afford the present system. And I certainly supported Senator Anderson's amendment which would afford them relief, but proposals have been considered whereby cash credits would be provided to individuals for the purchase of hospitalization and medical care. This would provide for the adoption of a voluntary approach to utilize insurance carriers rather than the present medicaid system. Those with low incomes who would not qualify under a form of volunary participation would be provided a payment basis for medical care and hospitalization insurance. I am wondering what your position on that type of proposal would be.

Mr. THROWER. Senator, we have not ourselves undertaken to direct thought to this proposal. I think it would be more appropriate with resepect to the utilization of a tax approach to seek first consideration by the Assistant Secretary of the Treasury for tax policy. Mr. Nolan here may have some further comment on that.

Senator FANNIN. Thank you, Mr. Commissioner. I would appreciate any information that you would like to present.

Mr. NOLAN. Senator, we would be glad to give attention to the possibility of a tax credit in this area. There is presently allowed a deduction for hospitalization insurance payments to persons who itemize their deductions as opposed to taking the standard deduction. I think we would want to give attention to the impact of this on low-income people, how much of a help it would really be to those people, what the revenue considerations involved were, but it certainly is a subject to which we can give attention.

Senator FANNIN. What has been proposed would be a formula basis where if the income was not over a certain amount, there would be a hundred percent allowance, and then graduating down to where there would be small participation, with income not over a certain amount, and no participation beyond that. Do you think that this would be a proposal that would be considered?

Mr. NOLAN. We would certainly be interested in studying that proposal and its impact on persons of various income levels and the revenue considerations involved. And we do have in our present legislative program certain relief for low income taxpayers. We would want to see about integrating any proposal of that nature with the relief we are already providing. I do think this is an area to which we can give further attention.

Senator FANNIN. Very good. And I will send some information to you and ask for your comments. I realize of course that those that have very limited income or actually no income would need to be taken care of. In fact, that would be the greatest need. But I am looking, and I know the committee is also looking, for some approach whereby we can get out from under this controversy that now exists with many of the States objecting to the amount of participation at which they would be involved and some of them simply stating that it would almost bankrupt them to carry through on the present program.

Thank you very much.

TAX TREATMENT OF KICKBACKS

Senator MILLER. Mr. Chairman, on this subject of kickbacks, I wonder if the Chairman would permit a brief statement to be introduced for the record by the Commissioner regarding the general tax law on this subject. Also, whether or not there are any areas of this tax law on which Congress should take some action.

As I understand it, the law is pretty well settled, but I think it might be helpful as long as we have gone into the subject to have such a statement. I am not talking about a long brief, but a general statement of policy which would put this kickback subject into proper focus.

The CHAIRMAN. Would you rather make it now or provide it for the record?

Mr. THROWER. I would like to provide it for the record, if I may.

The CHAIRMAN. That will be done. We will insert it at this point in the record. Thank you very much.

(The information referred to follows:)

U.S. TREASURY DEPARTMENT,
INTERNAL REVENUE SERVICE,
Washington D.C., July 25, 1969.

Hon. RUSSELL B. LONG,
Chairman, Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: You will recall that on July 3, 1969, I testified before the Senate Finance Committee with respect to certain matters pertaining to the Medicare program. During the course of the hearing there was some discussion of the current state of the tax law on the subject of the deductibility of kickback payments to doctors. At the conclusion of that discussion, Senator Miller specifically requested that I provide a statement on this subject for the record.

The subject of "kickbacks" is one with which the Service and the courts have been concerned for many years. Kickbacks are often involved in tie-in arrangements, for example, between doctors and pharmaceutical suppliers; doctors and nursing homes; and doctors and drugstores. The common kickback situation is where a person in business gives money or property to an individual as payment for causing his patient, customer, employer, client, etc. to purchase from, utilize the services of, or otherwise deal with the payer of the kickback. In most cases, the patient, etc. is unaware of the payment.

In general, section 162(a) of the Internal Revenue Code of 1954 provides for the deduction of all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business. However, ingrained within this general provision of deductability is the judicially created "public policy" doctrine. Briefly stated, the doctrine disallows otherwise ordinary and necessary business expense deductions where the allowance of such deductions would severely and immediately frustrate sharply defined national or state governmental prohibitions of various kinds of conduct. Over the years, this public policy doctrine has at times been utilized to deny deductions of kickback payments which otherwise might have been allowable as deductible business expenses.

Although the public policy doctrine was judicially created, the Supreme Court has been quite cautious in utilizing it. Thus, in the *Lilly* case (343 U.S. 90 (1952)) the Supreme Court upheld deductions claimed by opticians for kickbacks paid to doctors who prescribed the eyeglasses that the opticians sold, although the Court was careful to disavow "approval of the business ethics or public policy involved in the payments * * *." The payments in question were not illegal. In limiting the application of the public policy doctrine in the *Lilly* case, the Court stated that it could be applied only when the policies frustrated were "evidenced by some governmental declaration of them."

The recent *Coed Records* case (47 T.C. 422 (1967)) dealt with the deductibility of "payola" payments. "Payola" may be defined as the payment of money, or other valuable consideration, to disc jockeys of musical programs on radio and television stations to induce, stimulate or motivate the disc jockey to broadcast and promote phonograph records in which the payer has a financial interest. Such transactions usually involve an understanding that the disc jockey will conceal the receipt of the "payola" payments from the public. In the *Coed Records* case the "payola" payments in question were held to be nondeductible. Although the taxpayer had never been tried or convicted of violating any law, the Tax Court found that the "payola" payments in issue were paid in violation of the New York Commercial Bribery Statute, and therefore, the public policy doctrine should be applied to deny the deduction. The result reached was in accord with the published position of the Service set forth in Revenue Ruling 62-133, C.B. 1962-2, 45.

Administratively, the Service has published numerous rulings dealing with the application of one public policy doctrine as a basis for disallowing deductions for kickback payments. For example, in 1952, following the *Lilly* decision, the Service published the general rule [1] that payments made by surgeons to other physicians under referral fee-splitting arrangements were deductible provided such payments were normal, usual, and customary in the profession and in the community; were appropriate and helpful in obtaining business; and did not frustrate sharply defined National or State policies evidenced by a governmental

[1] I.T. 4096, C.B. 1952-2, 91.

declaration proscribing particular types of conduct. However, in 1954 the Service published a ruling[2] holding that kickback payments were nondeductible when made in violation of the provisions of the Federal Trade Commission Act, as amended, or the Packers and Stockyards Act, 1921, as amended. Similarly, in 1962 the Service published a ruling[3] that kickback payments were nondeductible if they were made in violation of a Federal or state law or regulation.

As you know, over the years the Congress has considered the use of the public policy doctrine, in at least one instance with respect to kickback-type payments, and specific legislation has resulted. In 1958 section 162 was amended to provide for the disallowance of a business expense deduction for improper payments to officials or employees of a foreign country. Also, the Staff Study of Income Tax Treatment of Treble Damage Payments Under the Anti-trust Laws, prepared for the Joint Committee on Internal Revenue Taxation, November 1, 1965, discusses the disallowance of business expense deductions on public policy grounds and recommends specific legislation to deny deductions for certain kickback-type payments. To our knowledge the only pending bill dealing with the deduction of kickback-type payments is S. 2631, introduced by you on July 15, 1969.

In light of the *Lilly* and *Coed Records* decisions and the Service's long-standing published position previously referred to, the Service would be justified in disallowing deductions for kickbacks paid to doctors as being contrary to public policy, provided such policy is evidenced by "governmental declaration". A possible solution would be for the Social Security Administration, in cooperation with representatives of the medical profession, to develop regulations which might be promulgated by the Secretary of Health, Education, and Welfare to prohibit the payment of any kickback to a doctor by a person or firm in connection with the sale of goods or services paid for under the Medicare and Medicaid programs. Of course, the firmest legal support for disallowing the deduction of the subject kickbacks would be in the form of a specific statutory prohibition against their deduction.

If there are any further points you would wish that I develop, I would be most happy to do so.

Sincerely,

RANDOLPH W. THROWER, *Commissioner.*

The CHAIRMAN. Senator Byrd, you had something else?

Senator BYRD. Just one comment, Mr. Chairman.

PUBLICATION OF NAMES OF PHYSICIANS RECEIVING FEDERAL PAYMENTS

With reference to Senator Anderson's thoughts in regard to the publication of names of the doctors, I have not thought this through and I would not want to urge that it be done without consultation with Mr. Ball and some opportunity to think about it, but I think it is worth pointing out that the funds involved have been taken from the pockets of every wage earner and every company in our Nation. They are public funds.

And I think it is worth pointing out, too, that the payments which the Government makes to all the farmers—and there is nothing illegal about it—all of those names are published. Senator Williams sees that they are put in the Congressional Record——

Senator WILLIAMS. They are made a committee document.

Senator BYRD. ——every year, and they are a part of the committee document. Some of the payments are large. It does not mean that those farmers have done anything wrong or illegal, but they have received substantial sums of money from the taxpayers. Now, whether the doctors should be in the same category as the farmers, I am

[2] Revenue Ruling 54-27, C.B. 1954-1, 44.
[3] Revenue Ruling 62-194, C.B. 1962-2, 57.

not prepared today to say, but I did think it was worth making this observation.

The CHAIRMAN. Well, that is something we will consider. Thank you very much, and you gentlemen from Internal Revenue are excused.

GENERAL ACCOUNTING OFFICE INVESTIGATION OF COOK COUNTY HOSPITAL

We would now like to hear from the General Accounting Office. These gentlemen were directed by the committee to investigate millions of dollars of Medicare claims made by so-called supervisory physicians at the Cook County Hospital in Chicago. I understand the General Accounting Office has worked long and hard on this investigation, and we will certainly be interested to learn what they found.

Mr. Iffert and Mr. Rother, please come up and take a seat here.

Would you please tell us what your findings were when you investigated the supervisory physicians' problem at the Cook County Hospital in Chicago?

Mr. ROTHER. Yes, Mr. Chairman. As you are aware we undertook this review at the Cook County Hospital in Chicago at your specific request. You requested that we undertake a factual examination specifically excluding any questions as to the legal or policy matters involved.*

What we found basically was, that payments had been made of $1.6 million for services provided for supervisory and teaching physicians.

The CHAIRMAN. How much?

Mr. IFFERT. $1.6 million.

Senator CURTIS. By whom?

Mr. ROTHER. By supervisory and teaching physicians.

Senator CURTIS. Now what is a supervisory and teaching physician?

Mr. ROTHER. These are doctors that provide direction to residents and interns who for the most part provide the patient care in the hospital.

Senator CURTIS. Who get the fee?

Mr. ROTHER. The fee is given to an association of physicians out there who bill on behalf of these supervisory and teaching physicians. The doctors did not get it themselves. Now, the association gets it; that is correct, Senator.

The CHAIRMAN. And what does the association do with it?

Mr. ROTHER. The association does a number of things with it.

Do you have a breakdown here on that Mr. Iffert?

Mr. IFFERT. Well, of the $1.6 million that they received from the carriers in medicare, they spent about half a million dollars.

Senator ANDERSON. For what?

The CHAIRMAN. Would you mind repeating that answer?

Mr. IFFERT. I say of the $1.6 million that has been received, they have spent about a half a million dollars.

The CHAIRMAN. And what did they spend it for?

Mr. IFFERT. About $383,000 was spent for the operating expenses of the association.

*The complete report entitled "Medicare Payments for Services of Supervisory and Teaching Physicians at Cook County Hospital, Chicago, Illinois," was received by the Committee, and is printed in this hearing as Appendix A, p. 287.

The CHAIRMAN. Well, what did they do with the rest of it?

Mr. IFFERT. About $95,000 has been spent for certain appropriations which were supposed to improve the health care at the hospital.

Senator BENNETT. Why do you not read the details of that?

Senator WILLIAMS. Yes, read the details of both the $95,000 and $383,000 expenditures.

Mr. IFFERT. Cash totaling $95,591 was expended for various purposes authorized by five separate appropriations. And I will get to those appropriations later. Three hundred eighty-three thousand was used for operating expenses: $9,291 was spent for fixed assets.

Now, getting to the nature of the appropriations, they have appropriated over a million dollars but only $95,591 has been spent. One of of the appropriations is for scholarship and education. The total of this appropriation is $128,997, of which $30,416 has been spent.

The CHAIRMAN. Well, maybe we should just let you start from the beginning. As I understand it, one of the expenses involved paying someone to show them how to get this money, is that correct? How much did they pay this fellow to show them how to collect this money?

Senator WILLIAMS. In other words, do you have a breakdown of the $383,000?

Mr. IFFERT. Not a breakdown, no. I can give you a general idea of what it was for.

Senator WILLIAMS. That is what we need.

Mr. IFFERT. The salary of the administrator of the association is now, I think, about $30,000.

Senator ANDERSON. A year?

Mr. IFFERT. Yes, sir; a year.

Senator ANDERSON. He does pretty well, does he not?

Mr. IFFERT. Additional operating expenses involved payments to dental students and medical students who would go through the hospital's medical records for the purposes of identifying billable services. In other words, the doctors in whose name they billed did not make the billing. This information was derived from the medical records of the hospital. And the association has a staff who does this.

Senator WILLIAMS. And then they send bills out on this information that was developed?

Mr. IFFERT. Yes, sir; to the carriers.

The CHAIRMAN. So that they first hire someone to find where an intern has provided a service and then they hired someone to find where he has provided the service and then they proceed to bill the person who received the intern's service for supervision of the intern, is that about the size of it?

Mr. ROTHER. That is roughly it, Senator. What they did was look for services provided to beneficiaries and then they billed for those services on behalf of supervisory teaching physicians, even though in many instances and perhaps in most instances the actual patient care was furnished by interns or residents at the hospital.

The CHAIRMAN. How did this scheme start and how was it pursued? Maybe we would understand it better if you did it that way.

Mr. ROTHER. The way it started as we understand it is back in—what was it, 1967?

Mr. IFFERT. Well, the association was incorporated I think in December 1967.

Mr. ROTHER. In 1967 the association was incorporated and it was specifically set up, as we understand it, for the purpose of billing the medicare program for these types of services.

Did you have a question, Senator Anderson?

Senator ANDERSON. To squeeze the money out of the medicare program.

The CHAIRMAN. Had they been billing anybody for such services in the past?

Mr. IFFERT. Yes, sir.

The CHAIRMAN. Is that correct?

Mr. IFFERT. Not this particular association but there was a fund at the hospital that had been in existence since May of 1959 that was billing private insurance companies for essentially the same type of——

The CHAIRMAN. So they had been billing private insurance companies for the same types of service.

Mr. ROTHER. We would like to make it clear, though, Senator, that that was a different organization. It was not this association.

The CHAIRMAN. What organization was doing that?

Mr. ROTHER. It was called the Physicians and Surgeons Fund which was administered by the Hektoen Institute.

The CHAIRMAN. Hektoen? Who is that? How do you spell it?

Mr. ROTHER. H-e-k-t-o-e-n, I believe.

Senator WILLIAMS. What distribution did they make of the earlier fund?

Mr. ROTHER. We did not go into that very extensively, Senator. We were asked specifically to go into the Associated Physicians' services.

The CHAIRMAN. Let me just read from this article here. It says that "March expenses will include, in addition, the tab for the association's annual meeting at the Drake Hotel at a cost of $6,170.54, with the organization footing the bill for refreshments, dinner, and car parking. Monthly charges include legal services supplied by Attorney Lewis Baron and a generous increase in Sale's"—that is the man who is the association's director—"Sale's salary from $12,000 a year to $30,000.

"On the recommendation of Dr. Baker, the group also contracted to raise this to $33,000 next year and $36,000 in 1971."

"In making the recommendation, Baker said he thought Sale 'had proved that he can deliver what he promised to deliver' and Dr. Vincent Collins, chief of anesthesiology and treasurer for the Associated Physicians remarked that 'Mr. Sale understood the subtleties of the medicare law better than anyone' he ever met."

Apparently they hired this fellow at $12,000 and he did such a good job of extracting money out of medicare for services that they were not charging for before, that they raised him from $12,000 up to $36,000 because he seems to understand the subtleties of how to get money out of this program better than anybody they ever met.

Mr. ROTHER. That is what they say.

Senator ANDERSON. Who is this man?

Mr. ROTHER. His name is Sales, or Sale I should say.

TAX TREATMENT OF FEES

Senator WILLIAMS. Was this association established and approved as a tax-exempt organization?

Mr. ROTHER. It is my understanding that it was, Senator.

Senator WILLIAMS. It was. Therefore, these fees would be tax exempt; the fees that were levied in the names of the doctors. Do we understand now that they would be tax exept?

Mr. ROTHER. We understand that the association has guaranteed to hold the doctors financially whole in case taxes are levied against these fees.

Senator ANDERSON. How can they guarantee that?

Mr. ROTHER. Well, presumably they would pay the taxes that the doctors would owe if it would be determined that they did owe any taxes.

Senator ANDERSON. Well, if the doctor were determined to have owed some taxes they would pay it from the fund.

Mr. ROTHER. That is right.

Mr. IFFERT. The assignments of fees for professional services from the individual doctors to the association contained a clause providing indemnity in case any tax liability is involved.

Senator ANDERSON. I did not hear that. Would you repeat it again, please?

Mr. IFFERT. I said the assignment of fees for professional services from each physician to the Association provides that the assignment is conditioned upon the agreement of the Association to indemnify and save the undersigned harmless from any claim against the undersigned —that is the doctor—by or on behalf of the Internal Revenue Service for any taxes in respect to professional fees covered by the assignment.

REACTION OF ONE COOK COUNTY HOSPITAL PHYSICIAN

The CHAIRMAN. Let me just read you what one of the doctors at Cook County Hospital said about this. This is by Dr. Samuel J. Hoffman, director of the division of laboratories. He says, "We are outraged just as a majority of our medical profession by the unconscionable looting of the public by some unscrupulous doctors and administrators of medical programs who have taken charge of medicare and medicaid. We would like to emphasize that we speak only of some physicians because we are certain that the vast majority of the medical profession feel as we do with respect to widespread abuses of taxpayer's money. These abuses have now reached epidemic proportions." He goes on to say, "Despite enormous costs the patients are still being treated at charity hospitals by interns and residents who no longer have the supervision or instruction of the experienced attending physician that they previously had." He continues: "Gang visits whereupon a doctor within an hour examines 50 or 60 patients are not the answer." And I would agree, not at $10 a patient or $9 a patient. Five hundred dollars an hour is pretty high pay, I would think, for gang visits. And that would mean that he only has about 1 minute to visit each patient on that basis at $9 a minute.

Dr. Hoffman says: "Inflated collection and administrative overhead of the Associated Physicans is not the answer. Extravagant expenditures is not the answer. The gravity of the problem continues

to be overwhelming. This present course must be changed as soon as possible. The Medicare and Medicaid Act as presently administered must be revised immediately. We are on a collision course which threatens to wreck the medicare and medicaid programs and in fact destroy our Nation's economy."

He states further: "We have described some problems associated with medicare and medicaid and we would like to make some recommendations for your consideration. We wish to address ourselves to primarily that part of medicare and medicaid laws that pertain to hospitalizing of patients at city, county, and other public institutions. We believe that parts (a) and (b) should be consolidated into a single act, that a single formula should be evolved which would result in major savings in bookkeeping and administration. These savings could be best used for hospital improvement as well as improved patient care. This formula would establish a fee for every medicare patient admitted to such institution. If you should include hospital X-ray, laboratory physicians', and surgeons' fees and the like." There are some doctors, who say they speak for a majority of their profession, who say this kind of a thing is an outrage. Did you discover that this Cook County arrangement is a general practice among hospitals?

I'll just include the complete statement in the record.

(The statement follows:)

STATEMENT BY SAMUEL J. HOFFMAN, M.D., AND LEO WEINER, M.D.

Gentlemen, I am Dr. Samuel J. Hoffman, Director of Division of Laboratories, Cook County Hospital, and Director of Hektoen Institute for Medical Research of Cook County Hospital, and Professor of Pediatrics, University of Illinois. I might add that I started as an interne at Cook County Hospital in 1926. I have been associated with the hospital continuously since then except for the 3½ years that I spent in military service. I speak not only for myself but also for Dr. Leo Weiner, who is present here today. Dr. Weiner is Director of Hematology, Cook County Hospital and Hektoen Institute for Medical Research. He is also Professor of Medicine and Professor of Clinical Pathology, Chicago Medical School.

We wish to thank you for inviting us to appear here and giving us the opportunity to contribute to these deliberations in the hope that they may lead to improved medical care for all segments to our population and particularly for the aged and indigent.

We are outraged (just as is the majority of our medical profession) by the unconscionable looting of the public till by some unscrupulous doctors and administrators of medical programs who have taken advantage of medicare and medicaid. We would like to emphasize that we speak only of some physicians, because we are certain that the vast majority of the medical profession feels as we do with respect to widespread abuses of the use of taxpayers' money. These abuses have now reached epidemic proportions.

There have been expenditures of millions, yes, billions of dollars without any improvement but rather with deterioration in the quality and availability of medical care. In many cases some of the worst features of an overbusy outpatient clinic at a large public hospital have been transferred to a socalled "private doctor's office."

The patient has been duped into believing that his medical service would improve now that he has a private doctor and that he has achieved a certain amount of status by no longer finding it necessary to attend a "charity clinic at a charity hospital."

Instead the patient often finds himself a bench with a hundred or more others in some store front that passes for a "doctor's office." In many cases these doctors devote even less time to such patients than formerly may have been possible at the hospital clinic.

Frequently, these doctors have not even been able to get on the clinic service of a hospital because of inadequate qualifications. In most instances these offices do not have the expensive and highly sophisticated laboratory equipment to be found in even the most modestly equipped hospital. Thus, we end up with a system where patients are treated with less dignity, in worse surroundings, with inferior medical and laboratory services even though the care required is being paid for adequately by the government, and the patient has a right to expect good quality medical treatment.

There are articles appearing in many newspapers throughout the country regarding the plundering of the public treasury by some unscrupulous doctors in the practice of medicine in their offices. But in truth these situations represent only unethical practices or at their worst petty theft on a retail scale. They are unethical because of the patient is seen all to briefly and a perfunctory examination is performed—but the patient is seen and is examined, however poorly the examination is performed. It is petty theft because a fair fee has been paid, and regardless of who pays the fee, government or individual, the patient has a right to expect proper examination and adequate treatment.

The procedures in some doctor's offices as described above represent, as stated before, unethical practices and petty theft.

The wholesale plundering, however, at some large city and county hospitals, represents grand larceny.

Cook County is one such hospital. Regardless, of the many disguises or devices used to obscure the facts—including the obfuscation practiced by the public relations man hired at a salary of $1,700 monthly regardless of the eleemosynary facade employed by the creation of fellowships—what is being practiced is fraudulent.

An Association of Physicians has been formed at Cook County Hospital. This Association has obtained a state charter as a not-for-profit organization. This organization has been formed upon the suggestion and advice of a $30,000 a year administrator. His responsibility is to devise ways and means of taking Medicare and Medicaid "for a ride" to quote an expression with which you may be familiar.

This Association includes in its membership approximately 100 full-time salaried attending physicians. These doctors are paid by Cook County. In addition, to this full-time attending staff, the Association, also includes the "voluntary physicians" who are not paid for their services.

The fraud that exists begins with the fact that the full-time physicians are paid by the County to perform certain services including the care of patients, teaching, and administration.

These full-time physicians unilaterally and arbitrarily declared that they were employed by the County and paid for administration only and thus justified in billing the Federal Government for their care of patients. This device of designating themselves as administrators is untrue and contrary to the by-laws of the hospital. Gentlemen, let me quote directly from the by-laws:

"ARTICLE IV

"CATEGORIES OF THE MEDICAL STAFF

"*Section 4. Attending Medical Staff*

"Subsection 1: The Attending Medical Staff will consist of voluntary physicians resident in the community and the permanent staff who have been appointed by the governing body to attend patients in the hospital."

These by-laws were approved by the Medical Staff and the Executive Committee of the hospital and by the Commissioners of the County of Cook. These are the rules by which the medical staff of the hospital is governed.

We might note that if all of these doctors were administering only, as they state, we would have the most extensively administered and certainly the most expensively administered hospital in the world.

It is therefore obvious that these physicians are guilty of double billing for one and the same service; the County, which pays their salaries, and the Federal Government through Medicare and Medicaid.

The fraud continues and is even further compounded with respect to the "voluntary physicians". It must be stated at this time and repeated again and again that these voluntary physicians do not receive one penny of profit from the fraud that is employed in their name by the administration of the Associated Physi-

cians. The president of the Associated Physicians has admitted before Dr. Morris Fishbein Committee appointed by the President of the Cook County Board of Commissioners to investigate the Associated Physicians. Whereas a few voluntary doctors may spend a number of hours at the hospital daily other voluntary physicians come but one in 8 weeks. Despite their infrequent appearance at the hospital, the Federal Government is billed for services that are not rendered to the patient.

When a patient is assigned to the service of Dr. John Doe the Federal Government is billed for daily visits by Dr. John Doe, up until the patient's discharge from the hospital. In some cases the government is billed for as many as 30 visits or more, even though Dr. John Doe saw the patient but once or twice or frequently not at all. In like fashion, the government is charged for surgery performed by residents and internes.

A third method by which fraud is perpetrated: one of the physicians at the hospital was a NIH Career Investigator. A Career Investigator is paid by the Federal Government to carry on research and for no other purposes. His contract is specific in that he is prohibited from practicing for a fee. Despite this prohibition, the Associated Physicians wilfully and deliberately made extensve billings in his name for considerable amounts.

The final aspect of the fraud that is being practiced at Cook County Hospital and we suspect in many other city institutions where similar associations exist is as follows:

The Associated Physicians is a private organization that has gone into business on the premises of Cook County Hospital, a publicly owned institution. They use its medical facilities. They bill and collect fees for services rendered in the hospital; they disburse such funds—all without the approval of the governing body of the institution; namely, the County Board of Commissioners. We question the legality of such procedure.

Alleged charitable aims do not justify fraud. If there is a need for funds at a hospital (and there are desperate needs at city, county, and public institutions because of shortage of staff and antiquated and outdated buildings and equipment) the city, county, state and Federal government should make provisions for the improvement and updating of these institutions.

Perpetrating fraud on the Federal government with the future intention of correcting these inadequacies of our hospitals is immoral and ill conceived. Fraud is fraud and is never justified, regardless of intended "charitable" use of the money. It becomes an expensive way of doing things, particularly, when the expense of collecting these fraudulent monies from government by a private organization may run as high as 25 to 30 percent or even higher. For example, the combined expense budget of the Associated Physicians of Cook County Hospital for January and February 1969 was $87,000.

Now as to persons seeking medical service, patients do not come to the hospital to see Dr. John Doe. They come to the County Hospital. Those who are responsible for the institution and its operation must be responsible for the collection and disurbsement of these fees.

The Medicare law was enacted to improve medical fare for the aged and indigent; to eliminate the concept of the charity patient in hospitals; to provide these people with private care by a private physician in a proper environment; to insure that no individual will be denied proper care with dignity.

Unfortunately, we believe that the law has not succeeded in attaining any of these goals despite the expenditure of 3.5 billions of dollars presently and the anticipated expenditure of $18 billion per year in the near future. According to available and reliable information: At Cook County Hospital alone the Associated Physicians billed for about $3 million and collected in excess of $1.2 million. Furthermore, the administrator of the Associated Physicians and his staff projected an annual income of $15 to $20 million per year in a combined program of Medicare and Medicaid. Despite enormous cost the patients are still being treated at charity hospitals by internes and residents who no longer have the supervision or the instruction of the experienced attending physicians that they previously had.

"Gang visits" where one doctor within an hour examines 50 to 60 patients are not the answer.

An inflated collection and administrative overhead of the Associated Physicians is not the answer, extravagant entertainment expenditure is not the answer. The gravity of the problem continues to overwhelm us. This present course must be

changed as soon as possible. The Medicare and Medicaid Act as presently administered must be revised immediately. We are on a collision course which threatens to wreck the Medicare and Medicaid program and in fact destroy our nation's economy.

Now, gentlemen, we have described the problems, some associated with Medicare and Medicaid and we would like to make some recommendations for your consideration. We wish to address ourselves primarily to that part of Medicare and Medicaid laws that pertain to the hospitalization of patients at city, county and other public institutions. We believe that Part A and Part B should be consolidated into a single pact; that a single formula should be evolved which would result in major savings in bookkeeping and administration. These savings could be best used for hospital improvement as well as improved patient care. This formula should establish a daily fee for every Medicare patient admitted to such an institution. This fee would include hospital, X-ray, laboratory, physicians' and surgeons' fees and the like.

The hospital staff would include full-time salaried physicians and part-time salaried physicians. The so-called voluntary physician would cease to exist along with the charity patient.

These salaried physicians both full-time and part-time would assign their fees that are due to them under Medicare to the hospital administration to be used by the hospital for the hospital. The salaries of the full-time physicians would be made competitive with the prevailing regional standards.

The part-time physician should be paid on the basis of sessions spent at the hospital, a session to consist of at leat two hours. If this were accomplished, it would be possible to have more attending physicians available for the care of patients and for the instruction of internes and residents.

Although we favor the plan outlined above we are not committed to it. We are certain that other procedures can be developed which would serve the purpose, and we urge you to give study to any proposal that may effect the ends in which all of us are so vitally interested.

Mr. ROTHER. We have not looked at it as a general practice. Our examination into this type of thing was confined exclusively to Cook County Hospital.

The CHAIRMAN. Those people want to testify and they will certainly have the privilege.

Senator WILLIAMS. Have you presented your statement yet? How about just proceeding with that?

MEDICARE BILLED FOR SERVICES NOT RENDERED BY SUPERVISORY PHYSICIANS

Mr. ROTHER. All right, sir. We selected a sample of the claims that were filed by the association on behalf of its members. Actually we took about 77 claims pertaining to about 75 different medicare beneficiaries who have received medical care in Cook County Hospital. In connection with these 77 claims, the association billed for 923 different services, and these included such things as initial visits, daily care, consultations, and surgery. The billings were made on behalf of 57 different supervisory and teaching physicians who were members of the association. The amounts that were billed in the case of——

Senator BENNETT. Excuse me. Would you pull that microphone a little closer to you?

Mr. ROTHER. Yes. The amounts that were billed in the claims that were sampled totaled about $16,000. The carrier in these cases allowed $15,000 of the charges but the actual payments that were made in the cases in our sample were $11,000 because the carrier had to take into account the deductible of coinsurance for which the patients were responsible. Our examination of hospital records indicated that, in most

of the cases that we looked at, the services for which the billings were made were actually performed by interns and residents. And these records also showed that there was very little personal involvement in patient care by the supervisory or teaching physicians.

I would like to briefly summarize our findings with respect to the cases included in our sample. There were 72 initial visits for which billings were made. These initial visits include such things as determining or preparing a patient history, giving them a physical examination and that sort of thing. For 60 of those we found that the medical records disclosed no involvement or identification of any supervisory or teaching physician. The records disclosed that the services were provided by interns or residents. For 129 out of the total of 747 followup visits which were included in our review, there were no notations made by any physician, not even by an intern or resident, to indicate that any physician had seen the patient. We therefore could not tell whether there was any service provided by a physician. Most of the remainder of those cases, about 580 of the 747, indicated the services were provided by interns and residents.

Senator ANDERSON (presiding). You mean the doctors were paid for services done by interns?

Mr. ROTHER. Interns and residents, yes, sir. There were 38 consultations included in the sample, and the medical records did not disclose any involvement by the attending physician in whose names the services were billed.

Senator ANDERSON. You mean the doctor did not supply any help on it?

Mr. ROTHER. Well, the billing was made in the name of one of the supervisory or teaching physicians.

Senator ANDERSON. But he had not been there?

Mr. ROTHER. Well, the record did not show any evidence of it, that is correct, Senator. With respect to 9 out of 18 cases involving charges for operating room surgery, the hospital records indicated that there was no attending physician, by that I mean no supervisory or teaching physician, present. In 31 out of 39 cases involving minor surgery, the records indicated no attending physician was specifically involved.

Senator ANDERSON. Just one second.

Mr. Ball, are you listening to this?

Mr. BALL. I certainly am, Senator.

Our investigation of this same situation, which preceded the General Accounting Office's, found essentially the same thing and payments of this type were stopped in early April. We directed the carrier to do that. This whole procedure is contrary to our regulations and we have instituted recovery procedure.

SOCIAL SECURITY ADMINISTRATION HANDLING OF COOK COUNTY HOSPITAL CLAIMS

Senator CURTIS. Mr. Chairman, may I ask a question right there?

It is contrary to the law, is it not? There is no provision that you can pay a medical fee for an unlicensed doctor and an intern is not licensed, is that not right?

Mr. BALL. Well, certainly it is contrary to the law, Senator, to do what this group did. Our requirement for payment under part B is that

the supervising physician, who does have a license, needs to actually perform individual services and our regulations require that that be documented. Both we and the GAO found that they had not documented these cases, and we have told the carrier——

Senator CURTIS. Who was the carrier?

Mr. TIERNEY. This is Illinois Blue Shield.

Senator ANDERSON. Blue Shield?

Mr. TIERNEY. In Illinois, yes.

Senator CURTIS. And who was in charge of the medicare office to which Blue Shield submitted these claims?

Mr. TIERNEY. The name of the person at Illinois Blue Shield?

Senator CURTIS. No, no, the name of the Social Security official in charge of medicare in that area?

Mr. TIERNEY. Well, they do not submit claims to the Federal Government. The carrier has the responsibility for review claims and seeing that they are in accord with regulations and making the payments. This came to our attention at a later point.

Senator CURTIS. What office had that responsibility?

Mr. BALL. This came to our attention in an audit situation——

Senator CURTIS. No, no, my question is what office, would it be Baltimore or would it be Chicago, or what office was responsible for the administration of medicare in the area where the Cook County Hospital is located?

Mr. BALL. Well, that is within the Bureau of Health Insurance. Mr. Tierney is the Director of the Bureau of Health Insurance.

Senator CURTIS. No, no. Who is responsible for the administration of the medicare in the area where the Cook County Hospital is located? Now, you certainly have somebody that is in charge.

Mr. TIERNEY. Senator, if I might reply, the Government person who is the regional representative of the Bureau of Health Insurance in Chicago is a Mr. Fred Wolfe. But no bills are submitted to him.

Senator CURTIS. Well, whether the bills are submitted or not, who is in charge of seeing that the medicare program is administered and carried out in the area where this hospital is located?

Mr. TIERNEY. Well, I am not trying to evade the question. From the standpoint of who is responsible for the Government administration of medicare in Illinois, I am responsible, Senator. For who is responsible for the processing and payment of bills to this organization and to the physicians of Cook County Hospital, the Illinois Blue Shield Plan was responsible, and the man's name——

Senator CURTIS. But there is no one in between Blue Shield and Baltimore?

Mr. TIERNEY. There is; my regional representative in Chicago.

Senator CURTIS. How big a region does he have?

Mr. TIERNEY. He has a region that encompasses Michigan, Illinois, Indiana, Ohio, and Wisconsin——

Senator CURTIS. Now, are there districts within that region or State offices?

Mr. TIERNEY. No, sir, not in the Bureau of Health Insurance. There are Social Security Administration District Offices, but they have nothing to do with this.

Senator CURTIS. Well, now, is it his responsibility to run the medicare program in that area?

Mr. TIERNEY. He does not really run it, but he is the top responsible Government official for the operation of medicare, yes.

Senator CURTIS. Well, I will put my question the other way.

Is he under your—is anybody responsible for seeing that this gigantic program operates according to law and accepted principles of business practice in a given area.

Mr. TIERNEY. Yes, Senator.

Senator CURTIS. Who is?

Mr. TIERNEY. I think in response to your question, that the man who is in charge of the medicare regional office in Chicago is Mr. Wolfe. He has responsibility to oversee providers, to oversee carriers and intermediaries, to see to it that beneficiaries get the benefits they are entitled to—the overall administration of the program.

Senator CURTIS. Now, when you asked him whether or not he knew about the arrangement at the tir .e it was made, what did he say?

Mr. TIERNEY. At the time the arrangement was made he did not know about it.

Senator CURTIS. Did he know about it as soon as it started to operate?

Mr. TIERNEY. Senator——

Senator ANDERSON. When did he first know it?

Mr. TIERNEY. Not as soon as it started operating, no.

Senator CURTIS. But soon after?

Mr. TIERNEY. He knew about it officially, or really he knew about some of the operating facts of the situation on February 10 of 1969, Senator, when for the first time a determination was made by the intermediary and the carriers that the contract of these physicians with the Cook County Hospital was solely for teaching and supervising. The only thing they said they got paid for by the Cook County Hospital in the way of a salary was for teaching and for supervising the training of residents and interns. Now, under the law, no payment can be made for the services of residents and interns. But under Part A you can pay for, and it is an appropriate hospital expense to cover the cost of education, including the training of residents and interns. But the law is specific that no payment may be made under Part A for professional services of a doctor to patients, no payment whatsoever.

So the original determination in this case first of all was—is there any money being paid in the way of a salary to these teaching physicians for professional services? The intermediary the Illinois Blue Cross Plan referred this to the Blue Cross Association for a judgment. The Association is the prime intermediary and they ruled that all of the payments being made by the hospital as salary to these physicians was for supervising.

It then came to our attention that these physicians in addition to being paid for that were also billing for professional services under part B. We immediately upon determination of that sent our own investigatory team in there. And as Mr. Ball said, they arrived at very much the same determination which the GAO has made in greater detail and they reported back that, quite contrary to our regulations, these physicians were not rendering professional services to individual patients but rather that mass billings were being made through an association without any identification or documentation that the professional services personally were being rendered.

As soon as we completed that investigation we notified the carrier to suspend all payments, and there have been no payments since. And we are undertaking now a review of the cases that have been billed to determine whether or not any payments should have been made and, if so, how much.

Senator CURTIS. When did this plan start, and that will be my last question?

Mr. TIERNEY. You mean when did they start doing this billing?

Senator CURTIS. Yes.

Mr. TIERNEY. I would have to look that up.

Mr. IFFERT. April of 1968.

Mr. TIERNEY. April of 1968, I am told. I do not have that date.

Senator ANDERSON. Well, obviously there is some fraud here, is there not? What have you done about that?

Mr. TIERNEY. I beg your pardon?

Senator ANDERSON. There must have been some fraud here. What have you done about that?

Mr. TIERNEY. We will investigate obviously to see if there is fraud. I think it should be said that, as the Chairman pointed out, the doctors involved here as far as we know to date, have not personally received this money; it has gone into this so-called educational fund, theoretically to be used for medical education and other improvement purposes in Cook County hospital.

Now, it is a total violation of our regulations, Senator, an absolute travesty on our regulations, but whether or not there is evidence of criminal fraud I do not know.

Senator MILLER. Would the Senator yield?

Senator ANDERSON. The point was they used $6,000 for entertainment. It was not a professional service at all. What do you do about it? If I go out here and pick somebody's pocket, you worry about that, but this fellow who has picked many times that amount of pockets, what about him?

Mr. TIERNEY. Well Senator, what we have done to date is to stop payment, to demand review of the bill submitted and make a determination of how much money has been overpaid and undertake action to recoup it.

Senator ANDERSON. I think that is fine.

Mr. TIERNEY. Now, in addition to that, if there has been fraud, Senator, we will certainly look into that.

Senator MILLER. Would the Senator yield at that point?

Senator ANDERSON. Go ahead.

CARRIER'S FAILURE TO FOLLOW SSA REGULATIONS

Senator MILLER. I think this is fine that you have gotten this investigation going, but I do not think it is fine that you ever had to have one going. Now, is the reason why you had to have this investigation due to the failure of the intermediary to put a stop to it, or to disallow it?

Mr. TIERNEY. Yes, I think the basic reason is that the carrier did not take the steps that it was directed to take under our regulations to document and have evidence of personal professional services before making any payments.

Senator MILLER. Well, now, because of that failure you have had to investigate and the Government has been put to a lot of expense to undergo this investigation. What is being done with respect to that carrier?

Mr. TIERNEY. We have not undertaken any action with regard to that carrier as yet, Senator. We have had that carrier under surveillance for some time because of other problems. It is not—we do not want to make it seem all black and white—as though they were just dishing out money without any justification at all, although that is almost the way it looks in this case. The determination of whether or not a physician is rendering a personal professional service or whether or not he is supervising or directing an intern or resident is sometimes a judgmental thing which require professional review and judgment. Under the regulations if he as a practicing physician is rendering personal services to his patient, that patient is entitled under our regulations to be indemnified and reimbursed for the appropriate reasonable charges he makes.

Senator MILLER. Well, I understand all that, but from what I understand your investigation found and the GAO found there was just no evidence of that.

Mr. TIERNEY. That is right.

Senator MILLER. Therefore, what is the idea of the intermediary or the carrier paying without any evidence of such service?

Mr. TIERNEY. He received the bills. He processed the bills, but he did not go behind the bills to find out what they represented, and there is no justification for payment of many of them.

Senator ANDERSON. Shouldn't he have gone behind the bills?

Mr. BALL. Certainly.

Mr. TIERNEY. Of course he should, Senator.

Senator BENNETT. Mr. Chairman, may I?

Senator ANDERSON. Yes.

REASONS SSA INITIATED THEIR OWN INVESTIGATION

Senator BENNETT. Mr. Ball, you said that the GAO investigation came as a result of a prior investigation that you began. What prompted your investigation?

Mr. BALL. Senator, I did not mean to say that it came as a result of that. I said that we had made a prior investigation. The GAO investigation came specifically at the request of this committee.

Senator BENNETT. What prompted your investigation?

Mr. BALL. What prompted our investigation was that the National Blue Cross Association advised us on February 10, 1969—I might say the prime agreement that we have is not with the individual Blue Cross plans, but with the National Blue Cross Association—of the decision that they had made which found the salaries of full-time and part-time physicians as fully reimbursable under part A.

Senator BENNETT. Is this a general decision applying to all physicians or just a specific decision applying to the Cook County Hospital?

Mr. BALL. Just Cook County.

Mr. TIERNEY. Cook County.

Mr. BALL. Now, I think I will have to turn to Mr. Tierney to ask

what specifically after that precipitated our investigation into the situation?

Mr. TIERNEY. Well, two things precipitated our investigation. One was that report itself that there were no professional services to individuals at all being rendered for the salaries being paid and that all of this was for teaching and supervising.

Now, we had to establish that that was true before they could be reimbursed under part A for the total salaries. So this triggered our initial inquiry into the situation, Senator. At the same time, I must tell you that this organization—and I suppose this is some indication of their feeling that they were doing the right thing—published an annual report in which they pointed out with some pride that they had billed for these services and that this was a major contribution to medical education in Cook County. This triggered further inquiry on our part and led to our investigation of the whole situation.

Senator ANDERSON. With all the triggering did anybody shoot?

Mr. TIERNEY. I beg your pardon?

Senator ANDERSON. With all the triggering did anybody shoot?

Mr. TIERNEY. Well, we shot on April 9, Senator.

CHICAGO AMERICAN STORY ON COOK COUNTY HOSPITAL

Senator BENNETT. Mr. Chairman, I have copies of articles that appeared in the Chicago's American, the first one on Thursday, March 20, the second one Friday, March 21, another Saturday, March 22, and the next one Monday, March 24, which lay this whole thing out.

(The articles referred to follow:)

[From the Chicago's American, Mar. 20, 1969]

COUNTY HOSPITAL'S DOCTORS PAID TWICE FOR HELPING AGED

(By Effie Alley)

Taxpayers are paying double for elderly, indigent patients in Cook county hospital. Once from tax funds from the county and once from federal taxes supporting medicare.

Under an unusual agreement with medicare officials, a large chunk of this money—eventually expected to total about 15 million dollars a year—is going to the Associated Physicians of Cook County Hospital, an independent corporation over which the county board has no control.

The arrangement permits 105 full-time salaried physicians—whose pay from the county ranges from $20,000 to $30,000 a year—to collect extra patient fees from medicare on the allegation that they are paid by the county only for supervisory and administrative work, not for the care of patients.

County Board President George Dunne replies, "Of course, we employ them to take care of patients."

Noting that the agreement between medicare and the hospital was made without knowledge of the county board, Dunne expressed the view that it penalizes the taxpayer.

"The taxpayer pays for the operation of the hospital," he said. "The use of funds generated there in a manner that ignores taxpayers is highly improper."

Moreover, he said, there are ethical and moral implications in the situation, now of growing concern to many persons.

With the board perennially short of money to meet the rising hospital costs, Dunne is chagrined at the thought of funds which might have been used for the hospital going for other purposes.

The Associated Physicians group consists of 380 members of the hospital's voluntary staff, doctors who donate their services for the care of the needy sick,

and 105 full-time doctors who are paid by the county board. Members collect no fees directly, but assign them to the A. P. C. C. H.

To date, this organization, headed by Dr. Robert Baker, a full-time county employe who serves as director of surgery has back-billed medicare for about 3 million dollars for attention to medicare patients from July 1, 1966.

This represents only partial billing for the period, the doctors say. About half again this amount is in the process of billing. Of the amount billed, they have collected about 1.5 million dollars, according to a report by the administrator, William B. Sale.

Sale also said that current billings can be expected to generate continuing medicare income of about one million dollars a year.

These amounts do not include medicare payments for services rendered by the department of radiology and anesthesiology, which have not yet been approved for reimbursement. Once they are, these services can be expected to add 20 to 25 per cent to the income of the Associated Physicians, Sale estimates.

A move also is being made to collect fees for out-patient services dating back to 1966 at the rate of $8 a visit. Visits to the hospital's Fantus clinic—one of the largest in the world—total about 300,000 a year with well over 10 per cent of the patients in the 65-and-over age group.

The Associated Physicians is also hoping to bill for the million dollars, according to a report by the administrator, Wiliam B. Sale.

Sale also said that current billings can be expected to generate continuing medicare income of about one million dollars a year.

These amounts do not include medicare payments for services rendered by the department of radiology and anesthesiology, which have not yet been approved for reimbursement. Once they are, these services can be expected to add 20 to 25 per cent to the income of the Associated Physicians, Sale estimates.

A move also is being made to collect fees for out-patient services dating back to 1966 at the rate of $8 a visit. Visits to the hospital's Fantus clinic—one of the largest in the world—total about 300,000 a year with well over 10 per cent of the patients in the 65-and-over age group.

The Associated Physicians is also hoping to bill for the care of county hospital's 12,480 privately insured patients and, according to Sale, anticipates an income of between $1,248,000 and $1,872,000 from this source during 1969.

Currently, the association is negotiating with Blue Shield—which in the past has never paid for its insured at county hospital—for reimbursement. Again, according to Sale, this is being given favorable consideration and, once in effect, should yield an income of about 1.17 millions.

Medicaid is on the agenda, too. No estimate of what could be expected from this is available, but the take would be enormous because all welfare clients coming to the hospital would be included.

However, Sale told a recent board meeting of the Associated Physicians, this may have to wait until 1972 because there currently is no provision for payment of such fees in the state or county budgets.

But, even without this, the physicians' group is counting on collecting more than 5.5 million dollars during 1969 in addition to the 1.5 millions already collected from medicare.

This may be why Dunne speaks wistfully of New York's Bellevue hospital and the other institutions in that city's hospital system.

At Bellevue, he said, the city has a contract with New York University to run certain departments. For all departments covered by contract, the city—not the doctors or the university—collects the medicare fees.

Doctors there who are not covered by contract or paid by the city, have formed an organization similar to the Associated Physicians to collect medicare fees, but the money is not being spent until the situation is clarified.

At New York's 17 other charity hospitals, where all doctors serve on salary, medicare fees go directly to the city.

Administrative costs of the Associated Physicians' operation run high even tho it enjoys free quarters in the old West Side hospital, including light, heat, and janitorial service. Despite this, operating expenses for the last 2 months—January and February—came to $87,000.

March expenses will include, in addition, the tab for the association's annual meeting at the Drake hotel at a cost of $6,170.54, with the organization footing the bill for refreshments, dinner, and car parking.

Monthly charges include legal services supplied by Atty. Lewis Baron and a

generous increase of Sale's salary from $12,000 a year to $30,000. On the recommendation of Dr. Baker, the group also contracted to raise this to $33,000 next year and $36,000 in 1971.

In making the recommendation, Baker said he thought Sale "had proved that he can deliver what he promised to deliver" and Dr. Vincent Collins, chief of anesthesiology and treasurer for the Associated Physicians, remarked that "Mr. Sale understood the subtleties of the medicare law better than anyone" he had ever met.

At one time, expenses also included the services of a well-known public relations man at a reported $1,700 a month to sing the praises of the group. Apparently he didn't sing loud enough. He was fired.

How the Associated Physicians, a group which was formed only a little more than a year ago, now finds itself in the enviable position of entrepreneur and benefactor of Cook county hospital will be told later in this series.

[From the Chicago's American, Mar. 21, 1969]

MEDICARE MILLIONS TAPPED—
HOW COUNTY HOSPITAL DOCTORS BECAME SUPERVISORS

(By Effie Alley)

The Associated Physicians of Cook County hospital was incorporated as a not-for-profit organization on Dec. 8, 1967, but county commissioners were not informed of its existence until well along in 1968.

Formal county board approval of its activities was sought only on Dec. 17, 1968, after $900,000 in medicare fees had already been collected.

In retrospect, a number of commissioners said, they were "surprised" at being faced with an accomplished fact, but on being told of the charitable intentions of A. P. C. C. H. toward the hospital were inclined to regard it "a grand gesture."

The surprise was to grow, Commissioner Harry H. Semrow recently told THE AMERICAN, when it was learned later that "about a year ago doctors at the hospital originally hired for patient care had changed their job descriptions and duties to allow them to participate in this fund."

The fund totals about 1.5 million dollars and doctors hope to increase it by 5.5 million dollars during 1969.

Under medicare provisions, members of the voluntary medical staff who donate their services to the hospital are entitled to reimbursement for their care of patients and can assign such fees as they wish. But permanent staff doctors—physicians paid full time salaries by the county board—are not entitled to medicare payments unless it can be shown that no part of their salaries is paid them for patient care.

Thus it was, Commissioner Semrow said, "that all at once everybody became a supervisor," with job listings being changed overnight on the hospital Univac.

Full time salaries range from $20,000 to $30,000 a year.

Commenting on the situation, one doctor said:

"If these 105 physicians are receiving these salaries only for administration, then surely, this would be the most expensive and best administered hospital in the United States."

But, of course, full time physicians do not say that they spend full time in administrative work. They only allege that their pay covers no other activity. But they also point out that they spend a great deal of time in the treatment of patients.

Especially medicare patients, records of the A. P. C. C. H. indicate.

Interested doctors say the way patient care is organized in a large teaching hospital such as Cook County makes for great flexibility in billing.

Each patient, they explain, on admission to the hospital is automatically assigned to one or other member of the attending staff. However, since routine care is given by residents and interns, the attending physician may see the patient once, twice, or not at all. In a busy and overtaxed hospital like county daily visits to a particular patient by an attending doctor are out of the question, the doctors say.

Senior residents may even operate without a member of the supervisory staff being present—especially on an emergency basis.

Yet because of the formal assignment to an attending doctor, the operation and daily visits for the full length of stay can be billed to medicare in the doctor's name, even tho he has never seen the patient.

Citing what they called a typical case, brought to light recently by the investigation, the doctors told of a fracture patient who remained in the hospital for 2 months with no more attention from the attending physician than a couple of token visits.

The medicare bill for this patient, the doctors say, not only included setting of the fracture but daily visits at $7 each over the entire 2-month period.

Interns and residents rate as house staff and their services to patients cannot be billed for directly under medicare rules. Their salaries are included in hospital costs and are reimbursable under Part A of the medicare plan which provides hospitalization for elderly patients.

William B. Sale, A.P.C.C.H. administrator, says the organization has backbilled medicare for some 17,000 cases and is currently billing for about 425 patients a month.

When the physicians group was formed in 1967, it became apparent that maximum returns from medicare depended on being able to collect for patient care services rendered by the permanent staff of salaried physicians.

At first this seemed to offer some advantage to the hospital since it would enable the hospital to include the entire cost of their salaries in reimbursable hospital costs.

At any rate, the then administrator, William M. McCoy, opened negotiations on this basis.

When Blue Cross-Blue Shield, which acts as intermediary for medicare, asked that the claim be supported, all heads of divisions at the hospital were sent a ready-prepared, carefully phrased letter to sign.

The letter certified that salaries received by each doctor in the division were "exclusively" for administrative services. Division heads showing reluctance were cautioned that they might lose out on some of the envisioned perquisites, such as free trips to medical meetings. In the end, all except one signed.

Blue Cross-Blue Shield was also furnished with a statement, purportedly from the hospital bylaws, that "all attending physicians will care for patients without compensation by Cook County" and a citation to the Illinois Revised Statutes which was said to "stipulate that physicians providing care at Cook County hospital shall receive no compensation from the county for patient care."

According to Dr. Samuel J. Hoffman, director of the division of laboratories who has been at the hospital since 1926, the bylaws contain no such provision, but rather set forth the contrary:

"The attending medical staff will consist of voluntary physicians resident in the community and the permanent staff who have been appointed by the governing body [the Cook County board] to attend patients in the hospital."

The State law cited by the doctors merely provides that appointment, employment, and removal of physicians be made in conformity with civil service rules and that the county board may fix the term for which "all such physicians and surgeons who serve without compensation" shall be appointed.

Edward P. Brennan, county personnel director and chief examiner for civil service, told THE AMERICAN that the statute in question was enacted to allow the county board to change the term of voluntary physicians from six years to four.

Nevertheless, Blue Cross-Blue Shield accepted the presentation, ruling that the total cost of the salaried doctors could be included as hospital cost. For the year ending Nov. 30, 1968, the hospital collected $3,130,801.93 for hospitalization of medicare patients.

The same ruling cleared the way for A.P.C.C.H. to bill medicare for services rendered patients by salaried as well as nonsalaried staff.

In a letter to members of Oct. 25, 1968, A.P.C.C.H. President Dr. Robert Baker hailed the ruling as of far reaching effect, saying it not only "unequivocably" established the association's right to medicare payments but also paved the way for future collections from Blue Shield, medicaid, and other third party insurance.

Semrow calls the changing of job descriptions and the presentation to medicare "subterfuge." Leonard J. Allegretti, vice president of Blue Shield or medicare, termed it a "rationalization." Some of the hospital's outraged and disillusioned doctors have other names for it.

They say they went along with the plan of the Associated Physicians at first not realizing all that would be involved, and thinking it would benefit the hospital.

The offer of the organization to relieve them of elaborate and troublesome medicare billings was another attraction. So was the proposal to pay voluntary physicians for their work at the hospital.

Recently, however, the association was questioned as to when this part of the plan would bo into effect. The answer at first was that to implement it now would cost the association its tax-exempt status.

Later doctors were told that payment of the voluntary staff has been given a priority at the foot of the list and must wait until more pressing objectives are gained.

[From the Chicago's American, Mar. 22, 1960]

MEDICARE MONEY CONTROL UNDERLIES COUNTY DISPUTE

(By Effie Alley)

Who is to control the money collected in medicare, payments and other physician's fees by the Associated Physicians of Cook County hospital and how is it to be spent?

These questions are at the root of the controversy over Cook county hospital.

The struggle going on—largely under cover—between the county board and the new physicians' association has far reaching implications. These not only involve disposition of the 1.5 million dollars already collected and the additional millions to be collected in the future but, very likely, the ultimate fate of the hospital itself.

In seeking recognition from the county board, Dr. Robert Baker, 42, A.P.C.C.H. president and chief of surgery, spoke of a number of good deeds for the hospital the group had in mind. But at the same time he insisted that the county board would have nothing to say as to how the money was spent.

He also told newsmen that his organization planned to give 20 per cent of its money to the county board toward a building fund to be held by the county controler.

A fuller explanation of the intentions of the A.P.C.C.H. in this regard is contained in the minutes of the Jan. 6 meeting of its board of directors.

Telling of negotiations with County Board President George Dunne, Baker said the county board wanted 20 per cent of the gross revenues of the physicians association set aside as a building fund to be held by the county comtroller.

Noting that 20 per cent of the gross would be 24 per cent of the net, Baker said: "This may be $200,000 or in 2 or 5 years it may be 5 or 10 million."

The question of paramount importance, he said, "is who holds the money?"

Dunne had refused any of the counter proposals on the building fund offered by A.P.C.C.H. and no meeting of the minds seemed possible, Dr. Baker reported

Lewis Baron, general counsel for the group, explained the importance of a building fund resolution on which the directors were asked to take action.

"The resolution does not put any building fund money anywhere now. It states, of course, that the association is in favor of a new county hospital. However, [it] simply says we will have a reserve for a building fund." Baron said.

"There are present advantages in the flexibility" offered by the proposed resolution.

The directors voted unanimously not to give any building fund money to the county board. The decision was later ratified by the membership.

Today, rumors are spreading among hospital personnel that ultimate use of the building fund reserve may be the construction of a private pavilion in connection with County hospital.

This could syphon off County hospital income from insured patients, leaving only the destitute to be cared for there. Doctors serving in the private section would stand to get a larger increase in income. Top specialists—and the hospistal's permanent staff is so rated—in private practice are said to earn in excess of $100,000 a year.

Observers, closely associated with the hospital over the years, express the

belief that considerations of this kind are behind the recurrent cries of crisis at the hospital and the charges of political interference.

"Is this a power play," an observer asked, "where crises are unduly created and publicized so that the medical hierarchy at the hospital can take over complete control without any responsibility to the governing body and the constituency of Cook county?"

Current projects of the A.P.C.C.H. also were finalized at the Jan. 6 directors' meeting.

First on the list is a $100,000 appropriation for scholarships. These are to be used to interest ghetto teen-agers in medical careers. According to Baron, 23 such scholarships have been approved.

Also included is a $200,000 item labeled "house staff development." Of this, Baron said, $146,000 has been obligated to buy term life, disability, and health insurance for residents, interns, and their families. Salaries for staff in these categories at County hospital are already among the highest in the city, ranging from starting pay of $9,000 annually for interns up to $12,000 or more for senior residents.

Other appropriations include $200,000 for research, $300,000 for improvement of hospital departments, and a $200,000 emergency fund to be spent on recommendation of Dr. Robert Freeark, hospital director, to meet special needs.

Despite this worthy list of objectives, the county board has not yet been sufficiently impressed to give the association a vote of total trust.

At the outset, Dunne said he wanted more definite specifications on what the group planned to do with its money.

"Then we won't be surprised or embarrassed," Dunne said.

In taking this position he was, perhaps, forewarned by a "go-slow" opinion given on Aug. 15, 1968, by then State's Atty. John J. Stamos at the request of Gov. Ogilvie, then president of the county board.

Stamos sidestepped comment on the legality of medicare payments to doctors, saying this was a question solely for the social security administration "and their action in continuing such payments is not subject to review by this office."

At the same time, he was definite that exclusion of the county board from control of the funds collected by A.P.C.C.H. "would be neither legally valid or desirable."

The opinion was grounded on certain basic considerations which Stamos noted as follows:

Payments of any kind to the doctors for patient care were possible only because of their employment at a hospital maintained by the county board from tax revenues and at the mandate of the electorate.

The county board alone is responsible for how the hospital is run. Under law, the hospital has one primary and overriding commitment—the care of indigent patients.

The A.P.C.C.H. seems not to understand this, Stamos said, but in its statement of principles said that care of patients was secondary and only a means to an end—the teaching of young doctors.

This view, Stamos said, "cannot in any way be embraced or find approval by the persons authorized by law to administer and control Cook county hospital."

The noting that objectives set forth by the A.P.C.C.H. were laudable and likely to benefit the hospital, Stamos cautioned that purposes of the organization might change in the future.

He suggested that an agreement be sought to legalize the situaiton by giving the county board control of the funds, the right to approve programs of the A.P.C.C.H., and the creation by the associated physicians of more programs to improve patient care at the hospital.

This is exactly what dissident doctors at the hospital would like to see, too.

Expressing the view that voluntary physicians, who have served the hospital so well for many years without pay, would be willing to assign their fees directly to the hospital's use, they said salaried physicians should also be ready to do so.

"If this money were put under proper control and properly allocated, the county board could get this hospital off the backs of taxpayers while at the same time making it what it used to be—one of the greatest in the world," one observer said.

[From the Chicago's American, Mar. 24, 1969]

COUNTY HOSPITAL CLASH

In a series of articles last week, Chicago's American science writer Effie Alley described in detail how the Associated Physicians of Cook County Hospital, an independent group of doctors formed late in 1967, has mushroomed into a million-dollar organization with a growing bankroll and an important voice—even a decisive voice—over the hospital's future.

The articles brought into focus some awkward questions about the A. P. C. C. H.—awkward because the group unquestionably is doing important and generous services for the hosptial. Among them are these: How far can a private, autonomous group, responsible to no outside authority, be allowed to set policy for a public institution? How autonomous can it be, since its funds do come from taxes? And is the A. P. C. C. H., in effect, benefiting from a kind of double charge on Cook county taxpayers—one from the county taxes that support the hospital and one from federal medical care programs?

The questions, of course, are not all one-sided. The doctors' group was an answer to a clear need. It is an emergency treatment for a seriously ailing institution, and questions about it should not disguise the fact that such treatment was—and is needed. What must be decided is how two sets of needs—those represented by the A. P. C. C. H. and the county board—can best be adjusted.

The A. P. C. C. H. consists of 380 members of the hospital's voluntary staff—doctors who donate their services to treat the county's indigent—and 105 full-time doctors who get their salaries from the county board. Members collect patient fees from the medicare program and turn them over to the association. So far, the corporation has collected about 1.5 million dollars in fees; eventually, money from medicare and other sources may bring the organization some 15 million dollars a year.

The A. P. C. C. H. proposes to use this money to provide the hospital with what it thinks the hospital needs, regardless of the county boards' views.

The doctors clearly have a claim to a voice in the disposition of these funds. A certain amount of autonomy is built in; after all, they don't have to turn over the fees or even collect them, and without their cooperation the money wouldn't be there at all.

But taxpayers, too, have a claim. They support the hospital that makes these collections possible; the medicare fees are ultimately paid by them. And they have an essential stake in the way the hospital is run. Their interest is to provide good medical care for the poor, not primarily to provide training and experience for new doctors, and no private group may change that scale of priorities to suit itself.

A promising answer to these difficulties was given by the Illinois House last week, when it passed a bill creating a commission to take over supervision of Cook county medical institutions from the county board. The new commission should provide the nonpolitical common ground on which all these interests can meet and be adjusted.

Rep. Arthur Telcser [R., Chicago], sponsor of this bill, may have answered more problems with it than even he expected. We congratulate him and all those who helped pass it—particularly the four independent Democrats who crossed party lines to do so.

Senator BENNETT. When did your investigation actually start, before or after these newspaper articles appeared?

Mr. TIERNEY. I think our actual onsite visit was either in the last week of March or the first week of April, Senator.

Senator BENNETT. So it came after the newspapers had blown the lid off. There was one statement in the opening newspaper story which intrigues me. It is in the first paragraph of the first story, and I quote it:

Taxpayers are paying double for elderly indigent patients in Cook County. Once from tax funds from the county and once from Federal taxes supporting medicare. Under an unusual agreement with medicare officials, a large chunk of this money, eventually expected to total about $15 million a year, is going to the Associated Physicians of Cook County Hospital, an independent corporation over which the County Board has no control.

Now, is there any such agreement in existence?

Mr. TIERNEY. No such agreement is in existence.

Senator WILLIAMS. Did you know about it?

Mr. TIERNEY. Any such agreement?

Senator WILLIAMS. No, did you know that this arrangement was being set up?

Mr. TIERNEY. No, sir.

Senator WILLIAMS. You never had any idea that any such arrangement was set up?

Mr. TIERNEY. That the Association of Physicians arrangement had been set up and were billing and all the rest?

No, sir, I knew of none of this, Senator, until as I have told you we were notified of the fact that all of the salaries of physicians were being paid for teaching and supervising—that is until it came to our attention through the press and through this annual report that the organization submitted and otherwise. We had no prior knowledge of it, and I have no knowledge of any kind of agreement.

Senator BENNETT. Let me ask that same question to the GAO representatives.

Do you know of any agreement, or any arrangement that involved social security officials with respect to this group of doctors and the arrangements you later went out to audit?

Senator ANDERSON. Well, obviously you ought to know about it and your office did not find out about it until quite late?

Mr. BALL. No, as Mr. Tierney says, it was February 10 of 1969 when it first came to our attention.

Senator ANDERSON. But you did not take any action on it until after that time. Senator Bennett quoted news stories. Did you have to read it in the newspaper out there? Could your own people not have told you about this?

Mr. BALL. No. The newspapers were in late March, I believe——

Senator BENNETT. Twentieth of March.

Mr. BALL. And it was on February 10 when this first came to our attention by the decision of the Blue Cross Association.

Senator BENNETT. May I get an answer to my question of the GAO?

Senator ANDERSON. Surely.

FEE SCHEDULE FOR SUPERVISORY PHYSICIANS

Mr. ROTHER. The only indications that we have, Senator, are these. Our review indicated that the fee schedule resulted from extensive negotiations in March, April, and May 1968 and that this negotiation process involved officials of the Associated Physicians of Cook County Hospital, Blue Shield of Chicago, and also the regional office of the Bureau of Health Insurance.

Senator BENNETT. So the regional office in early 1968 knew at least a fee schedule was being developed, and did they know why it was being developed?

Mr. ROTHER. I am not certain of the answer to that, Senator.

Senator BENNETT. For what other reason would there be a fee schedule developed?

Mr. ROTHER. Presumably to collect money from medicare for these services.

Senator BENNETT. It could not be any other reason?

Mr. TIERNEY. May I interrupt, Senator, please? This is quite appropriate and is part of our operation any place where there is a question about the determination of what is the reasonable fee for the personal services of a physician in the teaching setting. Now, when an organization of this kind, Cook County or anybody else, is negotiating with the carrier about reasonable fees to be charged for covered services, they often seek advice from the people in our regional offices and our regional office may participate in this negotiation. But it was totally for covered services, no negotiations of whether or not they were going to proceed in the future to just bill for everybody that came into that hospital, whether they received any physician services or not.

Senator BENNETT. But did your local office try to find out who made up the associated physicians? In other words if they had checked to see who made up the membership of that organization they would have found that it is made up entirely of supervisory hospital personnel, persons who under the law could not have collected any fees.

Mr. TIERNEY. Well, they could collect fees under the law for the personal physician services they rendered separate and apart from their teaching and supervising, if there were such services, Senator.

Now, suppose a man who is on the teaching staff at the Cook County Hospital and also belongs to this association, brings in a private patient, and there is no teaching or supervising involved, and this person is a medicare beneficiary, the physician under these circumstances can charge for his personal professional service.

Senator BENNETT. Do you negotiate a different scale for a group of supervising physicians in Cook County Hospital which is different than other physicians charge in Cook County hospitals that are not members of the supervisory staff?

Mr. TIERNEY. It is possible that this would be a different customary charge for that kind of a physician from the type of physician who is operating out of his office who has no connection with any kind of a teaching program whatsoever. We would assume a lower fee because of the lack of overhead and a lot of other things that might be different for a teaching physician, particularly a full-time teaching physician.

Senator BENNETT. In this case, it turns out to be a much higher fee than allowed for the outside doctor who brings his patient to the hospital.

Mr. TIERNEY. I am not sure of the comparability of the fee schedule.

Senator BENNETT. I see the GAO is shaking its collective head.

Mr. IFFERT. One of the points that the chairman asked us to look into was the basis for developing this schedule, and as we indicated before it was a negotiated thing between officials of the association and the carrier and the SSA regional office. And we found that the carrier did satisfy itself that the fee schedule would not be any higher than the prevailing rate in that area for those services.

Senator ANDERSON. You mean the same charge for doing nothing?

Mr. IFFERT. Prevailing rate for when services are provided, nor would the rate be in the aggregate higher than what the customary charges were for those——

BLUE SHIELD PAYMENTS UNDER THEIR OWN PLAN FOR SIMILAR SERVICES

Senator BENNETT. When Blue Shield had patients of its own who were not on Medicare in that hospital, did they pay the same rate of scale that they agreed was reasonable for these doctors?

Mr. IFFERT. They do not pay anything.

Senator BENNETT. They do not pay anything?

Mr. IFFERT. That is correct. They are one of the insurance companies that will not honor the billings of those other physicians.

Senator BENNETT. When they service patients in other hospitals, do they still take a position they do not pay anything?

Mr. IFFERT. I think that Blue Shield better answer that. We are just talking about what they allow at Cook County Hospital.

Senator BENNETT. What I am trying to get at, and maybe you feel you cannot answer it, is the scale that Blue Shield has set for that area for similar services, higher or lower than the scale they negotiated with this association of physicians for services which the members of the association rendered? Do you know or do you not know?

Mr. ROTHER. I do not.

Senator ANDERSON. The associated physicians, are they still authorized to do work?

Mr. ROTHER. Well, they are——

Senator ANDERSON. Still operating?

Mr. ROTHER (continuing). Within the State of Illinois. As Mr. Tierney indicated, they are not getting any more money from medicare.

Senator ANDERSON. Associated physicians is a corporation, is it not?

Mr. ROTHER. A nonprofit corporation.

Senator ANDERSON. I think we have some problems there. Do you know anything about it, Mr. Ball? Here is a bad organization quite obviously. What have you done about it?

Mr. BALL. Well, Senator, as Mr. Tierney indicated, as soon as our investigation was completed, all payments were stopped in that hospital to these physicians——

Senator ANDERSON. Since when to when?

Mr. BALL (continuing). And this was in early April, I believe—April 9, I am informed, and the carrier has been told to review all of the payments that have been made. Where they are not in accord with the regulations and there is not documentation of actual personal services, recovery will be instituted.

Senator BENNETT. May I ask a question, Mr. Chairman?

Senator ANDERSON. Go ahead.

DOUBLE PAYMENT FOR SERVICES UNDER MEDICARE

Senator BENNETT. Suppose there was an instance of personal service adequately documented? Do your regulations permit the double payment which is involved because these people are supervisory personnel whose salaries are charged to you under part A? Should you not automatically allow every payment to these people so long as their salaries are covered under part A?

Mr. BALL. Well, Senator, that depends on whether the salary is exclusively for teaching and supervision which was the determination of

the National Blue Cross Association here. But if it is exclusively for supervisory and teaching purposes, then, under the regulations, it is not considered double billing when they take on an individual personal patient and perform personal services for him and there is documentation to prove that has happened. Payment is allowed under the regulations on that basis.

Senator BENNETT. Have you investigated the members of this association to find out how many of them are, in fact, supposed to devote their full time to supervisory service at the hospital?

Mr. TIERNEY. We have investigated, getting back, Senator, to the first determinations and the subject investigations—their contracts with the Cook County Hospital are very clear, that their total compensation is for teaching and supervising, nothing for their professional services to individual patients.

SALARIES OF SUPERVISORY PHYSICIANS

Senator WILLIAMS. How much salary are they drawing in that hospital, and list the individuals and what salaries they are getting.

Mr. TIERNEY. I do not know, Senator.

Senator WILLIAMS. How do you know if it is reasonable if you do not know how much they are getting?

Mr. TIERNEY. Pardon?

Senator WILLIAMS. How do you know if it is reasonable if you do not know how much the salary is that is allowed and how much of it is being paid under part A? How do you make the determination that it is reasonable?

Mr. TIERNEY. We did not make that determination, Senator. That would become a factor for determination under part A when settlement was being made with the hospital, not with the doctors at all, whether or not the amount they paid was reasonable or unreasonable, just as any other expense.

Senator WILLIAMS. Do you not have any other information at all as to the amount of salary that they are drawing in the supervisory capacity?

Mr. TIERNEY. I am sure that the Blue Cross has that, Senator. That is not totally germane to this question. That is a question of whether or not what they are being paid for teaching and supervising is reasonable and, therefore, we should reimburse the hospital for that amount. But we have not had that information because it was not needed in the decision to stop the payments under part B. But we can get it, Senator.

Senator WILLIAMS. You can get it.

Mr. BALL. We will furnish it.

(The information requested had not been furnished at the time of printing.)

Senator WILLIAMS. Does the GAO have that?

Mr. ROTHER. No, Senator; we do not have that information with us. By way of clarification though, there are perhaps 512 members of this association——

Senator ANDERSON. Have you got the names of them?

Mr. ROTHER (continuing). And less than a hundred of those are actually receiving full- or part-time salary from the hospital.

Senator WILLIAMS. Well, according to the newspaper article the arrangement permits 105 full-time physicians at the hospital pay from the county ranging from $20,000 to $30,000 a year.

Do you know the amount they are being paid in addition to the amount they collected from salaried services?

Mr. TIERNEY. That is the amount they are being paid for teaching and supervising by the hospital. We will find out the specific amounts, Senator.

(The information requested had not been furnished at the time of printing.)

Senator WILLIAMS. I wish you would because I do not see how you can arrive at a conclusion otherwise. Now, are you going to permit this to continue if they bill only for services that they render?

Mr. TIERNEY. Senator, we are not going to permit this to continue, because, as the GAO people have indicated to you, payments have been made here for supposedly services rendered which were never rendered by these physicians and also for services that were rendered as a part of their teaching and supervising for which they are already being paid, so we would not pay them again.

PAYMENT FOR SERVICES NOT RENDERED

Senator WILLIAMS. And when did you find out that these payments had been made for services that had not been rendered, after the GAO told you about it?

Mr. TIERNEY. No, sir. We found out from our visit to the institution in late March or early April, and on April 9, Senator, we wrote to Illinois Blue Shield and told them to suspend all payments. Now, that was 20 days before the chairman asked the GAO to look into this situation.

Senator WILLIAMS. And there is going to be an effort made to recover these payments?

Mr. TIERNEY. I beg your pardon?

Senator WILLIAMS. Will an effort be made to collect the money back?

Mr. TIERNEY. Yes, sir.

Senator WILLIAMS. I will ask the GAO people whether any payments have been made under medicaid to this group.

Mr. IFFERT. No, sir.

Mr. ROTHER. It is our understanding that medicaid would not reimburse the association for these services.

Senator WILLIAMS. They have refused?

Mr. ROTHER. That is correct.

DIFFERENT MEDICARE AND MEDICAID POLICIES ON PAYMENT FOR SUPERVISORY PHYSICIANS

Senator WILLIAMS. Do you have a dual standard in HEW?

Mr. TIERNEY. No, sir; we do not have a dual standard. I think, Senator, what you are talking about is whether or not the basic provision in the law which allows physicans to be reimbursed under part A for administrative or teaching and supervising precludes all physicians who may be engaged in those activities from also rendering bills for their professional services under part B to their own patients where they are the physician.

Now, our regulations now allow that type of situation. They do not allow the type of situation in Cook County.

Senator ANDERSON. How many other physician groups are there in this same trouble?

Mr. TIERNEY. I beg your pardon?

Senator ANDERSON. Are there any other physician groups in this same trouble?

Mr. TIERNEY. I am not aware of any other physician groups in this to the extent of this across-the-board billing for services, whether or not personal services are involved. We have advised all the carriers in the country that until they can satisfy themselves in any teaching situation—and there is a wide range from a university affiliated hospital all the way down to a community hospital that has a resident intern training program—that they have full documentation that personal services are being rendered, no payments are to be made.

Senator WILLIAMS. Well, you say there are not dual standards. On September 16, 1968, the AMA News reported, and I will quote, "New York City is refusing to pay medicaid title 19 fees to supervisory physicians at teaching hospitals as required under a new statewide regulation that went into effect September 1." Now, New York City is refusing it. Medicaid refused it in Illinois. Are you paying supervisory fees in New York, too?

Mr. TIERNEY. We are not paying any fees under part (B) for supervision.

Senator WILLIAMS. Under part (A)?

Mr. TIERNEY. To the extent that these same doctors who may be teachers are, in addition to their teaching, rendering personal services to patients, payments can be made under the regulations.

Senator WILLIAMS. Have you established how much was paid in the name of each of these individual doctors?

Mr. TIERNEY. The billings were made in behalf of individual doctors so that would be a part of the record, Senator.

Senator WILLIAMS. Have you furnished that to the committee yet?

Mr. TIERNEY. Have we?

Senator WILLIAMS. Yes.

Mr. TIERNEY. I do not know whether they are in the GAO report or not.

Mr. ROTHER. I do not think that can be done, really, without going over every bill.

Senator WILLIAMS. Well, Mr. Tierney will furnish that to the committee, the amount that was allowed for each of the individual doctors under were their billing by name and the amounts paid to this association.

Mr. TIERNEY. Yes, Senator; we will ask the carrier to go through all of the bills and get the individual identity of each physician. I think it should be said—and this in no way excuses the pattern of the situation in Cook County, but these doctors did not receive the money, the individual doctors. All of this money went into this association for the purposes for which it was established.

(The information requested had not been furnished at the time of printing.)

Senator WILLIAMS. But the taxpayers were stuck with the bill.

Mr. TIERNEY. To the extent that there were any payments which were inappropriate, we will recover them, Senator Anderson.

Senator ANDERSON. They had a party, did they not, spent $6,000 on one dinner.

Mr. TIERNEY. Whether they spent it for parties or whatever they spent it for, if it should not have been paid in the first place, we will recover it, Senator.

Senator MILLER. Would the Senator yield?

TAX TREATMENT OF SUPERVSORY PHYSICIAN FEES

You say these doctors did not receive that money. The billing, however, on the basis of which the payments were made to the association was premised upon their own rendering of services, however, was it not?

Mr. TIERNEY. That is right.

Senator MILLER. Well, now, let us not be naive about this. If I perform some legal services for you, and I have my son over here who needs a little help who wants to buy a house, and I say do not send the check to me, send it to my son, are you going to tell me that I did not receive it? Are we going to play around like that?

In tax law there is a fundamental principle of constructive receipt, not only did I render the service but I constructively received it. And you can horse around all you want to, but I am going to have to pay that on my tax return. That is one thing about this association out there that troubles me a little bit: How naive anyone can be to think that after they render services, just through the vehicle or subterfuge of having money sent to an association, they are not going to have to report it on their income tax returns stretches my imagination.

Mr. TIERNEY. Senator, I think of course that it is obviously an Internal Revenue Service ultimate determination, but there are situations in which the medical faculty of teaching institution charge personal fees which go into a faculty fund. They get paid salaries.

Now, whether or not the Internal Revenue Service allows that or whether they regard it as constructive income and a charitable contribution, I think depends on the facts of each case.

Senator MILLER. They do, and there is a tax ruling on that particular point, I might say. Revenue Ruling 69-275 covers that one. And it shows very clearly that that is their income.

Now, they may be allowed to take a tax deduction for any charitable contributions, but in the initial state it is their income and no horsing around with some third party or some subterfuge such as that indicated in Chicago. But I would like to ask Mr. Ball this question.

We have had testimony here, if I understood it correctly, that Blue Shield would not accept billings from associations, but as I understand it we now have a situation where Blue Shield did accept billings from associations with respect to medicare, is that correct?

Mr. BALL. You are speaking of the Illinois Blue Shield?

Senator MILLER. I am speaking of the Illinois Blue Shield.

Mr. BALL. That is the GAO testimony. I have no reason to think it is not correct.

Senator MILLER. Well, why should the Federal Government under medicare operate any differently than Blue Shield does on this point? In other words, it seems to me that if Blue Shield says to the average person who is not covered by medicare, if you want to get payment under your insurance policy, don't have the bill sent in by an association; have it sent in by a physician. Why should we operate any differently than that.

Mr. BALL. I am really not sure, Senator Miller, whether this is a general situation as far as Blue Shield across the country. I was answering in Illinois.

Senator MILLER. Well, let's just talk about Illinois. Why should we have operated any differently in Illinois?

Mr. BALL. As the General Accounting Office officials brought out, this pattern of paying for the personal services to patients of teaching physicians who are on salary is the pattern in Illinois for many private insurance companies, and these third party payments were being made from 1959 on to another group organized by the physicians.

In other words, the precedents aren't only Blue Shield but private insurance contracts generally there. And I would be glad to supply for the record, Mr. Chairman, a listing of the various companies that have followed, before medicare, a policy similar to what we are speaking of.*

The issue that troubles us so deeply here is that the regulations were not followed, the services were not rendered, the payments that were made were not documented as being for personal services. Had they actually been for personal services, then payments to a faculty fund which is used for the purposes of increasing the educational facilities of that hospital are allowable under medicare and by many third parties prior to medicare.

Senator MILLER. Did it occur to you, though, that the Internal Revenue Service might be interested in knowing about this arrangement, because apparently some naive individual set this thing up so that the

*See p. 231.

doctors who were members of that association would not have to report these fees on their income tax returns.

Senator ANDERSON. And didn't have to.

Senator MILLER. And they certainly did have to report such fees, Mr. Chairman. In a situation of constructive receipt they certainly would have to.

Senator WILLIAMS. If the Senator will yield, we have a situation where the agency of the Government is in conspiracy with them to set up this arrangement where they would presumably not be taxed on these fees. Now, under the Revenue Code only a fixed percentage of a man's income can be deducted for charitable contributions and you had no way of knowing whether that amount will exceed that income. Maybe it is 50 percent they are donating into this, or whatever percentage it might be. And I consider it highly irregular that an agency of the Government entered into any such arrangement. I am concerned that we get an impression here that you are semidefending this arrangement.

Mr. BALL. Senator, I am not defending what happened in Cook County at all. It was completely 100 percent contrary to our rules and regulations, and we are in the process of recovering the payments made. Mr. Blumenthal, associate general counsel, informs me on the point that you and Senator Miller were inquiring about, that there were discussions with Internal Revenue on this specific point and perhaps you would like to have him at this point in the record indicate what those discussions were and what they amounted to.

Would you like to have Mr. Blumenthal report?

Senator WILLIAMS. Yes, but I don't want to interfere with Senator Miller.

Senator MILLER. I have a couple more points that I wanted to make with Mr. Ball.

Mr. BALL. Perhaps it would be all right for Mr. Blumenthal then at this point in the record to indicate what the discussions were.

Senator WILLIAMS. No, I want to hear his answer when we get around to it.

BENEFICIARY'S LEGAL OBLIGATION TO PAY SUPERVISORY PHYSICIAN

Senator MILLER. Well, Mr. Ball, you indicated, I believe, at the beginning of your testimony that not only have you stopped payments but that you intended to go after the payments that have been made.

Mr. BALL. Yes.

Senator MILLER. Now, I can understand how you could go after the payments that have been made with respect to those billings in which there is no evidence to support the billings.

Mr. BALL. Correct.

Senator MILLER. What about part A payments? Now, I understand that if under part A they and some of these supervising doctors did work with some interns, then they could be paid under part A as an education matter. But is there any legal obligation that would extend from the patient to that supervising doctor?

Suppose you are a patient. The intern comes in and I am the supervising doctor and I come in and I look things over and I give the intern

a little advice. Is there any legal obligation on your part to pay me for any service?

Mr. BALL. Since you are asking a question of a legal obligation, Senator, I would like to ask Mr. Blumenthal to respond to that.

Senator MILLER. What is your position, Mr. Blumenthal?

Mr. BLUMENTHAL. I am the Assistant General Counsel of the Department of Health, Education, and Welfare.

Senator MILLER. Yes, sir.

Mr. BLUMENTHAL. I head up the Division of Health Insurance in that Office.

In most instances the courts which have ruled on this issue have found an implied obligation to pay in situations where emergency services have been furnished by physicians to emergency patients in hospitals. In the State of New York there is a decision which has held that the supervisory service performed by teaching physicians do not result in an obligation to pay on the part of the patient.

Senator MILLER. Now, you say that is a New York case?

Mr. BLUMENTHAL. Yes, sir.

Senator MILLER. Court of appeals?

Mr. BLUMENTHAL. This is not a court of appeals decision. The case itself is very difficult to reconcile with the substantive provisions of title XVIII. On the facts of the case with regard to the supervisory services performed by the teaching physicians, the result reached by the court would be in full accord with the result which would be reached under our regulations and under our program procedures.

Senator MILLER. I do not know what that means.

Mr. BLUMENTHAL. I mean that, Senator Miller, in a situation where the services are performed by interns or residents and mere supervisory services being performed by the teaching physician in a teaching capacity, we would not honor a billing for such services under our regulations.

Senator MILLER. All right. Now, that is just my point, Mr. Ball. I had understood—there has been quite a bit of conversation here on the part of the witnesses—that there is payment that can be made under part A to these supervisory physicians, but now I understand from Mr. Blumenthal that your regulations would prohibit such payment, and, further, that this would be in line with a court decision.

I might say that the staff has provided me, Mr. Blumenthal, with a statement referring to this as a New York Court of Appeals case. And I have here a reference to the fact that the New York Court of Appeals, which is their highest court in New York, has held that a patient does not incur any obligation to pay the attending physician in a teaching hospital a fee when the care involved is rendered by interns or residents. So that is right in line with your statement, but it is a New York Court of Appeals case.

Mr. BLUMENTHAL. I am not familiar with that decision. I am familiar with the decision of the Supreme Court of New York.

Senator MILLER. Well, the supreme court was upheld by the court of appeals. So now you have the New York Court of Appeals standing for that very principle which you now have enunicated. But what troubles me now is that it appears as if the new regulations which would be promulgated pursuant to section 1862 of the Social Security

Act would allow payment under medicare for services rendered in that type of a situation where no liability was incurred by the person furnished the services.

Mr. BLUMENTHAL. Where the services are performed by interns or residents?

Senator MILLER. That is right.

Mr. BLUMENTHAL. But I would point out, however, that where the physician—this is the teaching physician—himself undertakes responsibility for the case with a personal involvement in the care of the patient we would then honor a charge attributable to that service.

Senator MILLER. Under part B?

Mr. BLUMENTHAL. Under part B.

Senator MILLER. Oh, yes. I am not worried about that at all. I am concerned about part A, and I understood the witnesses to testify this morning that you were ready, willing, and able to pay under part A for the supervisory physicians.

Mr. BLUMENTHAL. The part A payment to the hospital would cover supervision of interns by a teaching physician, and that would mean that the salary of the teaching physicians attributable to teaching services would be recognized as a factor of hospital cost. The payment would not be made to the physician directly.

Senator MILLER. All right. So in that case the payment would go to the hospital?

Mr. BLUMENTHAL. Yes, sir.

Senator MILLER. But what we have been talking about here this morning have been those payments that went to this association. And as I understand it both part A and part B services were covered by that——

Mr. BALL. The payments to the association were made only under part B.

Senator MILLER. All right.

Mr. BALL. And this was supposed to be for personal services. And we have no documentation that any such services were rendered.

Senator MILLER. All right. Well, I am glad we had this point clarified with respect to this legal obligation.

I have no further questions, Mr. Chairman.

RECOVERY OF $1.6 MILLION AND LIABILITY OF INDIVIDUAL PHYSICIAN

Senator FANNIN. Yes, Mr. Chairman. I am just wondering about the legal entity of these associations. Here you have, I understand 512 members with about a hundred full- or part-time employees. Do they have an executive committee? Are they incorporated? What type of entity is involved?

Mr. TIERNEY. I am not sure that I can tell you about the whole structure of the organization, Senator. I think the GAO can because they have gone into that in greater detail than we have. What we have primarily concerned ourselves with whether or not they were rendering services to the beneficiary. When we found out they were not, we stopped it. But part of the continuing investigation would be into the structure of the organization itself, but I think maybe the General Accounting Office can reply to that.

Senator FANNIN. One reason I am concerned is that we are talking about a recovery. I think we stated $1,600,000 had been paid to them. I do not know what the disbursements have been up to date, but their figures used one considerably below that amount, but naturally I imagine that the disbursements are continuing. I was wondering if there would be individual liability or whether it would just be a liability of that association if they dissolved themselves or had paid out all this money, then, what position would the Government be in?

Mr. BLUMENTHAL. Senator Fannin, the payments would have been made presumably on behalf of the individual physician, and the recovery efforts could be directed against the individual physician regardless of whether or not he actually received the amounts which had been paid.

Senator FANNIN. Then the individual physician is responsible if it is determined that those payments were made improperly?

Mr. BLUMENTHAL. In my opinion, yes, sir.

Senator FANNIN. Do they have an agreement with the association as far as the liability is concerned?

Mr. BLUMENTHAL. Senator, I am not at all familiar with the facts in this case.

Senator FANNIN. I see. I am trying to determine not only in this case, but what we can look forward to in the future if these associations are going to operate hospitals, or at least participate to this extent. I am worried about how many others there might be that are in the same position, especially where there is this amount of money involved. And I do not know just what action is normally taken if a billing is illegal. You are saying it will be taken against the individual doctor. So if the doctor has received the money he is responsible for his income tax and all, but here you have that recovery from him whereas the money really has been involved in the association. I am wondering if you really can make that recovery.

Mr. BLUMENTHAL. Well, I would have very little doubt in my own mind that the action would lie against the individual in whose name the billing was made.

Senator FANNIN. Are there any stipulations in any agreement when a carrier does start to pay for the claims that are being made?

Now, certainly, they must have some type of an understanding.

Mr. Ball, maybe you can clarify that for me?

RESPONSIBILITY OF CARRIERS

Mr. BALL. Senator, rather detailed instructions are in the hands of all the carriers as to what they are required to do in the way of documenting these cases, in the way of making sure that they have a basis for payment. And I would be very glad, with the permission of the Chairman, to insert those instructions in the record at this point which tells the carriers what they are required to have from such groups, from such individuals before making these payments for personal services of supervising physicians.

Senator FANNIN. It is the carriers' responsibility. If they do not follow through and so instruct the association or the individual doctors, and they are not aware of the requirement, then of course the

carrier would be at fault. Then, the recovery would be against the carrier, is that right?

Mr. BALL. Well, I believe the recovery would actually be against the individual physician, but we would certainly say that the carrier was at fault in not following those instructions.

RESPONSIBILITY OF SOCIAL SECURITY ADMINISTRATION

I would like to add, though, Senator, that we consider that the Federal Government and the Social Security Administration have a strong responsibility for monitoring carrier performance. And as I discussed yesterday, we do this in a variety of ways. The regional offices on the spot are in touch with carriers. We have a much more indepth review of carrier performance from central office personnel periodically.

And now in these larger carriers we are going to have a person on site with the carrier all the time so that we are fully aware of any problems and difficulties and perhaps failure to follow instructions in some instances. We are stepping up that whole carrier monitoring function.

Senator FANNIN. Well, now, will that mean that we will need to have additional employees to assist in that area? In other words, can't we hold that carrier responsible so that they will follow through? I mean they certainly have the obligation if they are accepting this assignment.

Mr. BALL. There is no question, Senator, but that they have the obligation, but I believe that the only way to get uniformly good performance is not just to describe what a person should do in this area and then not pay any attention to it, but rather to describe what should be done and then for us to be closely connected with that performance and in addition to spot check what is actually happening. We are moving in to look at providers and Senator Williams read yesterday, from several reports of what we found by looking at the actual providers, the hospital, the extended care facilities and that way get an idea of what the carrier performance is like.

Senator WILLIAMS. You are only just now doing that, but that is nice.

Mr. BALL. I think we need a strong monitoring system. We do it in a variety of ways, Senator. You know we also send through blind claims to see how they work out.

Senator WILLIAMS. Most of them have been blind up to the last few months.

Senator FANNIN. Well, Mr. Ball, I heard your testimony yesterday and I certainly realize that you are starting a procedure that perhaps will dismiss some of the problems we have had or at least partly take care of them. But I am still concerned that we are not setting out the rules and regulations and stipulations as to just what the procedure is so that we don't have to, that is the Federal Government does not have to pay for somebody practically on an on-the-job basis for the carriers.

I feel that we could have a tremendous number of employees involved.

Mr. BALL. The instructions to the carrier in area after area are extremely detailed, Senator Fannin, and I believe that there is docu-

mentation of policy and procedure in one area after another, and I am making only the point that we want to see that they are followed.

CARRIER PERFORMANCE

Senator FANNIN. Yes; well, I understand but what I am concerned about is the reports that we have had of negligence, just utter disregard of any of the rules and regulations, in many instances, by some of the carriers, as I think has been brought to our attention very forcefully for the last several weeks. Until there is a change of their whole attitude toward their responsibility we will continue to have these troubles.

Mr. BALL. Well, Senator, I would want to say for the record, again, as I said yesterday, that there are isolated examples of poor carrier performance and in some instances a relatively low level of performance on the part of an entire carrier operation. But I would not want to have this be a blanket indictment of the carrier performance generally. I believe that, by and large, most carriers have taken hold of a very difficult large problem here and helped the Government develop this operation in a way that brings credit to most of them.

Senator FANNIN. Mr. Ball, I agree with you, and I have talked to some of the carriers and I know the extent of what they have done and how extensive their operations have been and how cooperative they have been.

Some of them we highly respect and feel that they are carrying through in their other activities very diligently, but in many cases that we have had disclosed to us there has been great negligence and that is why I am concerned. I feel that even the best of them, and certainly we have some wonderful people and outstanding companies involved, and we have confidence in them, but at the same time we lose some of that confidence when we see the records that have been disclosed to us.

Thank you.

CARRIER POLICY ON BILLINGS BY ASSOCIATIONS

Senator MILLER. Mr. Ball, when I made the point to you that Blue Cross, or Blue Shield, in Illinois had not been accepting billings from associations and why should we do it, I believe you said that there were carriers in Illinois that have been accepting billings from associations.

Mr. BALL. Private insurance companies.

Senator MILLER. Yes; but that was not Blue Shield.

Mr. BALL. No; you are correct.

Senator MILLER. And then you indicated you would give us a list of those which had been accepting association billings. Would you mind including with that list those carriers which did not accept association billing at that time.

Mr. BALL. I would be very happy to, Senator.

Senator WILLIAMS. Could you incorporate those in the record at this point?

Mr. BALL. Yes, sir.

(The material referred to follows:)

COMPANIES AND ORGANIZATIONS WHICH REIMBURSED THE HEKTOEN INSTITUTE FOR MEDICAL RESEARCH FOR SERVICES RENDERED BY SUPERVISING PHYSICIANS IN A TEACHING SETTING PRIOR TO MEDICARE

The Hektoen Institute for Medical Research, Cook County Hospital, 627-637 South Wood Street, Chicago, Illinois 60612, is a nonprofit research corporation. The Institute has submitted the following list of organizations which make payments to its Physicians and Surgeons Fund. The fund was established to receive payment by third-party payers for services rendered by attending physicians on the staff of the Cook County Hospital.

INSURANCE COMPANIES

Aetna Life Ins.
A & H Alberts Association
All American Life
Allstate Insurance Company (Sears)
Bankers Life and Casualty
Bankers Life of Des Moines
Beneficial Standard
Benefit Trust Life
Businessmens Assurance
California Life
Catholic Knights of St. George
Conferedation Life
Concordia Welfare
Connecticut General
Continental Assurance, All Continental groups pay
Continental Casualty
Crown Life
Employees Mutual of Wausau
Equitable Life
Firemens Fund
Gateway Life
Globe Insurance
Golden State Life
Government Wide Indemnity
Great West Life
Guardian Life
Hartford Life
Home Life
Insurance Co. of North America
John Hancock
Kemper Ins. Co.
Lincoln National
Lumbermens Mutual
Massachusetts Mutual
Metropolitan
Municipal Life Ins.
Mutual of New York
National Association of Letter Carriers
New England Mutual
New York Life
Northwestern National
Occidental Life
Patriot Life
Paul Revere
Provident Life
Prudential
Republic National Life
Sentry Life Ins.
Standard Life Ins.
State Mutual Life Ins.
Teachers Annuity
Tenessee Life
Travelers Ins.
Union Labor Life
Union Mutual
United Benefit
United Federation of Postal Workers
U.S. Fidelity
Washington National
Western and Southern
Zenith
Zurich American

UNIONS

American and Bakery and Confectionery Workers
Bakery and Confectionery Workers
Casket Workers
Furniture and Bedding Workers
I. B. T. Local No. 705, self insured.

SELF INSURED COMPANIES

A. E. Staley Mfg. Co.
Chicago Wirecraft
Edison Bros. Stores
Marriott-in-Flight
Phoenix Closures
Skil Corporation
Wilson and Company
Wilson Pharmaceutical

Documentation supplied by: The Hektoen Institute for Medical Research of the Cook County Hospital.

LIST OF COMPANIES AND ORGANIZATIONS WHICH DID NOT REIMBURSE FOR SERVICES RENDERED BY SUPERVISING PHYSICIANS IN A TEACHING SETTING PRIOR TO MEDICARE

INSURANCE COMPANIES

Allstate Life Insurance (private pol.), Amalgamated Labor Iife, Blue Shield, Commonwealth Life Ins., General Accident, Liberty Mutual, Mutual of Omaha (Armed Forces), Security Mutual, United Insurance Co.

UNIONS

Amalgamated Clothing Workers, Liquor and Allied Workers Union, Local No. 705, 220 S. Ashland.

SELF-INSURED COMPANY

Cracker Jack Co. (Borden, Inc.)

GAO INVESTIGATION OF BILLING BY HOSPITALS

Senator MILLER. May I ask both Mr. Ball and also our GAO team, in your investigation did you look into billing by the hospital?

The reason I ask that is because of what appears to be very, very unsatisfactory records with respect to the physicians' services. And there was no indication I think as you testified of any supervisory activity in many of these cases. I am wondering whether we shouldn't take a look at the hospital billing for hospital reimbursement which would include the supervisory activities, or the education activities on the part of these supervisory doctors.

Have you gone into that?

Mr. ROTHER. The General Accounting Office has not included that phase of it in our review, Senator.

Mr. TIERNEY. We have not since the uncovering of this situation made any particular audit of the cost reports of the hospital. They have to file annual cost reports and they of course are all audited and we will certainly give them a very close look, Senator Miller.

Senator MILLER. Well, I wonder how much of the hospital billing for, say, one of these represented this so-called educational activity. The thing that troubles me is that with regard to these supervisory doctors who are supposed to be in on the billing under part B at least, the records show no indication that they were around on many of these cases. So I wonder whether or not there was some educational activity that the hospital was billing the Federal Government for which wouldn't have any evidence to support it.

Mr. TIERNEY. I think I can assure you we will pay very special special attention to that.

Senator MILLER. Well, I would suggest that where you find a little fire over here you might find a little fire over there, and as long as this hospital is the one that has these doctors and the association in it, I think you ought to check that point.

Mr. TIERNEY. Yes, sir.

Senator MILLER. I am not making any blanket indictment here, but I just think we found one area of abuse and as long as you are going into it on one side you might as well go into it on the other side, thank you, Mr. Chairman.

Senator WILLIAMS (presiding). Well, Mr. Tierney, I understood you to tell the Senator from Iowa that the hospital has been audited. Now, what did you find?

Mr. TIERNEY. No; I said they are to file annual cost reports. I don't know, Senator——

Senator WILLIAMS. Oh.

Mr. TIERNEY (continuing). The present situation of the audits in Illinois or in Cook County. I was only telling the Senator that we will certainly take a long look at their cost reports.

Senator WILLIAMS. That was my understanding, that you never looked and I wanted to make it clear because I thought the record showed that they had been sending their bills in periodically.

Mr. TIERNEY. They are called upon to do it once a year, Senator. I haven't looked at the Cook County record.

Senator WILLIAMS. They are just put off for safety purposes.

Senator MILLER. Mr. Chairman, could I suggest that they provide for the record the amount of the hospital reimbursement for 1968 attributable to this education activity on the part of supervising doctors? I think that figure would be of interest to the committee.

Mr. BALL. I would be glad to do it.

Mr. TIERNEY. We would be glad to do it, Senator.

(The information requested had not been furnished at the time of printing.)

SOCIAL SECURITY ADMINISTRATION REGULATIONS

Senator WILLIAMS. Mr. Ball, I understood you to tell the Senator from Arizona that you sent out these regulations to the hospitals and so forth. When did you send them out? What is the date of them?

Mr. BALL. They are getting the dates.

Senator WILLIAMS. The last was——

Mr. BALL. There are two sets, Senator. This general position and procedure on the original regulations went out some time ago.

Senator WILLIAMS. I know. I am speaking of the ones that you are just referring to.

Mr. BALL. Now, in addition to that when this type of situation came to our attention we issued a fuller, more detailed calling of attention to all the carriers to the situation.

Senator WILLIAMS. And that was in April of this year?

Mr. BALL. And that was in April. But that was not the first, Senator. The first was on February 7, 1967, where the carriers were informed of what was needed in the way of documentation.

Senator WILLIAMS. Well, we can put both the records in, but I thought we should get the dates.

LETTER FROM GREATER NEW YORK'S BLUE SHIELD OPPOSING SUPERVISORY PHYSICIAN REIMBURSEMENT

As an indication of what some other groups think of this type of billing, I notice a letter that was written to Dr. Thomas G. Bell, the Assistant Bureau of Health Insurance Director under date of March 6, 1967. It is signed by Dr. Harold J. Safian, vice president of Medical Affairs of Blue Shield in the city of New York, and he condemns this particular principle. I will put the letter in the record, but first I will just read a couple of sentences:

I believe that the Social Security Administration should be aware of the essential dangers in the regulations it has established and proposes to establish for reimbursing supervising physicians for services performed by interns or resi-

dents. The Social Security Administration should establish a program of reimbursement which primarily benefits the patient, which seems to be something that is forgotten so often. The payment for services a beneficiary is not obligated to pay for, and which is excluded under the Medicare Law, does not benefit the beneficiary directly and will lead to abuse and increased costs under Medicare.

The proposed regulations are of serious concern to us since they provide for reimbursement for services for which, under the law of New York State at least, the beneficiary has no legal obligation to pay.

And they go on and cite the court case and all.

Continuing here—

Physicians in a teaching setting do not regard patients cared for in out-patient facilities or admitted from out-patient clinics or emergency rooms as their private patients.

I ask that the whole letter be put in the record.

The CHAIRMAN. Yes, the letter to which you refer will appear in the record at this point.

(The letter referred to follows:)

GREATER NEW YORK'S BLUE SHIELD,
New York, N.Y., March 6, 1967.

THOMAS G. BELL,
D.P.A., Assistant Bureau Director, Intermediate Operations, Bureau of Health Insurance, Social Security Administration, Baltimore, Maryland

DEAR DR. BELL: Mr. Molloy has asked me to reply to you on the draft of a proposed Intermediary Letter concerning payment for the services of attending physicians supervising interns and residents. Since this proposed Intermediary Letter is intended as an amplification of Section 405.521(c) of the Criteria for Determination of Reasonable Charges as published in the Federal Register on February 8, 1967 and is also a proposed supplement to Intermediary Letter 196, I feel it advisable to comment on the overall matter of reimbursement for services of supervising physicians in the teaching setting.

To begin with, it is our opinion that the administrative implementation of Medicare should not disrupt the medical and economic situation in a community. I believe that the Social Security Administration should be aware of the essential dangers in the regulations it has established and proposes to establish for reimbursing supervising physicians for services performed by interns or residents. The Social Security Administration should establish a program of reimbursement which primarily benefits the patient. *The payment for services a beneficiary is not obligated to pay for, and which is excluded under the Medicare Law, does not benefit the beneficiary directly and will lead to abuse and increased costs under Medicare.*

The proposed regulations are of serious concern to us since they provide for reimbursement for services for which, under the law of New York State at least, the beneficiary has no legal obligation to pay. *The Court of Appeals of the State of New York has held that a patient does not incur any obligation to pay the attending physician in a teaching hospital a fee when the care involved is rendered by interns or residents.*

As you are well aware, Section 1862 of Title XVIII provides that no payment shall be made under Part A or Part B for any expenses incurred for items or services:

"(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for."

In my opinion, when beneficiaries are treated by residents or interns under the supervision of attending physicians in teaching hopsitals, there is no contractual obligation between these physicians and these beneficiaries, they have no choice of physician, and they, in fact, look to the hospital for their medical care. There is language in Section 405.521(b) and in the proposed regulations which

gives bases for denying reimbursement under Medicare for the services of supervising physicians in a teaching setting and I would appreciate clarification from you if the Carriers would be correctly interpreting the regulations in denying reimbursement. It is stated (the italic is mine) that

"Many will receive care in these hopsitals *as patients of physicians* who, in turn, will involve interns and residents in the care of *their* patients."

It is also stated that:

"Payment on the basis of reasonable charges in applicable to the professional services rendered to a beneficiary by *his* attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of *his* patients".

Physicians in a teaching setting do not regard patients cared for in outpatient facilities or admitted from out-patient clinics or emergency rooms as their private patients. In these situations the beneficiary cannot claim the attending physician as *his* physician. Thus, if the beneficiary in these circumstances asked to see a physician he would not be able to see the attending physician but rather a resident or intern assigned to him. The only time he sees the attending physician is when the attending physician makes his rounds. The attending physician is not that patient's physician and the responsibility of the attending physician is to supervise and teach the residents and interns rather than to provide personal care to the patient. It would be my interpretation of the above stated regulations that, in these situations, the attending physician in the teaching setting is not entitled to reimbursement.

Another statement in the regulations could also be relied upon as a ground for denying payment under Medicare in these situations. It is stated in the regulations that a charge should be recognized under Part B:

"Only if his (the physician's) services to the patient are of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients."

Some attending physicians in a teaching setting do have an independent private practice in which they recognize that their responsibility to the patient is direct and personal and quite different from their responsibilities in the teaching situation. Accordingly, the foregoing statement could be a basis to deny reimbursement in the situation in question.

Since some physicians in a teaching setting do have an independent private practice, it is conceivable that they would have a relationship with beneficiaries that would entitle them to charge a fee. If the physician in the teaching setting was permitted private practice, and if beneficiaries consulted him in his private physician capacity, if he personally admitted beneficiaries to the hospital as his private patients, and if he assumed personal responsibility for the care and treatment of the beneficiaries as his patients, then the bases would seem to be there for the charging of a fee.

United Medical Service is most concerned about this matter. There is the question of the legal obligation of the beneficiary to pay for the physician's services in the teaching setting when the services are actually being rendered by interns and residents. There is the question of reimbursing these physicians in a teaching setting out of Part B funds when, in fact, there is already some payment being made out of Part A funds for teaching which might duplicate, in part, payment for these teaching services. Further, it seems that serious consideration should be given by the Social Security Administration to the question of whether it is not creating a liability where one has not previously existed. If such are the circumstances, the Social Security Administration would certainly be increasing the costs of medical care to its beneficiaries and this is the fundamental problem which we have with the regulations and the proposed amplifications of these regulations.

You will recall that the proposed regulations state that the amount payable under the Program for supervising may be determined in accordance with the same criteria for the determination of reasonable charges as are applicable to the services a physician customarily charges outside the teaching setting. While this procedure would also be a factor in increasing the costs of medical care, it raises an additional question. It is my understanding that the Carrier has prime responsibility for the determination of reasonable charges. The proposed regulations modify this to the extent that the Carrier is now told that the charge for supervising in a teaching setting may be equal to the charge for a personally performed service made outside the teaching setting. It does not seem logical

to use the fees charged in private practice to determine reasonable charges for the supervisory services performed in the teaching setting. In the teaching setting the intern or resident performs the services as in the case of surgery, the operation, and at most, the attending physician will be present. It seems to me that there must be a difference, even if the Social Security Administration continues to insist on reimbursement in these situations, between the value of the attending physician's services when he personally performs a medical service or operation and their value when he is merely present or supervising.

I would urgently request that the proposed regulations be seriously reconsidered. In the event they are not reconsidered by the Social Security Administration, I would also appreciate further clarification that would permit Carriers to implement the reimbursement provisions of the proposed Intermediary Letter and Intermediary Letter 196, in view of the comments I have expressed in regard to eligibility for reimbursement and the extent of reimbursement.

Sincerely yours,

HAROLD J. SAFIAN, M.D.
Vice President, Medical Affairs.

Senator WILLIAMS. There is an argument that these types of payments are not in the best interest of the profession and certainly not in the best interest of the medicare program. I am concerned a little bit because I get the impression you think this is all right and you are going to continue it as long as they do not bill for the interns, but this setup is going to be continued. Am I correct or not?

Mr. BALL. Senator, it is our present intention—I will be very happy to take a thorough look at this whole fundamental policy again—but it is our present intention to continue the payments when this physician does actually render his own personal services to a personal patient. That is the basis under which the payments are made under part B, with detailed documentation.

Now, you are raising the fundamental question of whether any such payments should be made——

Senator WILLIAMS. I am not raising it. It has been raised several times and it has been decided in the courts in some cases. But I am just raising it again with you.

Mr. BALL. Senator, as Mr. Blumenthal suggests, it was his opinion that the decision in New York was reconcilable with our basic position—that that decision is not in conflict in his opinion with our position was what he testified to a few minutes ago.

Senator WILLIAMS. Well, I hope you reevaluate that.

POSSIBILITY OF FRAUD IN SUPERVISORY PHYSICIAN CLAIMS

Has there been any reference or suggestion that any of these instances discovered in this Cook County investigation may be referred to the Department of Justice for erroneous billing and so forth?

Mr. BALL. I do not believe we are at that point in any of them, Mr. Chairman.

Mr. TIERNEY. No, Senator, we have not made any such recommendations yet. We have not discovered on the part of individual physicians a fraud. Now, whether or not the whole emerging pattern of the entire operation will indicate fraudulent intent is something that we will be investigating. And if it does we will proceed accordingly.

Senator WILLIAMS. Well, let me just ask GAO a question in that connection. Was there any evidence of erroneous bills and, if so, what type billing was it? Was there billing for services not rendered?

Mr. ROTHER. We found several cases which I included in my opening remarks, Senator. In 129 out of 747 follow-up visits which we included in our review we could not find any record of any service by anyone, any physician I should say. By that I mean that we could not find any record of even a resident or intern providing the service. Those are about the only cases where that issue came up in our review.

Senator WILLIAMS. Well, now, Mr. Tierney, just assuming for the moment that there has been billings for services for which there is no evidence of having been rendered, how would you describe it?

Mr. TIERNEY. If there had been deliberate billing for services for which no services were rendered—I am not making a legal conclusion—that sounds fraudulent to me, sir.

Senator WILLIAMS. You say it would be fraudulent?

Mr. TIERNEY. I say it sounds that way to me.

Senator WILLIAMS. Yes. And appropriate steps would be taken if you find such to be the case?

Mr. TIERNEY. Yes, sir.

Senator WILLIAMS. The committee will recess until 2 o'clock.

(Whereupon, at 12:45 p.m. the committee recessed, to reconvene at 2 p.m. on the same day.)

AFTERNOON SESSION

The CHAIRMAN. I think it might be well, for the benefit of the press, to note that we intend to start hearings on Tuesday, July 9 with regard to the tax bill that the House passed the day before yesterday. The Secretary of the Treasury will be here on Tuesday as our first witness.

We will start at 9 o'clock on Tuesday.

Now, Senator Bennett, I believe that you had a few questions.

JUSTIFICATION FOR SSA INITIATION OF NEW POLICY OF PAYING SUPERVISORY PHYSICIANS

Senator BENNETT. Thank you, Mr. Chairman. I would like to proceed with this question of the payment to supervisory physicians, and my questions will be addressed to Mr. Hess, but I will take my answers from anybody.

What motivated you to set up an elaborate system of payments to supervisory physicians in teaching hospitals? Is this not the kind of thing for which payments were generally rejected by Blue Shield and private health insurers before medicare?

Mr. HESS. What motivated us was that this was a very far-reaching and fundamental question of basic importance to the medical education system of the country, and that is that physicians, private practitioners involve their private patients in what are called teaching programs or residency programs. Depending upon the extent of experience of the resident or intern, whether he is new or whether he is a fifth year or sixth year resident, supervision is necessary, both to give good medical care and to make it possible to run these residency programs. In hospitals all over the country, community nonprofit hospitals, great big medical school hospitals, all kinds of hospitals that have residency programs, it is necessary for the private physician to involve his patients in teaching programs. And if we said, if the law were to say, that because a resident or intern may at some point

in the procedure have a significant responsibility for an episode or part of an episode of care to this patient, then the private physician loses not only his doctor-patient relationship but his right to a fee—this would be a very grave problem for the teaching programs.

Now, we sought precedents. We had consultations and we found that there were a number of our large carriers who recognized these fees, unlike the New York carrier, in its contract with its subscribers, did not.

We found a number of large carriers, including several large Blue Shield carriers and some private insurance carriers, who recognized the fee of an attending physician when he is the attending physician but is assisted to some degree by an intern or resident.

Now, it is easy to tell who is the attending physician when the patient comes into the doctor's office first and then is admitted to the hospital and the doctor keeps a continuing relationship even if the intern and resident may get heavily involved. But, what happens when you are dealing with an admission to the hospital where the patient no longer comes to the hospital as a service patient, as used to be the case, and then becomes a ward patient? Now under medicare, he comes to the hospital with a little red, white, and blue card in his hand, and by law he has the right not only to a semiprivate accommodation, but to a private physician.

The hospital may assign a senior man—whether he is on salary or whether he is a community physician—to be that man's attending physician. That senior man very frequently will see him within a number of hours after admission and will confirm the diagnosis, or check with the resident or intern, and so on. He takes responsibility for the care and has a legal responsibility for the care, and under the law could be recognized as the attending physician.

This situation ranges all the way from the famous private patient clinics like Mayo Clinic or Henry Ford Hospital, to the municipal hospitals like Cooke County. So we tried to draw a line that said we will pay where a physician gives personal and identifiable service, even if that service includes substantial supervisory or teaching responsibility with an intern, if this is his patient but only if he renders the kind of services to this patient that he would to other private patients. The original regulation set forth such requirements for payment as being present at major surgery, examining the individual, confirming the diagnosis, checking the course of the treatment and so on.

If these factors occurred and a charge was made, it would be recognized that the patient had an attending physician.

Now, many of the physicians in these programs are not on salary in the hospital. They have traditionally volunteered their services as teachers as a part of their obligation to the medical staff of the community hospital. But again, the circumstances range all the way from the local doctor who is on the staff of a teaching hospital—one with interns and residents—and assumes responsibility for a teaching program for some period of time, to the medical school faculty who are full time and may not be on the payrolls of hospitals at all. They may be on the payroll of the medical school, and if they get fees that come from a doctor-patient relationship and personal service to patients they turn them over very frequently to a medical education fund from which

salaries and other things that have to be paid in the medical school are paid.

I think what happened in Cook County was that somebody had a very crude idea of applying to a municipal hospital situation a concept that the regulation recognized could occur because it is something that does occur in teaching and residency programs around the country; namely, billing for an identifiable service by a practicing physician to a patient.

The CHAIRMAN. Have you seen this statement by Dr. Sam Hoffman about that situation in Cook County?

Mr. HESS. Yes, sir.

The CHAIRMAN. Did you read it?

Mr. HESS. I would have to refresh my recollection.

The CHAIRMAN. Well, he said he interned there and is now the director of the division of laboratories, and also director of the Hektoen Institute for Medical Research in Cook County as well as professor of pediatrics at the University of Illinois. He refers to the situation that is going on there as "looting", he refers to it as "burgling of the treasury by unscrupulous doctors", he refers to it as "unethical practices and petty theft", and he refers to it elsewhere as "grand larceny" and he says that the majority of physicians agree with him.

Mr. HESS. I agree, too, sir.

The CHAIRMAN. You think that is right?

Mr. HESS. There is no comparison between what they set up in Cook County and what was permitted under the regulations.

The CHAIRMAN. In other words, you never had anything like that in mind at all?

Mr. HESS. No, indeed.

RECOVERY OF FUNDS

The CHAIRMAN. Well, those people want to testify and we will see them. Now, are those claims that those people pursued, are those payments beyond recall?

Mr. HESS. We have stopped payment and we have recovery proceedings underway.

The CHAIRMAN. Well, they got a million and a half dollars so far. Are you going to see if you can get your million and a half back?

Mr. HESS. Yes, sir. Not all of it, necessarily. You know, we will have to look at the claims. Now, there are out of these 500 physicians who are members of the foundation—only a hundred and some who are on salary. There may be some who can show that they performed a direct personal service with respect to a patient. Not every single case is undocumented, although the GAO indicated, as our examination indicated, that the vast majority are undocumented.

So, we have to see whether there is any part of this amount that may be legitimate that they may have collected.

The CHAIRMAN. It would seem to me when they get paid for all sorts of things that they were not paid for before, that at the minimum they ought to be willing to do a little something now for mankind or for humanity, that they were not getting paid for. In this particular case it would seem to me that the $20,000 to $30,000 salaries these doc-

tors were getting were supposed to pay for that supervision. Is that your understanding?

Mr. HESS. Yes, sir. The salaries they are getting, of course, have been treated as being entirely on the part A side and as though the salaries are strictly for teaching and administration, and the point we brought up this morning was that we need to also check and make sure that services were fully rendered for that.

The CHAIRMAN. Go ahead.

NUMBER OF HOSPITALS INVOLVED

Senator BENNETT. The inference I get from your testimony is that this is a program which extends over many hospitals, which in the case of Cook County was subverted and exploited. Do you have a record of how many hospitals are operating under this supervisory physician system?

Mr. HESS. The question of defining the supervisory physician system is one of whether you mean all of the residency programs in the country, which involve practically all of the largest hospitals in all communities. I do not know how many thousands of residencies we have in the program.

Senator BENNETT. What you are saying, then, is the situation of a relationship between the supervisory physician and a resident or intern and the patient exists in every hospital in which there are residencies?

Mr. HESS. Yes, potentially in every residency situation, and that is why we tried to draw a line between where we would pay and where we would not.

NATURE OF PATIENT'S RELATIONSHIP WITH SUPERVISORY PHYSICIAN

Senator BENNETT. Then, to go back and make my interpretation of one of the things you have said earlier clear, that a patient comes in under medicaid——

Mr. HESS. Medicare.

Senator BENNETT. Medicare. He has no personal physician so one is assigned to him or he is assigned to one of the supervisory physicians by the hospital staff, and that physician takes the place of his personal physician during the time he is in the hospital?

Mr. HESS. This is generally the situation. If the person comes in without a physician, he cannot get services in the hospital until he has a personal physician assigned.

Senator BENNETT. Well, now, let me go back on that. A man presents himself to a hospital with a little card, as you said, and can he come there without a physician as indication that he needs it? Can he just present himself in the front door with his card and say I would like an appendectomy, please?

Mr. HESS. This can happen in an emergency, it can happen if he is a stranger in town or—as is the case for many people in large cities—if he has not had a personal physician.

Senator BENNETT. So, without a personal physician he, in effect, comes to the hospital and says, "Please assign me a personal physician to find out whether I need one"?

Mr. HESS. What he says is, he is ill. The hospital has to make a decision—they cannot turn him away from the doorstep, they have to put him through at least an admission procedure to determine whether or not he needs a physician and hospital services.

Senator BENNETT. And then having determined that he can use hospital services they then assign somebody, either from their supervisory staff or from a list of physicians who are willing to serve?

Mr. HESS. Right, and in hospitals like Cook County and in many hospitals traditionally in the past, I suspect that very often it was the resident or intern who was assigned. As for the supervising physician, his relationship can be direct or casual, as the evidence shows that it was in this case.

Senator BENNETT. Is his relation to the resident or intern permanently determined before the resident or the intern is assigned?

Mr. HESS. You mean——

Senator BENNETT. In other words, if I am assigned to resident A do I automatically pick up the services of supervisory physician B?

Mr. HESS. That depends on the arrangement in the hospital. That could be. That could occur, but more frequently you are assigned to a practicing physician who is either on duty at that time or who is a staff member in the department, and he may or may not be present in the hospital at the time. But as soon as you are assigned to him, the first medical person who gets connected with your case will check in with him, will let him know; or when he checks into the hospital he will know that there is a patient that he has to see.

Senator BENNETT. A resident or an intern cannot collect fees for service to that man, so he passes behind him, one man behind, who then becomes in a position to collect the fee for service of that individual?

Mr. HESS. Only if he accepts the responsibility as the attending physician who, as the regulation states, performs for this patient the kind of services that he performs for his own patients.

Senator BENNETT. Then what you are saying about the charges in Cook County is in effect that these people accepted the fee without having accepted the obligation to perform?

Mr. HESS. Yes, sir, and I would like to add what we have said over and over again to physicians who pointed out the import of our regulation, that there would sometimes be Medicare patients for whom a part B fee would not be payable because they did, in fact, get most or all of their care through a resident or an intern. We said, "Well, that is the way the law is written, and that is the game. If you admit a patient and, in fact, you do not find it necessary to assign an attending physician—or if the attending physician does not find occasion to perform any significant personal, identifiable service—then there will not be any Medicare payment except for picking up the cost of that resident's or intern's salary. That is the way that it was intended to be."

Senator BENNETT. Do you have any record of the amount of money that you have paid out under this system to the supervisory physicians?

Mr. HESS. We have in a few places some identification of this, but basically, because the claim comes through as the attending physician's claim we do not have separate records. The carrier would have to have the records of the teaching organizaitons he is dealing with and he would have the proper documentation.

Senator BENNETT. Is there not another element of this situation? Do you not only have to discover or verify that there was an identifiable service personally rendered; do you not have to discover that there was a legal obligation to pay?

Mr. HESS. Well, there has to be a legal obligation under our law, yes, sir, and under State law. I know of no State law where an attending physician serves a patient in a doctor-patient relationship and performs services for him where there is not a legal basis for a fee and a doctor-patient relationship.

Senator BENNETT. Is there any particular or precise way by means of which that legal obligation is specifically created, any record, any contract, any indication that the patient has created a legal obligation?

Mr. HESS. Well, I would like to just generalize on this and then ask if Mr. Blumenthal would like to comment on it. I think if you were to look at the law with respect to malpractice or with respect to a contract there is a legal obligation the minute a licensed physician begins to perform personal services for the patient. There does not have to be any contractual obligation in writing between the individual and his physician.

Senator BENNETT. I am quoting from the Cleveland Plain Dealer, an article that appeared on February 28 of this year regarding the problem of a Mrs. Fay Miller. She was a patient at the Highland View Hospital in November and she questioned the bill because she got a bill from the doctor which she questioned because the doctor was on the county payroll. Mrs. Miller permitted reporters to copy statements that show that medicare paid the internist $356 for treating her husband. He had billed medicare for $445, so he sent her husband the bill for $89 for the difference between what they paid him and what medicare paid him and what he thought he was entitled to.

Now, he is a county employee, and presumably this service was in the county hospital. William G. Snodgrass, acting hospital director said that if a private patient-doctor relationship had not been agreed upon, this same doctor would have treated Miller and there would have been no charge, and the Millers denied that they made any private-doctor-patient relationship.

Now, is not that the situation when a person walks into a hospital without a request for a particular doctor or without agreeing in writing that this doctor is satisfactory to them, just has the doctor assigned who may never see them, except casually? Is this a legal obligation, in your opinion?

Mr. HESS. Well, if he sees them only casually—I do not know whether there is a legal obligation or not. We are not obliged to pay under the regulation in that situation.

Senator BENNETT. Well, are you—on the contrary——

Senator WILLIAMS. But you did pay it.

Senator BENNETT. You did pay it. Now, I wonder, on the contrary, if you are not under an obligation to test the legal obligation before you do pay it? Are you in a position to just accept these bills that came to you from the Cook County Hospital and just automatically assume that there is a legal obligation, and pay them without checking?

Mr. HESS. Well——

Senator BENNETT. The carriers tell us that they cannot find out whether a legal obligation exists or not in these cases, that they were told to pay them.

Mr. BLUMENTHAL. Senator Bennett, the law generally recognizes the legal obligation to pay when a patient places himself in a position where he expects the rendition of medical service. More specifically, sir, under the provisions and the legislative history of title XVIII, this issue that you are raising goes beyond the teaching physician problem. You may recall, sir, that in 1965 when the title XVIII legislation was under review both by the Ways and Means Committee and subsequently by this committee, the issue of the hospital-based physician was commented on and reviewed at great length.

These are the physicians who practice pathology, radiology, anesthesiology, and include also the physiatrist, physical medicine.

At that time the question was raised whether these physicians, many of whom were salaried physicians, should have their services recognized as hospital services payable under part A, or as physician's services payable under part B.

There had been a difference of view between the two committees. The issue was resolved through the adoption of the views of the House of Representatives that in these instances the professional services performed by the physicians for hospital patients would be recognized and payable under part B as physicians' services performed for beneficiaries.

Now, in these instances, sir, the arrangement for services is not made by the patient with the physician. The parallel, I think, is quite clear, and I think also it influenced us in large measure in reaching the conclusion we did on the issue that we are discussing now.

Senator BENNETT. That history was on the typically hospital-based service doctor, the radiologist, the patholgist, the anesthesiologist.

I am sure that, neither committee ever expected that this would be spread out to apply to the surgeon and the internist, and all of the rest of these people who are now collecting these fees. Are you suggesting to us that we actually intended that surgeons and other practitioners, other specialists should be considered as hospital based?

Mr. BLUMENTHAL. I believe that the legislative history so reveals, sir, although the committees made reference to these specific specialties the discussion centered on those physicians who are hospital-based because their remuneration was received by or through the hospital, not with regard particularly to the type of practice that they engaged in.

Senator BENNETT. OK.

Mr. BLUMENTHAL. Now, let me say beyond that, and I refer again to my original statement, as a matter of law generally, even beyond the specific provisions of title XVIII of the Social Security Act, where an individual places himself in a position where he is seeking medical service there is recognized the physician-patient relationship even without the presence of a choice of a particular physician by the patients, and this is true in law in the hospital patient setup.

Senator BENNETT. This is the interpretation you put on the law as we passed it?

Mr. BLUMENTHAL. Yes, sir.

Senator BENNETT. Yes, sir, and you put the most liberal interpretation you could which, in effect, says that if a hospital employs a doctor of any discipline there they are then free to give him an opportunity to serve his patients that come into the hospital, and regardless of the amount of the hospital pay for his services, he is free to accept payment from the patient assigned to him, according to the schedule?

Mr. BLUMENTHAL. Senator Bennett, may I address myself to the second part of your statement, and this is with regard to the allowable fee.

Now, I have discussed the establishment of a relationship which would give recognition to a payment.

Senator BENNETT. Yes. May I stop you there?

Mr. BLUMENTHAL. I did not suggest, sir, that there would be a fee allowable that would not be related to the arrangement between the physicians and the hospitals.

Senator BENNETT. All right, but you have allowed in this case, and I am not sure how many others, the hospital to go on paying these people and allow them also at a second level of relationship to take the normal fee for the service of the patients which are assigned to him.

Mr. BLUMENTHAL. Now, we do not recognize dual payments for the same service.

Senator BENNETT. No, I do not say that. You recognize that the hospital can pay this man under title A, and then he can charge under title B and you can get, in effect, twice as much money for these services of that doctor.

Mr. BLUMENTHAL. Well, first of all, we both recognize, sir, that there are two different services for which payment is being made, one the hospital service and the other the professional service to the patient.

Now, with regard to the establishment of the customary charge in such a situation, the customary charge would be geared to the portion of his salary attributable to professional service, if his arrangement with the hospital provided for such compensation.

Senator BENNETT. Have you ever checked, or do you maintain a file showing the proportion of salary that is attributable or attributed by these various hospitals to their various in-house physicians and how much of the time these people have to serve private patients?

Mr. BLUMENTHAL. Well, you understand, of course, that in my office we do not review the individual cases except insofar as arrangements are submitted to us.

Senator BENNETT. What is your office?

Mr. BLUMENTHAL. This is the Office of the General Counsel of the Department, sir.

Senator BENNETT. You would not be concerned with that, and I will ask Mr. Ball.

Mr. BLUMENTHAL. But I do want to make mention of at least one instance where such an arrangement was submitted to our office in which this very issue of customary charge was raised, because under the contract between the teaching institution involved and the hospital the teaching physicians were, by contract arrangement, compensated not only for their teaching services, but also for the patient care services in that institution, and in that instance we advised the Social

Security Administration that based on the contract under review the customary charge would be that extracted from that portion of the contract arrangement to take care of patients in the institution, and this means specifically that the payment would be a portion of the salary and only that amount which is attributable, based on salary, to patient care would be allowable under part B, and this, of course, is embodied also in our regulations which relate to the hospital-based physicians, all hospital-based physicians, not only those in the teaching section, where the compensation is received from the institution.

Senator BENNETT. Well, now, what you have told me is not quite clear. Here is a man who has a dual salary and let us say it is $1,000 a month for his services to the hospital and $1,000 a month for his service to patients of the hospital, and he serves the patients.

Would that hospital allow him to make any charges to the patients directly?

Mr. BLUMENTHAL. This would be a matter of contract arrangement, but assuming that it did not——

Senator BENNETT. Well, assuming that it did not, we have no problem.

Mr. BLUMENTHAL. This still would be recognized where the billing by the hospital is on behalf of the physician services.

Senator BENNETT. Suppose the hospital's billing for that physician's services instead of being $1,000 was $2,000, who got the extra thousand?

Mr. BLUMENTHAL. There would not be allowed the extra thousand under those circumstances.

Senator BENNETT. Well, now, wait a minute. Here is this man serving 20 patients with procedures which would average $100. If you are going to bill at the average rate you bill $2,000. You say you will not allow it. At what point would you stop it?

Mr. BLUMENTHAL. At the point of billing, sir. I am assuming again, and I believe you are also, that in this instance the physician is compensated on a salary basis.

Senator BENNETT. That is right.

Mr. BLUMENTHAL. So the——

Senator BENNETT. But the hospital is going to bill the patient, it is not going to bill it directly, it is going to bill it through an intermediary and the intermediary bills the patient at the regular price for the procedure, and in 1 month that service generates $2,000. What do you do?

Mr. BLUMENTHAL. I am suggesting to you, sir, that the point of reference with the establishment of the allowable, customary charges would be the salary arrangement that the physician has with the hospital, and not the charge which is made by the hospital to the program.

Senator BENNETT. Who gets the extra $1,000?

Mr. BLUMENTHAL. There would be no extra $1,000.

Senator BENNETT. You bill Medicare for 20 procedures at $100 apiece——

Mr. BLUMENTHAL. Then the amount would be reduced to reflect the portion——

Senator BENNETT. At what point?

Mr. BLUMENTHAL. At the point of payment.

Senator BENNETT. In other words, medicare would catch it and refuse to pay the intermediary?

Mr. BALL. When the physician is paid for all his services on a salaried basis, the intermediary, Senator Bennett, would have estimated a rate which would not go over the maximum when they are adding together or reaching that $1,000 that was the contract arrangement between the hospital and the physician.

Senator BENNETT. In other words, the intermediary would have a little ticket which says as far as Dr. Jones in concerned, do not pay him more than $1,000, regardless of how many operations he performs at the regular rate?

Mr. HESS. Well, Senator, he will have a little ticket that says as far as Dr. Jones is concerned—let's assume he is a pathologist—the rate that the intermediary has established, after consultation with the hospital and with the physician to put these two pieces together is a rate per service that is related to his compensation.

I think we are now using the term "intermediary" perhaps in a way that may cause some confusion, sir. The intermediary in this situation, is either the part A intermediary or it is the "carrier," as the term is used in part B. The instructions to our carriers and intermediaries at the beginning of the program and directions that we have issued and reviewed with them involve their getting together where there are hospital-based physicians with the hospital on the one hand and the physician groups on the other—some of these are groups that are under arrangement with the hospital—and determining what is the reasonable charge, always understanding that these payments can be made only for services which are personal services to a patient.

Senator WILLIAMS. Does not the carrier or an intermediary at times allow payments that are in excess of the fees allowed and agreed upon?

Mr. HESS. They are not supposed to.

Senator WILLIAMS. They are not supposed to, but I am saying do they not often do it?

Mr. HESS. This occurs. I do not know whether I would characterize it as ofttimes.

Senator WILLIAMS. The reason I mention this is that in a different case the Comptroller General sent down a report to us today on another hospital and he said that one physician submitted 14 separate bills for operations performed in 1967, eight of which exceeded the prevailing fee level and they were all allowed. Now, nothing was done about it and the Comptroller General is referring it to you. Let us just face it and do not be too emphatic.

I am just wondering how the Social Security Administration knows what is going on, as to whether these figures are exceeded or not, because in this instance they were exceeded and it was not picked up until the Comptroller General found it.

Mr. HESS. I do not know that case. I would have to see it, sir.

TREATMENT OF SUPERVISORY SURGEON

Senator BENNETT. Now, let me change my examining a little bit. As I understand what you just told me, the carrier has a list furnished by the hospital of hospital-based physicians and surgeons and they

are instructed to handle each one in a different way. Now, would they put a supervisory surgeon on such a list?

Mr. HESS. A supervisory surgeon, in the sense that he is a practicing surgeon who performs surgery on patients—having a customary fee which results from the fact that he has privileges at the hospital and charges his patients the customary fee, or that he is a salaried member of a clinic such as the Mayo or Henry Ford Hospital—surely he would be on the list.

Senator BENNETT. All right, but he is a supervisory surgeon of a teaching hospital and he does not perform the operation, a resident performs the operation. Is he on the list for a fee to be paid because the resident performed the operation?

Mr. HESS. No. He is on the list so that if a charge comes in which is billed because he performed an operation for a patient or served as an attending physician for a patient, and this is a documented service, the carrier can recognize it.

Senator BENNETT. Is the carrier in a position to get proof that he actually performed the operation or served in any other capacity, or is he just on the list and he sends the report down, and because his——

Mr. HESS. Carriers and intermediaries have access to the operating reports including the patient's record in the hospital, and there has been a good deal of this kind of spotchecking and auditing, and the question of whether or not he saw the patient, and this can be checked by reviewing the records, has got to be documented. Under proper medical practices which they have to be operating under, the physician has to "sign off" on a procedure he performs and the record has to show on each day which physician is doing what for that patient.

Senator BENNETT. If he just is shown as an observer or as an attendant with no part of the procedure, does the carrier accept that as full responsibility and pay off to him? They cannot pay off to anybody else. Do you allow that?

Mr. HESS. The instructions are specific with respect to major surgery. He has to be in attendance.

Senator BENNETT. Well, in attendance? That means he stands in the corner of the room?

Mr. HESS. No, sir. Generally he is scrubbed and by the table, but he may be present and responsible even though at the particular moment, either in the whole operation or a part of the operation somebody else may be carrying on a part of the procedure.

In an instruction that we put out in April, which is being communicated to all of the teaching physicians in hospitals by the carriers and the intermediaries, we recently issued some further clarifying information. This was intended to call their attention to the strict import of the regulation and of the procedural materials that we sent out, and we said that the amount paid for direct medical services rendered by the teaching physicians should be related only to that discrete portion of the patient care for which the physician exercises the pertinent responsibility.

Senator BENNETT. Now, those are good words, but by interpretation they can be made to mean that if the physician shows up, looks at the chart, he gets paid. Is an appendectomy considered to be major surgery?

Mr. HESS. Yes, I think it is.

Dr. LAND. Yes, sir.

Senator BENNETT. Well, let me put it this way: My staff told me that they thought you considered that minor surgery. A tonsillectomy, is that minor?

Mr. BALL. The physician at the table is Dr. Land here.

Senator BENNETT. Well, this is not a physician's problem, this is a problem of the regulations. Do you regard——

Mr. HESS. Probably a tonsillectomy would be minor surgery. We have not spelled out in the regulations the procedures that can be performed and whether the surgery is major. Carriers and intermediaries have medical staffs, they have their own physician consultants and they are responsible for looking at the billings and the circumstances under which they are made. It is perfectly conceivable that for an aged person, if there is need of a tonsillectomy, that might be considered a major procedure because if he goes under anaesthesia the situation depends on his physical condition.

Senator BENNETT. All right. Are there any kinds of minor surgery for that part of the service in which he acted as an attending physician. cian or surgeon?

Mr. HESS. Yes.

Senator BENNETT. And can he still claim money for the performance of that procedure if he did not or cannot demonstrate his presence?

Mr. HESS. Not for the surgery, not for that part of the procedure, but he may very well have admitted the patient, or seen him along the way, or been post-operatively in the situation, and if that is the case, the only thing he has a legitimate charge for is the reasonable charge for that part of the service in which he acted as an attending physician.

Senator BENNETT. But, does the carrier go to the point of breaking it down? Do they not in fact accept a statement from the surgeon that this is his case and they pay him what he asks for?

Mr. HESS. I think that may occur, yes.

Senator BENNETT. The carriers responding to the committee staff said they had no way of knowing, had no way of going behind the statement of the surgeon that this is his case.

Mr. HESS. Well, the medical records are available. It is a carrier practice and a perfectly feasible situation to check the medical records. Now, if the surgeon says it is his case and they check the medical record and it shows that he was present at surgery, they would not try to go behind that except when a fraud problem is indicated.

PATIENT'S LEGAL OBLIGATION TO PAY

Senator BENNETT. Going back to this gentlemen who joined you—and his name I did not get——

Mr. HESS. Mr. Blumenthal.

Senator BENNETT. Mr. Blumenthal. Earlier we had a discussion of this question of legal obligation to pay. May I just restate again my interpretation of what you said: The minute any patient allows himself to be treated or accepted for treatment by a doctor an obligation to pay is immediately created?

Mr. BLUMENTHAL. In a general sense I believe that is so, yes, sir.

Senator BENNETT. So there is no formal activity required and they are not required to create any document or evidence that can later be checked?

Mr. BLUMENTHAL. Well, in the hospital setting the admission record and the admission form which is executed by the patient generally contains a statement authorizing the hospital and the staff to perform the required treatment, short of surgery. I make mention of that because there has to be a special authorization for surgery.

Senator BENNETT. I know. If they will not sign the statement they are not admitted?

Mr. BLUMENTHAL. This is generally so, yes, sir, except, of course, in the emergency admission.

Senator BENNETT. Though they have a right to the service. Mr. Hess, do you know of any beneficiaries who maintain that they did not engage the supervisory physicians and, therefore, have refused to authorize the payment of bills to these supervisors?

Mr. HESS. Sir, we have millions and millions of bills and have such situations. As Mr. Ball indicated yesterday we send the beneficiary a notice of every bill for which we have recognized an allowable charge and made a payment, whether it is taken on an assignment by the physician or whether it is a payment by way of reimbursement or indemnification to the patient. He gets a statement.

Now, we have situations where a patient may get in touch with the carrier or with our district office, or he may write a letter to us and say: "I do not recognize the name of this physician. I do not think that he performed a service for me. Who is he?"

And then the answer to that will be: "He was the radiologist who performed the X-ray studies or read your plates; or he was the pathologist who charged a fee for your laboratory tests; or he was the attending physician in your case, surgery or otherwise."

In some instances, and we check into these, I am sure there is a confrontation or a question as to whether or not there is an obligation. Sometimes in these instances the co-insurance billing, quite aside from our notice, is something that will trigger the patient's questions as to what service it was that he received.

Senator BENNETT. No, do you know whether you received any such complaints? Have you received any such complaints from the Cook County Hospital?

Mr. HESS. I do not know, personally.

Senator BENNETT. From the carrier?

Mr. HESS. I do not know personally.

Mr. TIERNEY. I do not know, Senator. I do not know whether the carrier has or not.

Senator BENNETT. That is the end of my questioning, Mr. Chairman.

MEDICARE'S OBLIGATION TO PAY FOR SERVICES OF SUPERVISORY PHYSICIANS

Senator MILLER. I am still not clear on this. We received testimony now that if the physician, who is a supervisor or teacher does render some services, that he is reimbursed for those?

Mr. HESS. If he does render personal, identifiable service.

Senator MILLER. Yes, but I assume that you are talking about services for which there is a legal liability to pay?

Mr. HESS. Yes.

Senator MILLER. That is understood, is it not, in your answer?

Mr. HESS. Yes.

Senator MILLER. In light of what the counsel said this morning, and in light of the court of appeals decision, I understand your regulations, according to Mr. Ball, follow that.

Mr. HESS. They are consistent with it.

Senator MILLER. So that your testimony implied that you do not pay them unless there is a legal liability to pay. Am I correct?

Mr. BLUMENTHAL. Yes, sir.

Senator MILLER. I am asking him.

Mr. HESS. Yes, sir. I also said, sir, that I do not know of any State law where a licensed physician serving as an attending physician and performing the kinds of personal services that are called for in our regulations would not have—or rather, where a patient who received those services would not have a legal obligation to pay.

Senator MILLER. Well, then, what was the court of appeals decision all about?

Mr. HESS. The court of appeals decision, as I understand it, was with respect to a contract the patient had with Blue Shield in New York, and it was held that there was no liability under that Blue Shield contract for Blue Shield to indemnify on behalf of the patient.

Senator MILLER. Well, what is the difference between that contract and your regulations?

Mr. HESS. Well, I think that contract took off on the general question of whether the insurer had a liability to recognize any payment where there had been an intern or resident service in the episode of medical care.

Now, in New York State there are many private insurers who will recognize such charges by virtue of their contracts—who will not raise a defense to the terms of the contract in reimbursement of the patient who receives such a bill—and the hospitals characteristically will look for such third-party liability in New York State.

Senator MILLER. Well, why should the Medicare do other, in New York, than what Blue Shield does?

Mr. HESS. Because the policy for the Medicare program is established by law and does not follow the terms of the Blue Shield contract.

Senator MILLER. Well, I understand the policy, I mean the program of medicare is established by law, and when I read this law which says:

> Not withstanding any other provision of this Title, no payment may be under Part A or Part B for any expenses incurred for items or services . . . for which the individual furnished such items or services has no legal obligation to pay,

and I am wondering whether this was an exercise in futility on the part of the Congress.

Mr. HESS. I would like to have Mr. Blumenthal reply to that.

Mr. BLUMENTHAL. I would like to refer back, sir, to the New York decision that seems to be the basis for a conclusion that there is no legal liability to pay, and I want to make two observations on that decision.

In the first place, it was a decision interpreting the responsibility of Blue Shield under its contract terms. The legal liability to pay in that case in New York was established and recognized by the court as having been established by the ordinance of the city of New York.

The question on which this case turned was the fact that there had been no arrangement between the patient and the physician calling for an obligation by arrangement between the physician and the patient, so that the physician would have or could have billed the patient direct and because this was an arrangement for indemnification with no expectancy for indemnification under the facts of the case, the court reached the conclusion it did.

I so interpret the decision, and as I say, I have read it with some care.

I pointed out earlier to Senator Bennett that I find distinguishing features between the requirements of the medicare law and the conclusions of the court that extend beyond the circumstances where the services in question were performed by interns or residents.

If you will recall when I testified this morning I attempted to make clear that there was no conflict between the Department's regulations and the decisions of the court insofar as it pertained to the billing by physicians for services performed by interns or residents.

Senator MILLER. Well——

Mr. BLUMENTHAL. There is another feature to the case, sir, with which the court had a little struggle, also, in the decision with which I am familiar, and I must concede that I have not read the decision of the court of appeals. One of the services for which a billing had been made included the surgery performed by a surgeon for a patient covered under the Blue Shield policy.

The court denied recovery in that instance also. I do not believe that I could reach the same conclusion on that fact situation under the Federal program.

Senator MILLER. Well, what troubles me, and I did not write this, I just read it, but what is the purpose of having the law say this:

> Notwithstanding any other provision of this Title, no payment may be made under Part A or Part B for any expenses incurred for items or services . . . for which the individual furnished such items or services has no legal obligation to pay?

What is the purpose of that if in the interpretation of it in the regulations promulgated under it, it looks like payment will be made where there is no legal obligation to pay?

Mr. BLUMENTHAL. Again, referring to the New York situation, Senator Miller, the legal obligation to pay had been established by the ordinance of the city of New York, which entitled specifically the physicians under the circumstances outlined in the decision to make a charge for personal services, so that the question of legal obligation to pay is not the question which was decided by the court in that case.

The question was the responsibility of the carrier, Blue Shield, to pay under the total circumstances of the total facts of the situation they are presenting. But, I would submit, sir, that if the physician had billed the patient and the patient had claimed indemnification under the policy with Blue Shield on the rationale of the decision, it would

appear that, and of course this is speculative because this was not decided, it would appear that the court would have found a right of recovery.

Senator MILLER. Because of the New York City ordinance?

Mr. BLUMENTHAL. Because also of the fact of payment by the beneficiary to the physician.

Senator MILLER. Because of the payment by the beneficiary?

Mr. BLUMENTHAL. Yes. I am talking about a situation on the same medical facts where the patient had been billed directly by the physician and paid the physician and claimed indeminfication under the policy. It seems clear to me, sir, that the court, on its own theory of decision, would have found the carrier liable to the beneficiary of the policy direct.

Senator MILLER. Well, as you say, that is speculative.

Mr. BLUMENTHAL. It is, yes.

Senator MILLER. But for practical purposes, it looks to me as if the interpretation of section 1862 of the Social Security Act is meaningless as far as the taxpayers are concerned.

Mr. BLUMENTHAL. I do not think I could concur in that. There are many instances——

Senator MILLER. Well, may I ask you this, or Mr. Ball, do you have any situations in which there has been a refusal by the Social Security Administration or a refusal by the carrier, supported by the Social Security Administration, to pay under either part A or part B for services rendered by one of these physician-teachers?

Mr. HESS. Well, there are many types of situations involving noncovered service, and the issue generally is determined on whether the service is covered or not. We will supply for the record whether or not there are situations specifically on the point of no legal obligation to pay. I am not aware now of a particular case.

Senator MILLER. Well, I would guess that you would be engaging in an exercise in futility in trying to find situations where the Social Security Administration has turned down on the basis of no legal liability to pay.

What I am interested in is whether or not there have been any cases where payment was turned down at all. Now, let us go beyond that, for any case, I mean, apart from the fact that maybe support the claim by a showing of services. I am talking about a situation where there has been a showing of service rendered, where that physician-teacher was turned down on his payment.

Mr. HESS. You are talking now specifically of the physician-teacher?

Senator MILLER. Yes.

Mr. HESS. There are many situations—I cannot say the extent to which bills are presented—but there are many situations in which the carriers have met with hospital staffs and teaching staffs in which they have drawn the line as to what they will pay and what they will not pay, and if cases of that kind come in it is a question of the bona fides of the claim. The validity of the documentation is the carrier's responsibility in the first instance, and this is audited and spot checked.

Senator MILLER. But, have those lines been drawn to which you refer?

Mr. HESS. Oh, yes.

Senator MILLER. Let me finish my question. Have those lines been drawn on the basis of legal liability to pay?

Mr. HESS. They have been drawn on the basis of whether or not there is a personal identifiable service to the patient in a doctor-patient relationship for which, as I say, I know of no general situation where a legal liability would not arise in an instance of that kind.

Senator MILLER. Well, then, what you are really telling me is when the Congress wrote into the law, "Notwithstanding any other provision of this title, no payment may be made * * * for which the individual furnished such items or services has no legal obligation to pay," they were engaging in an exercise in futility. It is just an empty gesture, it is just a bunch of words because we do not have that situation.

Mr. HESS. The history of this particular section, I think, is that it was lifted by the draftsman almost word for word from the typical kind of contracts that you have in some private insurance where, for example, you have a situation where the individual is a veteran and receives services from the Government or otherwise, and they would not pay in that type of a contract.

In our drafting, or in the drafting that the Congress directed of the part B provisions, there were some other specific exclusions such as the one for veteran services, so I do not know of any class of cases that would fall under this provision.

Senator MILLER. Well, I understand. I am not going to take any great offense at this, but it just seems to me that if section 1862 had not contained the language that I have been reading it would not have changed the operations of medicare one bit, as I see it.

Mr. HESS. That could be, but I think at the time that the draftsmen could not anticipate what all the situations might be that we would be faced with, and as I say, this was taken by and large from standard terminology that is found in some insurance contracts.

Senator MILLER. Well, in other words, if the Congress saw fit to delete this language you would have no objection, would you?

Mr. BLUMENTHAL. I think I would be concerned, sir, if the section were deleted, and I think that perhaps part of the difficulty I am having in communicating my thought to you is that I reach a conclusion in particular situations that you presented to me that there may be a legal obligation to pay. You asked for reference to a situation where there had been a finding of no legal obligation to pay and I have in mind one situation that came to the attention of my office very early in the history of this program where an employer made inquiry about the obligation of the program to subsidize the cost of medical care to employees who enjoyed the privileges of the health care plan.

We concluded that no payment under the medicare program could be made because the beneficiaries, the employees, had no legal liability to pay for this service that was received under the employed health plan.

Now, I give you that as one concrete illustration of a ruling that was issued by my office on that subject.

Senator MILLER. Now that, however, I presume, related to a regular physician rather than a teacher-physician?

Mr. BLUMENTHAL. Oh, yes.

Senator MILLER. I see. I think one thing that is troubling people

like me is that the physician-teacher seems to have gotten into this picture considerably more than formerly.

Mr. BLUMENTHAL. Senator Miller, I think I would agree with you fully, that this has occurred beyond the contemplation of the regulations, and very frequently there may be a failure to accomplish conceptual objectives, and this may be an instance of that type.

Senator MILLER. Well, it happens all the time over here on Capitol Hill, and I might say that I think it would be welcomed by the committee if you could present us a draft or a little modification of this which might, in your judgment and your experience, clear this thing up so that the concept would be effectuated, if you would not mind doing it. I know I would welcome it.

Would that be all right, Mr. Chairman, and have them submit it for the record?

Senator WILLIAMS. It will be all right.

Senator MILLER. Thank you.

EXCESS PHYSICAL THERAPY IN HOLLIS PARK GARDENS NURSING HOME

Senator WILLIAMS. Mr. Ball, yesterday we were discussing the excessive amount of physical therapy, and so forth, that had been approved in a certain nursing home, and in that colloquy we pointed out that they have been paid about $372,000 in one short period, I think it was about a year, and as I understand it, that case has been settled with prospective repayment of $150,000, I believe, to be deducted from future payments; is that correct?

Mr. BALL. I remember, Senator, that $150,000 was the figure that we were going to recover. I do not understand that it necessarily was going to be all charged against future payments. I am just not clear on that, but it is $150,000 that they owe us.

Senator WILLIAMS. Yes, but the agreement has been settled; there is a settlement agreement that has been effected and agreed upon?

Mr. BALL. Mr. Hess informs me that that is an approximation, that actually it is going to turn out to be over that.

Senator WILLIAMS. Well, the reason I mention that is that we have been withholding the name of the institution and all of that, and I talked with the chairman, but since that case has been settled we thought we would just include the complete report in the record, so that it could be along with the settlement announcement at the same time. We will incorporate that report in the record along with the attached exhibit No. 14, in particular, and we will let the staff fix the record on that.

(The material referred to follows:)

PROGRAM VALIDATION VISIT MARCH 24–28, 1969

TRAVELERS, HARTFORD, CONN., GARDEN CITY, N.Y.; PROVIDERS, HOLLIS PARK GARDENS (ECF), ORTHOPEDIC AND REHABILITATION INSTITUTE

Report of Extended Care Facility survey of the Travelers Insurance Company (Hartford Home Office and Garden City Field Office), Hollis Park Gardens Nursing Home and the Orthopedic and Rehabilitation Institute, Hollis Park, New York—March 24 through March 28, 1969.

The SSA team consisted of George Gordon, team leader, DIO; Gertrude Armstrong, Registered Nurse, DRB; James Riley, Jr., Certified Public Accountant, DR; Richard Dresner, Program Integrity Officer, New York Regional Office; and Ben Sandberg, ARR, New York Regional Office—Garden City Field Office only.

Hollis Park Gardens Nursing Home

The purpose of visiting this 80-bed ECF was to review the arrangement of purchased ancillary service provided by the Orthopedic and Rehabilitation Institute (ORI); trace the services billed to the patient medical records; and review the supporting records of the billings by ORI; and review the other financial records of the ECF.

The arrangement between Hollis Park and ORI was formalized in a written document which in essence provided for a five point rehabilitation program—physical therapy, occupational therapy, speech therapy, psychological therapy, and medical social services—with a charge of nine dollars ($9) per treatment. The agreement was for one year, to be canceled by either party upon 30 days notice (no written provision for renewal or extension), and a provision for an escrow account based upon 20 percent of the billings to be held by the provider in the event any billings were ultimately determined not to be acceptable by Medicare (see attachment 9). In 1967, ORI billed the ECF for approximately $312,000. The escrow account was approximately $53,000 in December 1967. However, as of March 1969, the ECF had gradually returned the 1967 escrow money to ORI. The 1968 escrow account contains about $50,000.

One billing cycle (two each month) for December (1–20) 1967, was chosen for verification. The *billing* from ORI, which detailed each patient (81) and each therapy, was traced satisfactorily into the financial records of the ECF. Three patients were selected for verification to the medical records for each therapy.

The medical notes indicate the progress a patient is making but often does that the various therapists make entrees as to progress usually on a weekly basis and, therefore, did not record daily treatment.

The medical notes indicate the progress a patient is making but often does not go into specifics as to type of therapy, etc. All therapy treatments appear to run on and on until such time when the patient is discharged regardless of the fact that he had reached maximum improvement early during his rehabilitation program.

The ECF did not have the records that ORI used to make the billings. We later found that these records were maintained by ORI. ORI completed the Medicare billing form by having their personnel write in the amount of ancillary service. The only attendance record maintained by Hollis was a daily sign in sheet by all the therapists who provided service. We reviewed these records and found a daily average of 20 to 24 therapists signing in each day.

Although each floor had a large room with bathtub and toilet facilities where daily living needs could be taught to the patients as occupational therapy, there were only two other rooms available for treatments—a treatment room about 10′ by 10′ and a physical therapy room 10′9″ by 12′. It would appear that from a pure physical standpoint that it is extremely questionable whether any meaningful therapy could have been provided in view of (1) the overwhelming number of billed treatments, (2) the physical attributes to the facility, and (3) the observation of some physical therapy being given in the ECF—approximately nine wheelchair patients were assembled in a line in the hall and range of motion exercises were performed at the direction of one therapist aide.

Generally, the medical records showed that the doctor left an order for full rehabilitation program and the Orthopedic and Rehabilitation Institute group came in and each department (physical therapy, occupational therapy, speech therapy, psychological and social service), did an evaluation. Then they had team conferences on the patient and prescribed plans of treatment were set up. These orders were reviewed by the attending physician and he signed them and then the plan of treatment was begun. It seemed that once a plan of treatment was started the orders generaly continued to run until the patient was discharged.

A review of the billing form itself from ORI (see attachment 10) indicated that a tremendous number of services were presumably rendered during this 20-day period. The billing covered 81 patients who received 2,309 billable treatments for a total of $20,781. This means that a daily average of 136 units of service were rendered—excluding Sundays. As stated earlier, the ECF maintained only a daily sign in book for the employees of ORI. A review of this book disclosed that 20–24 ORI employees signed in daily except Sunday.

An interview with Mr. Lewis (owner-administrator), Mr. Schummel (accountant) concerning the arrangement by ORI and the frequency of treatments revealed: (1) that the attending physician gave his permission for a rehabilitation evaluation, (2) that ORI made the evaluation and initiated treatments

for the services deemed necessary, (3) that the progress of each patient was evaluated periodically (apparently by ORI personnel), (4) that the ECF did not get into the frequency of treatments, (5) that the ECF only spot checked the services billed to the medical records, (6) that the ORI furnished personnel to complete the Medicare billing form so they (ECF) did not incur any additional expense, (7) that allegedly there was no involvement between the Director of ORI (Dr. D. Goldberg) and the ECF, (8) that allegedly the ECF did not receive any compensation in any form from ORI, (9) only spot checks were made on therapists—the rehabilitation was completely under ORI supervision.

When asked why practically every patient was receiving at least four of the five point program, irrespective of the patient's medical diagnosis, the administrator stated the doctor ordered them. (This certification appears to be questionable.) The administrator appeared to be completely unaware that from a coverage standpoint (by Medicare), the services rendered had to be related to the medical diagnosis for which the patient was admitted to the hospital and ECF.

Orthopedic and Rehabilitation Institute (ORI)

The purpose of visiting the ORI was to ascertain further information on how the billings were made to Hollis Park; how the $9 charge for a unit of therapy was determined; generally how ORI operates; and to review the financial records.

It was determined that the $9 charge was derived through a survey by Dr. Goldberg of the going rate in New York which presumably was $10–$12. It was also determined that the ORI therapists rendering services in Hollis Park prepared a daily "Activity Sheet" showing the name of the patients. These activity sheets were given to the ORI office who transcribed the data to summary sheets which showed by patient the services rendered, for example:

Patient	Therapy (days)	PT 124567	OT 124567	SS 124567	SS 124567	PSY 124567	Total week POSSY
A		XXXXXX	XXXXXX	XXXXX	X XXX	X X	66642
B		XXXXXX	XXXXXX	X X	X X X	XX	66232
C		XXXXXX	XXXXXX	XXX	XXX	XXX	66333

We reviewed the activity sheets and the summary sheets of the visits reflecting the services that were rendered to the patients at Hollis Park and the related billings. In reviewing the activity sheets prepared by the registered therapists, it was not unusual to find that they provided services daily to about 30 patients and sometimes more. (See attachment 11.)

The Orthopedic and Rehabilitation Institute billed Hollis $9 for an ancillary service regardless of whether it was provided by a registered therapist or by an aide. The $9 rate was charged for an individual treatment as well as for a treatment given in group therapy. Generally, on Wednesdays the therapists completed their work fairly early in the afternoon and they would assemble for a "team visit" to evaluate the progress of various patients. The patients were not present during these conferences. The intermediary and other representatives of SSA were aware of these team visits; but it was the understanding that $9 was charged for each therapist for whatever time it took to perform these evaluations similar to a utilization review committee. However, in actuality ORI made a $9 charge for each patient that was evaluated by each type of therapist. A review of some of these team visits showed that 58 patients were evaluated in one day, and a charge was made for each therapist or a total of 218 team visits for this one day. In addition, there were 142 units of therapy given for a grand total or 360 billing items at $9 a unit or $3,240 for one day's activities. It was observed from the summary sheets that many patients received excess therapies until the day of discharge or death. These benefits were usually provided for the full number of benefit days even when not medically necessary. Attachment 12 shows a study of three beneficiaries in a 20-day period. It reveals excessive services provided even though the team conference notes show the patients to be vastly improved and apparently in no further need of treatment—but treatment was continued.

When we tried to relate the billings with the records on the number of social services and psychotherapy treatments given to a patient, we found that ORI

appeared to bill for more treatments than actually given. Further examination showed that individual treatments were broken down into units. Dr. Goldberg explained that these services involved different modalities, each one charged at $9. Therefore, on this basis one social worker could conceivably perform seven modalities for one patient in one day resulting in a charge of $63. (See attachment 13)

We were not able to examine any of the financial records of ORI because we were told that the accountant had all the records at his office and he was out of town. Tentative arrangements have been made to review the records on April 16 and 17.

Validation of bills submitted by Dr. Goldberg to Group Health Insurance for visits to beneficiaries in Hollis Park Gardens Nursing Home.

GHI has been closely reviewing Dr. Goldberg's claim for medical necessity for quite some time. This has always resulted in substantial reduction of the number of visits for which Dr. Goldberg has received payment. The regional office representative obtained a random selection of 14 cases showing Dr. Goldberg's Medicare claims processed by GHI. Although some slight discrepancies existed between the number of visits billed and the number of services rendered, the Part B carrier has been consistently disallowing a large number of Dr. Goldberg's visits and, therefore, even where there is a discrepancy, there is no overpayment involved. The only problem uncovered in relation to Dr. Goldberg was that involving his partner, Dr. Moskowitz, who was the attending physician. However, the bill was prepared and submitted under Dr. Goldberg's name. GHI allowed $20 for an ECF visit, whereas Dr. Moskowitz' allowance would have been only $15. As Dr. Moskowitz and Dr. Goldberg are both orthopedic surgeons, we cannot be sure that Dr. Goldberg was aware of this. When they informed Dr. Goldberg that he could not bill for another physician in the future and they have also reduced Dr. Goldberg's allowance from $20 to $15 per visit. In October of 1968, Dr. Goldberg apparently changed his billing procedure in acknowledgment of expected action on the part of GHI. (See attachment 14)

The same 14 random cases used to review GHI Part B payments were also used by the survey team in reviewing medical records at Hollis to determine whether the care provided was covered. A summary of our findings disclosed that in the team's opinion nine cases were covered care, two were not covered, and three should have been partially denied.

Travelers Insurance Company—Garden City Field Office

Our survey disclosed that the intermediary has upgraded their level of care claims process since our January 1969 visit. The following steps have been taken:

1. All admission notices and some subsequent bills are screened by two reviewers—Richard Klafky (Dartmouth graduate) and Art Macey (Syracuse graduate). Although these men do not have any medical background they will work under the supervision of a registered nurse who was to report on duty March 25. After reviewing the admission notice they take one of the following actions:

   a. Approve the admission of subsequent bill for payment. If indicated, tickle the case for an early follow-up.

   b. Require a completed skilled care form or other information to determine coverage. (See attachments 1 and 2)

   c. Refer the admission or subsequent bill to medical or paramedical personnel for a judgment on covered care.

2. Mr. Leon Kane, a registered nurse-specialist in physical therapy and psychiatry, was hired to report for work on Tuesday, March 25. He will also review admission notices as well as make visits to providers, train claims reviewers, and refer questionable cases to medical personnel.

3. Dr. Daniel Sheehan, Internist, 80 John Street office, started the week of March 10 and spends every Friday at Garden City reviewing every questionable case. He will be available more time if necessary, and will render assistance to the two reviewers. Dr. Sheehan either clears the case for payment or denies it and the case is documented accordingly. If he denies the case, a medical denial letter is sent to the ECF which states that if more medical evidence to support covered care is not received within 30 days the case will be denied. (See attachment 3)

The case is tickled for 30 days. The intermediary has found that when the 30-day denial letter was sent, the ECF's utilization review committee denied the case and submitted a termination bill.

4. Dr. Marlyn Wertzel, Physiatrist, has been employed initially as a consultant. She has taken steps to upgrade the quality of review and to establish meaningful profiles on ECF's. (See attachments 4 and 5, sent to all ECF's). She will review cases referred to her with a view toward ironing out problems related to over-usage of therapy. At the present time ,she is examining all outpatient bills for the month of March in order to determine if any coverage problems exist. She will consider the medical necessity of the physiotherapy ordered and the reasonableness of the charge structure.

5. The intermediary has issued two notices to all ECF's encouraging them to submit skilled care forms on any claims in which they feel that the diagnosis may not describe the condition. The notices also remind them to complete the billing form to show the primary diagnosis for the ECF stay. (See attachments 6 and 7)

6. Records kept by the intermediary since March 3, 1969, reveal that about 40 percent of admisssions are now being questioned. (See attachment 8)

The following actions were taken regarding Hollis and Woodcrest Nursing Homes:

1. The intermediary stopped paying Hollis Park any money pending the further results of our visit.

2. Hollis severed its relationship with the Orthopedic and Rehabilitation Institute and has hired their own therapist, consisting of five occupational therapists, five physical therapists, one speech therapist, three social workers, and one coordinator, presumably, all of whom moved over from ORI. This capacity appears excessive to the normal needs of an 80 bed ECF. They submitted a request to Travelers to increase the interim rate to cover the additional cost of the therapists. (See attachment 16) Subsequently, Dr. Golberg gave us the impression that Hollis was releasing all of the therapists.

3. Travelers has continued to pay Woodcrest bills but they have deleted all ancillary charges. Woodcrest has now also hired therapists and requested Travelers to increase their per diem rate. The situation remains strange, however, in that the newly hired therapists for Hollis Park and Woodcrest transferred en masse from ORI. (See attachment 16)

Travelers—Hartford office

The purpose of the home office visit was to review the intermediary's overall procedures relative to reimbursement activities. This included such items as establishing interim rates and subsequent adjustments: recoupment of overpayments, desk review audit of cost reports, etc., for ECF's. The procedures employed by the intermediary were discussed with appropriate representatives, and several provider folders were reviewed to ascertain the implementation of these procedures. However, our review disclosed that the intermediary in general is not executing its reimbursement activities as fully as anticipated.

Interim rates and revisions.—Although the interim rates were generally well documented, it was found that there was little or no follow-up program to review and determine the accuracy of the rate on a continuing basis. In other instances, particularly with new facilities, the initial interim rate was established without any anticipation of increased occupancy. As a result, liberal rates were established; and, when subsequent reviews were ultimately made reducing the rates, there was no commensurate action taken to offset any overpayment that may have occurred during the intervening time between revisions.

In addition, based upon the provider files reviewed, there were no interim rate revisions made after the desk review of the cost report. It would appear that revisions would be appropriate prior to the final audit where there was a substantial under or overpayment.

Overpayments.—In general, the intermediary has not taken any positive or affirmative action in achieving recoupment of overpayments until about January 1969. Currently, the intermediary is withholding amounts from interim payments.

Basically, the intermediary has taken a very soft approach in this area. A review of provider files shows that the intermediary in several instances determined substantial overpayments generally due to interim rate reductions but did not take effective or timely recoupment measures. In some cases, the overpayment was revealed in mid-1967 but recoupment was not actually initiated until 1969.

The extent of overpayments to providers serviced by Travelers is not known.

However, an observation of a large file of overpayments maintained by the intermediary would give the appearance that it is extensive and a review of just a few providers indicates that the amounts are generally substantial.

Current Financing.—Generally speaking, the intermediary is following the directives and procedures for making current financing payments (CFP).

Intermediary Letter No. 22 states that in recomputing a CFP—use the average of four months billings or a designated "key" month whichever is *higher*. The intent of the phrase was to use whichever period was more representative. A review of recomputations showed that some providers appeared to be "loading-up" the "key" month (by delayed billings) to make it the *higher* base. Accordingly, larger CFP's were made by the intermediary. This matter was discussed with representatives of the intermediary who confirmed that this practice was being used by many ECF's.

Desk Review.—The intermediary has an established desk review program that covers many aspects which has resulted in adjustments in several areas, such as low occupancy and owner's compensation, and items have been identified for the audit, capability to investigate. Our review of some cost reports indicate, however, that many areas are being overlooked. For example, where providers have elected to use the estimated percentage method of cost apportionment, very arbitrary percentages have been approved. In one case, the trial balance showed almost no identifiable ancillary costs, yet ten percent was approved by the intermediary. Another area involves services purchased under arrangements. In such cases ancillary services are purchased directly from an outside source with virtually no cost incurred by the provider. Cost reports reviewed showed providers allocating as much as 200 percent overhead to such services. When significant dollar items of this nature are overlooked, and tentative settlements are made after the desk review, the possibility of overpayments are greatly enhanced.

Audits.—The intermediary has contracted for its auditing services primarily with Ernst and Ernst (E&E). With respect to ECF's, only 11 audited providers have been completed out of a total of over 500. It was observed from the provider audit files that extensive requests have been made and approved to extend the audit completion date. The most prevalent reason offered by E&E is "staffing not available." These frequent requests raise the question as to E&E's physical capability of assuming its contractual relationship. The delays not only hinder the final settlment but it effectively precludes any analysis of audit adjustments so that we can identify and pinpoint problem areas and develop appropriate solutions; and, in addition, it precludes the cost analysis program from using reliable data.

Observations in other areas.—It is quite apparent that a wide variety of problem areas exist that we have suspected and attempted to cope with in the principles of reimbursement. For example, locking and/or related corporations and owners, owner's compensation, change of ownership which may not be at arms length, etc. Common-owned ECF's which raise questions concerning compensation were revealed, such as:

Provider No.	Name	Related organization(s)
22-5018	Wentworth Manor	60 Associates, N.H. Development Co.
22-5105	Ann Vinal	Clivedon Corp. and Ann Vinal Development Co.
22-5097	Mildred Alford, N.H	Dunholme Trust andDunholme Corp.
22-5107	Linda Richards, N.H	Clivedon Corp. and DAAN Realty.

An analysis determined that the owners are claiming owner's compensation in each facility with no designation of the amount of time devoted. A total of ten individuals are involved (three-five in each EFC) who have claimed about $196,-200. While visiting the Hartford office of Travelers, there was apparently no indication either in the files or on the part of the individuals that these multiple ownerships existed. Consequently, no effort was made or is contemplated to evaluate an individual's total owner's compensation in the various facilities.

It was also noted that related organizations are involved with each of the facilities. A review of the reports revealed that management fees and/or consultant fees, interest expense, and rental expense were shown as expenses. The desk review of these cost reports should have screened out these items for additional development before a tentative settlement was made. However, there is

no indication from the desk review summary sheets that any of the aforesaid mentioned items were either considered or questioned. In the event any of these items are eliminated, an overpayment exists. The attached chart (see attachment 17) outlines the relationship of the various individuals, the amount of owner's compensation, relation organizations, and the cost of certain identifiable transactions claimed and allegedly paid to the related organizations.

There may be other questionable items, such as purchased laundry and supplies, etc., but they cannot be specifically identified from the cost report to any organization directly related to the provider.

The Abbet Manor Convalescent Hospital (#5087), Bridgeport, Connecticut, is a case involving several points. It was built by one of the corporate owners, Abraham D. Gosman, who also owns several other facilities through the New England area, such as, Wyndor Convalescent Hospital (#5190). Colchester Convalescent Hospital (#5075), a new facility under construction in Danbury, Connecticut, and about six others handled by Travelers. He has, of course, compensation in each of these facilities plus an undetermined number serviced by other intermediaries. Abbet Manor has been sold to North American Nursing Home, Inc., but Mr. Gosman received stock instead of cash; and, apparently other similar transactions are in process or completed. All such transactions should be closely scrutinized to evaluate the bona fideness of the sale and the basis for depreciation purposes.

Other reports have been received concerning Mr. A. Gosman and the cost basis of the facilities. Because he is a building contractor, the facilities were built at a cost far below fair market value in that (1) the normal profit factor was eliminated, and (2) all actual costs were not necessarily recorded because they were ultimately charged to other clients. Therefore, he has attempted to get appraisals instead of his actual costs.

It was also noted that a possible conflict of interest may exist between the intermediary in that Mr. Gosman has directed that all insurance for facilities under construction (Danbury) be placed with Travelers.

Wrap-Up Session, Friday, March 28

1. Areas of excessive billings were discussed with Travelers personnel and they agreed that there was excessive payments made to the Hollis Park Gardens Nursing Home.

2. They also recognized that some type of audit was necessary to recover payments made for excessive ancillary services and for noncovered care.

3. A quick review of bills from the *Woodcrest Nursing Home* revealed a similar picture as Hollis, excessive ancillary services. The intermediary was advised that whatever action they take with Hollis should be taken with Woodcrest and they agreed.

4. Hollis and Woodcrest have hired therapists who were previously employed by the Orthopedic and Rehabilitation Institute. Since the addition of these therapists has increased the cost of operating the nursing home, the ECF's submitted letters to Travels requesting an increase in their interim rate. The request for staffing-up therapists was informally reviewed with Travelers and it was agreed that the requests were excessive and further that it was the intermediary's responsibility to determine what was reasonable in this area before approving the request for an increase in the per diem rate. (See attachment 16).

Attachment

JOSEPH GODFREY, REGIONAL REPRESENTATIVE, BUREAU OF HEALTH INSURANCE, NEW YORK, APRIL 2, 1969

On March 24th I met with Leo Bell and Jim Nobles of GHI to obtain a random selection of cases submitted by Dr. Goldberg. I was provided with printouts on 14 beneficiaries showing all Medicare claims ever processed for them by GHI. I also obtained many of the SSA-1490's on most of these individuals. In addition, I learned the following:

1. Dr. Goldberg was in partnership until recently with a Dr. Moskowitz and is currently in partnership with a Dr. Cirillo. Neither of these doctors ever sent in a bill under Medicare, instead Dr. Goldberg bills for them in his name. GHI recently advised Dr. Goldberg that he can no longer do this and if Dr. Cirillo performs services he will bill for them himself. Dr. Moskowitz and Dr. Cirillo are both orthopedic surgeons and are qualified specialists. Dr. Goldberg, of

course, is also an orthopedic surgeon. Up until recently Dr. Goldberg's fee for a nursing home visit was $20, and this is what GHI allowed him per visit. Their allowance for Dr. Moskowitz and Dr. Cirillo would have been $15. GHI told Dr. Goldberg that he could no longer bill for physicians with whom he is in partnership when they learned of this discrepancy. In addition, GHI has lowered Dr. Goldberg's allowed charge from $20 to $15.

2. GHI reviewed the bills received from Dr. Goldberg for the months of October, November, and December 1968. They found that the only bills for ECF visits submitted during this period were for inpatients at Hollis Park. Total payments to Dr. Goldberg for professional services in October 1968 were $6,967.50, in November they were $3,217.80, and in December $1,447.80. Payments to Dr. Goldberg for therapy performed by the Orthopedic Rehabilitation Institute (ORI) were $2,688 for October, $1,572 for November, and $1,119 for December. Some of these treatments were rendered to outpatients of nursing homes. The homes involved are St. Albans and Elizabeth Irwin where there are very few Medicare patients. Some work was rendered to patients of Hollis Park at the Institute but not in any great numbers. Patients are transported to Dr. Goldberg's office directly from the nursing homes.

On Tuesday, I met with Lloyd Nichols of Travelers and the Central Office team which is looking into Travelers' ECF's. The team was led by George Gordon of DIO and included Jim Reilly of Reimbursement, and Gertrude Armstrong, a nurse. I spent most of my time reviewing the 1453's submitted on behalf of the 14 people whose claims GHI had given me. We learned that Dr. Goldberg had not submitted any bills to the Part B carrier for therapy and had supplied therapy to Hollis Park under arrangement. The Nursing Home was billed by ORI and then billed the program for PT, OT, Social Service, Speech Therapy, and Psychotherapy. From the 1453's it became apparent that we were paying an average bill of about $1,000 per patient. I compared the 1453's against the printouts which GHI supplied to verify that we are not being billed twice for therapy and to determine the extent of outpatient work Dr. Goldberg performed for patients of Hollis Park.

On Wednesday, I visited the Hollis Park Nursing Home with the Central Office team, and we met with Eli Lewis, the home's administrator, the home's accountant, Mrs. Matson who is the bookkeeper, and Mrs. Lottheimer, the head nurse. Mr. Lewis took us on a tour of the ECF, and everyone was quite impressed with the physical plant as well as the treatment which beneficiaries were receiving.

Mr. Lewis no longer has arrangements with ORI to provide therapy but has hired several of Dr. Goldberg's former employees to provide therapy in the ECF. Hollis Park does not have extensive therapy equipment, and we saw only one individual receiving personal attention. We saw many people sitting and making doilies, pot holders, and things of that sort. We also saw about 20 people lined up in the corridor receiving PT from a RPT. There was only one therapist present and the people were merely moving their arms from one side of their bodies to the other. All of the individuals were in wheelchairs. We later learned that Medicare program would be paying $9 for each of these individuals for physiotherapy even if they received no other form of PT during that day and even if they never received individualized attention.

We next began to examine medical records and billing records. I examined the medical records of the 14 beneficiaries for whom I had claims material. I also examined the therapy billings. In the medical files I examined the progress notes, nursing notes, and doctors' orders to determine how many visits were actually made. It turned out that Dr. Goldberg had been billing for himself, Dr. Moskowitz and at times Dr. Samuel Grubin. Dr. Grubin is a GP and GHI would allow only $8 for his visits. On the other hand, we could establish that all the services for which Dr. Goldberg billed were performed by someone. In many instances where Dr. Grubin was rendering services, both he and Dr. Moskowitz or Dr. Goldberg would visit the patient on the same day.

Dr. Grubin would write a progress note or order treatment, and Dr. Moskowitz or Dr. Goldberg would then come by and merely countersign the note or order. We could not verify every single date of service but we were able to come very close to it. Surprisingly, in some cases Dr. Goldberg was billing for less visits than were actually rendered.

It should be noted the medical records at Hollis Park are extraordinary. They are complete in almost all aspects and are quite detailed.

It should also be noted that although some slight discrepancies exist between the number of visits billed and the number of services rendered the Part B carrier has been consistently disallowing a large number of Dr. Goldberg's visits and therefore even where there is a discrepancy, there is no overpayment involved.

I also examined the medical charts used by ORI which are kept in each patient's file. The therapists do not sign this record each time they see a patient, but we were told they try to sign the chart about once a week. The charts themselves reveal no pattern in relation to the frequency with which they are signed. Nevertheless, I recorded for each patient the number of PT, OT, and other therapy or social service visits shown on these charts. I checked to ascertain whether therapy had been ordered by a physician and in all cases it had been; most of the time Dr. Moskowitz wrote the orders. In many instances the file also contained an authorization by the patient's personal physician permitting ORI to make an evaluation of the therapy that would be needed. In addition, we found that on about a monthly basis there would be a team conference held on each beneficiary. At these conferences the various therapists who are treating a patient review his chart and make a progress report. Sometimes a physician is present at these conferences as well.

Next I examined the bills which Hollis Park had received from ORI. These bills are the home's basis for their Medicare billings. Each month they receive a billing sheet from ORI which lists the patient's name and the number of treatments rendered; this is broken down by type of therapy and the charge for that specialty. The usual charge is $9 per visit. The full records for the visits themselves are not kept at Hollis Park but are in the possession of Dr. Goldberg. Mr. Lewis said they did not know exactly how Dr. Goldberg arrived at the number of visits although they did know that each therapist would keep a record of each patient seen on any given day. The only records the home keeps of the therapist is a sign-in book. (Each person who comes in to work at the home each day must sign in and out.) The ECF enters the services from ORI's monthly billing on to 1453's and sends them to Travelers. Travelers, in turn, paid for all the therapy. There apparently has never been any medical consideration of what the intermediary was paying for.

The summary for all visits for 1963 showed the following: 41,387 visits by therapists of all types at $9 per visit for a grand total of $372,483. This comes out to approximately 113 visits per day. When you consider that all the visits were to Medicare patients and that the facility has only 80 beds and that therapists did not come regularly on Saturdays and Sundays, we were charged for about 2 visits per day per beneficiary. In fact, we were charged 1.4 visits per bed per day for the entire year. The breakout by types of services is as follows: PT, 12,026 visits for $108,234; OT, 15,432 visits for $138,888; Speech Therapy, 3,415 visits for $30,735; Social Service, 6,129 visits for $55,161; Psychotherapy, 4,385 visits for $39,465.

For the individual beneficiaries, I found that the 1453's reflected the billing from Hollis Park but that the medical charts maintained in the Home showed only about 1/10 to 1/4 of the visits for which we had been billed. Mr. Lewis maintained that he was sure Dr. Goldberg had the full records for these visits and that he was of the impression that Dr. Goldberg's records had been spot checked in the past by someone on his staff. It should be noted that the amount of therapy for which we were billed in 1967 was $311,000.

On Thursday, we visited Dr. Donald Goldberg at the ORI. Dr. Goldberg spent about one hour haranguing us and informing us of the venial nature of the Social Security Administration. He then calmed down and took us on a tour of the Institute. Once again everyone was quite impressed by the type of treatment and the physical layout of the facility. To a layman it appeared obvious that there was a distinct difference between the type of therapy which could be rendered at the Institute and the type of therapy which was being provided at the ECF; that being performed at Hollis Park is certainly worth a whole lot less.

Dr. Goldberg then took us into his office and opened all his records. His records are extraordinarily extensive and complete. Dr. Goldberg explained to me that whenever he or Dr. Moskowitz saw a patient at Hollis Park they would mark this down on a piece of paper and then give this paper to their billing office. In practice, these physcians saw 10 or 15 people each time they went into Hollis Park and were actually filling out a roster of the people they saw on any given

day. These records are placed in a book by the billing office and SSA–1490's are prepared directly from them. I examined Dr. Goldberg's copies of the SSA–1490's to verify this.

From the records kept by Dr. Goldberg of Nursing Home visits, it is impossible to tell whether the visit was performed by Dr. Goldberg, Dr. Moskowitz, or Dr. Cirillo.

However, several of the sheets were signed by Dr. Grubin, and it is possible to determine what visits he actually made. I examined the Hollis Park visit sheets to get an idea of the extent of Dr. Goldberg's activities in the Home. These records proved to be quite interesting. For example, on November 20, 22, and 24, 1967 a total of 48 visits are recorded. For November 27, 29 and December 1, an additional 50 visits are shown. During the week of December 18, 1967, an additional 55 visits are recorded. For the week of February 12, 1968, 50 visits are shown. For the month of July 1968, 176 visits were billed. Either Dr. Moskowitz or Dr. Goldberg visited the home almost every other day, and each time they visited between 11 and 15 patients. Beginning with October 1968, the effect that GHS has had on Dr. Goldberg's billing became apparent. For the entire month of October, only 32 visits were billed. Dr. Goldberg and Dr. Moskowitz visited Hollis Park no more than once a week and saw only 8 patients each time. In November, the weekly visit pattern continued and the total number of visits was 30. In December, the same pattern existed and the total number of visits was 34. It would seem that any overutilization that once existed has been efficiently eliminated.

I also examined the visit records for each of the 14 people for whom I had claims. These records matched quite closely with the Nursing Home records and, at times, reflected fewer visits. Dr. Goldberg also pointed out that he had billed for Dr. Grubin on several occasions. Dr. Goldberg later learned that GHI's allowance for Dr. Grubin was substantially lower than what he was allowed and he sent in amended claims substantially reducing the number of visits. In addition, he also withdrew bills for visits to patients under Dr. Grubin's care. These were identifiable because the charts pertaining to these patients bore notes signed by both Dr. Grubin and/either Dr. Goldberg or Dr. Moskowitz. Dr. Goldberg was quite upset with GHI's limiting of his payments and is of the opinion they are trying to destroy his medical practice. From the other side of the fence, however, it would appear that GHI is doing an excellent job in limiting physicians' fees.

While at Dr. Goldberg's office, the team also examined the therapists' records. I did not do too much of this myself, but I learned the following things:

1. For OT, PT, and Speech Therapy treatments, the program was billed for no more than one visit per day per specialty per patient. This was the case regardless of the number of times the patient was seen by therapists and regardless of the number of modalities involved.

This means that if a person was seen 5 times by one physiotherapist or by 5 different physiotherapists we would receive only one $9 charge for physiotherapy. On the other hand, if the patient were part of a group of 30 people receiving PT at the same time and this was the only treatment he got, we would still be charged $9.

2. For psychotherapy and social services, we are billed on a unit basis. At the time of discharge for example, the social worker who is, of course, an employee of ORI, would interview the beneficiary, the beneficiary's family, make arrangement for beneficiary's discharge, and complete a report on the beneficiary. Each of these activities would be considered a unit, and we would be billed $36. We discovered several instances in which we were billed for 7 or 8 units of social work for one individual in a single day. We also saw that it was quite common for a social worker to do 20 to 25 units of work a day. My recollection is that Dr. Goldberg used two, or perhaps three, social workers at Hollis Park.

We checked the number of visits shown on the records kept by the individual therapists and determined that they were in substantial agreement with Dr. Goldberg's bills to the ECF. In general, the number of visits recorded came within one of the number of visits billed. For example, Dr. Goldberg may have billed for 19 visits and we discovered 18 or perhaps 20.

Another extremely interesting procedure for which SSA has been paying is the team conference. A team conference is a meeting of the therapists who are treating an individual. This may involve anywhere from 3 to 5 therapists, each representing a different specialty. At times, the therapists are also accompanied by

a physician. The team examines the beneficiary's chart and discusses his progress. They also keep minutes of their meeting for each patient. At times, these minutes can be as long as 3 pages while at other times each therapist's report is no more than one line. The program is billed $9 for each therapist at a team conference and no direct visit is ever made to the beneficiary during these conferences. In fact, if a beneficiary does receive treatment on the day of the team conference, we would be billed another $9 for each specialty that treats him. The team conferences average about one per month per beneficiary, although we discovered that on December 6, 1967 there were 58 team conferences in one day. This means that the intermediary received a bill for $2,088 in team conferences alone. This seems incredible since it does not at all involve direct contact with the beneficiary. On the same date, we received an additional bill for $1,116 for actual visits to patients. This represents 124 actual treatments. Thus, the grand total for one day of therapy was over $3,200.

The only problem I uncovered in relation to Dr. Goldberg was that GHI allowed him $20 for an ECF visit whereas Dr. Moskowitz' allowance would have been only $15. As Dr. Moskowitz and Dr. Goldberg are both orthopedic surgeons, we cannot be sure that Dr. Goldberg was aware of this. When GHI actually became aware of this situation, they informed Dr. Goldberg that he could not bill for another physician in the future and they have now reduced his allowance from $20 to $15 per visit.

It should be noted that GHI has been closely reviewing Dr. Goldberg's claim for medical necessity for quite some time. This has always resulted in substantial reduction of the number of visits for which Dr. Goldberg has received payment. In October of 1968, Dr. Goldberg apparently changed his billing procedure in acknowledgment of expected action on the part of GHI.

I am enclosing summaries of each of the 14 patients whose medical history I examined as well as the SSA–1490's and SSA–1453's which are currently in our possession. We are requesting the remaining claim forms for all services rendered our 14 beneficiaries during the time they were inpatients at Hollis Park and will forward them in the near future.

Mr. BALL. Dr. Bell suggests that we should clarify the status of that case. This is one of our reports, and I do not think that we could say that it was finally settled.

Dr. BELL. No, Mr. Chairman. The intermediary is reviewing a sample of bills back to the beginning of the program from this facility, from this provider.

There has been no final settlement of the first year of Medicare services by this provider, and so the whole matter of the amount of the overpayment is still open for an audit.

Mr. BALL. The figure should be more.

Senator WILLIAMS. Then the $150,000, where did that figure come from that you gave? What did that relate to yesterday when we were told that you had stopped future payments until you collected $150,000?

Now, has it been settled, or has it not?

Mr. TIERNEY. Senator, if I might add a point there——

Senator WILLIAMS. I think you had better.

Mr. TIERNEY. It is $150,000 that has been indicated without the detailed review that is now going on—there is $150,000 indicated as an overpayment. That is being withheld at the rate of 10 percent of all amounts that are being paid now, and all bills are now being reviewed to assure that only appropriate covered services are being paid for. Now, as a result of the overall audit it may be that the total overpayment amounts to more than the $150,000. But, on an interim basis, we are now withholding until we have withheld $150,000.

Mr. BALL. In other words, that is just the minimum, Senator.

Senator WILLIAMS. You are going back beyond this period of the audit report?

Dr. BELL. Yes, sir.

Senator WILLIAMS. Now, on this $372,000 in physical therapy, about how much was paid in the 12 months preceding? I am delighted to know that you have that information. I did not know you had it. I did not ask for it yesterday.

How much was paid in this same nursing home for physical therapy in the preceding period?

Dr. BELL. Sir; we will have to submit that for the record.

Senator WILLIAMS. Approximately how much?

Dr. BELL. I do not know, sir.

Senator WILLIAMS. Do you not have any idea?

Dr. BELL. No, I do not have that information in front of me, sir.

Mr. BALL. We can get that, I think, relatively quickly, Senator Williams. It is just that you and I are both working from this report that the staff made that had that 1 year in it. We are now examining into the past years, too, and we just do not have the figure here.

Senator WILLIAMS. You will have the report on all of the other years? Well, do you have any objection to putting this in the record for this one year?

Mr. BALL. No, we have no objection.

Senator WILLIAMS. I mean, this would not interfere with your collection proceedings or anything if we put this 1-year report in?

Mr. BALL. I do not see why it would interfere, Senator, at all, as long as we do not say that it is a final report.

Senator WILLIAMS. I accept that, that this is your preliminary statement, and that is fine, and we will put the report in the record.

(The information requested had not been received at the time of printing.)

MASSACHUSETTS CASE

Now, I want to ask you a question about another case. I will not identify it for the moment, but it is included in your April 8th report in Massachusetts, and without identifying it further it is identified only by the number, PM225124. It is on page 3 of that report, if that is any good to you.

Mr. TIERNEY. Senator, would you mind telling me which report you are reading from? Our report?

Senator WILLIAMS. Yes; the April 8, 1969, audit report of survey.

Mr. TIERNEY. I am afraid that I do not have it here, Senator.

Mr. HESS. Is this the GAO report or the HEW?

Senator WILLIAMS. No, this is the HEW report.

Mr. TIERNEY. Validation visit report?

Senator WILLIAMS. Yes; I will read it just briefly here. The accountant member of the firm did not visit this provider. However, an auditor

from the intermediary contract audit firm visited the regional office of the intermediary in Boston while the accountant member of the team was making his review.

The auditor disclosed that he had discovered several issues that had significant medicare impact, and then continuing he states that he discovered that the extended care facility was paying a cleaning corporation, which was a related company to the nursing home, $64,000 for so-called housekeeping services, and that the extended care facility also entered into a purchase-lease agreement with another subsidiary company of the same group, and it agreed to pay the related company $3,900 per month for 60 months for the leasing of all of the equipment, to a total of $234,000.

In addition, the extended care facility paid another related company $15,000 for management fees, and in addition, the auditor tentatively projected—the extended care facility to be overpaid in the amount of $100,000 and he also believes that the same amount will be owed for the subsequent accounting period.

Now, what steps have been taken on that and how does that situation stand? Can you recall that one or not?

Mr. TIERNEY. I do not recall the case offhand, Senator. I can tell you this, that the regulations prohibit any kind of automatic recognition of payments between subsidiary companies. They do require that they be on the basis of reasonable cost. We will not allow a charge arrangement with a subsidiary to simply be passed through the cost of the participating institution.

Now, if in our audit we have discovered this we would, of course, move to recover it. I cannot tell you about the individual case.

Senator WILLIAMS. Now, this was April the 8th and you do not know whether any steps have been taken to recover this or what procedure was taken with this nursing home?

Mr. TIERNEY. Generally, we certainly would have this information, Senator.

Senator WILLIAMS. What concerns me is that it is the same carrier that had this other one.

Mr. TIERNEY. I beg your pardon?

Senator WILLIAMS. The same carrier was handling this as was handling the other one.

Mr. TIERNEY. Then I assume we have also directed recovery on this, but I do not want to tell you that until I find out specifically if it is true. I am not familiar with that case.

Senator WILLIAMS. You will check that and give us a report as to its status?

Mr. TIERNEY. I certainly will.

(**Clerk's Note**: The committee was informed by letter dated July 30, 1969, from Howard A. Cohen, Deputy Assistant Secretary for Legislation, Department of Health, Education, and Welfare, that the data requested was not available at that time. The committee was further advised that as the material became available it would be forwarded to the committee. At the date of printing, October 1, 1969, the information to be furnished had not been received.)

Senator WILLIAMS. Are arrangements such as this permitted under your regulations?

Mr. TIERNEY. No, they are not, Senator. There are specific provisions in the reimbursement manual that any kind of contractual relationship between either a subsidiary or affiliated corporations cannot be accepted simply on a contract price basis, but rather that the reasonable cost of the services rendered is all that is reimbursable.

Senator WILLIAMS. How does it work in the cases of forming, not exactly conglomerates, but putting together four or five or half a dozen nursing homes and putting together a package of hospitals, and then setting the organizers up on a rather liberal salary scale, and with the ownership of this company being passed out to either firms who would be in a position to deal with the facilities and have some of the stock, or having several members of the medical profession who will be working in these homes and hospitals as stockholders also?

Is there any conflict of interest involved in that? Is there any conflict of interest where the doctors, in effect, would be working for themselves under medicare or medicaid?

Mr. TIERNEY. I do not know that you can automatically conclude a conflict of interest because a doctor has a stock interest in a facility, Senator. It certainly raises some issues.

I think the American Medical Association itself has said that where there is doctor ownership of a drug store of another health facility that the possibility of conflict of interest exists.

Senator WILLIAMS. I know that the American Medical Association has taken that position, and in fact it has taken a stronger position—as I understand it—than has the Department, and I am wondering just what your position is on that?

Mr. TIERNEY. Our position is in full accord, Senator. Reference was made yesterday to a report on a doctor-owned extended care facility where the doctor lives in the penthouse—we discovered that case sometime ago and have stopped all payments to that doctor—we think there was definite conflict of interest there.

There was a pattern of charge for his medical services that just was unreasonable. We are not making any further payments to him. We are initiating a full investigation and, of course, will recoup payments. I do not think this is the appropriate action, Senator, in every instance. I am not sure that there are not doctors who own small hospitals or extended care facilities who are operating them fully legitimately, but the inference is there and it is worthy of our investigation.

Senator WILLIAMS. Well, the case that you and I discussed about a month ago involved a doctor setting up a company with five nursing homes and then contracting with himself for $75,000 or $80,000 a year in salary for 5 years, and adding his wife at another $15,000 a year. These homes were then capitalized at about three times what it was just before this changeover. I have as yet not been able to get your department to tell us just how much of that salary you are going to recognize or whether you are recognizing it as what you would call management services or whether you will reimburse him as a doctor with his captive patients, or just what steps you are going to take.

Mr. TIERNEY. Well, as we talked yesterday, that institution has just changed hands and, of course, it will now be setting up a whole new

balance sheet and a whole new reimbursement mechanism. Let me answer your question specifically. As far as the $75,000 and the $15,000, we will allow only the portion that would be paid to such a manager in the open market. We have specific regulations on the amount of owners' compensation that can be reimbursed and it must be determined on the basis of what is being reasonably paid on an arm's-length basis in that area to hire an administrator, a qualified person, and that is the limit of our payment.

As far as the establishment of new assets for depreciation purposes, that has not been done yet because no cost report has come in.

I think, Senator, you have put your finger on a very important point, that we should include in our examination of the adequacy of a facility to participate in the program a requirement of a full financial statement. Our examination has focused largely on the health and safety provisions of the statute and whether or not it is equipped to render appropriate services.

We have not put into the conditions in the past a requirement for a full disclosure of the facilities financial setup. Now, the law has some limitations on how far we can go into looking into financial setups, but it seems to me appropriate that that kind of a condition be included in the future and we are now working on amendments to those conditions.

Senator WILLIAMS. But there is no limit as to how far you can go when they are being financed to a large extent with money coming out of the public Treasury. I do not think you are handicapped as to——

Mr. TIERNEY. Certainly not for denying payments. I am talking now about getting a pre-look—prior to finding that a facility qualifies as a provider of services. What you are looking for, Senator—what kind of financial arrangements are they going to have—I cannot tell you now because they have not as yet furnished the information.

Senator WILLIAMS. Well, but this particular case I am speaking about is operating at 85 percent medicaid right now.

Mr. TIERNEY. Medicaid, yes, sir. But it is not participating in medicare now as an extended care facility, although it expects to be in the future.

COORDINATION OF MEDICARE AND MEDICAID

Senator WILLIAMS. It is my understanding that medicaid is still a part of the U.S. Government's program.

Mr. TIERNEY. There is no question about that.

Senator WILLIAMS. And maybe it is proper that I introduce you to Dr. Land, and maybe Dr. Land can tell me how we are going to work on these. I am not trying to separate one program from the other.

They all come out of the same department, and I suppose they clear through Mr. Ball's office or they talk with them, and if they do not, maybe we need some place where they could be cleared.

Mr. TIERNEY. Senator; if I may, we have a provision that we will make full disclosure to the State agency in this situation of the cost reports which we have from that institution and the cost figures which we have developed.

Now, as we talked yesterday, this institution is in Massachusetts. Am I not correct? Dr. Land can talk to this, but medicaid pays on a flat

negotiated fee basis. I do not recall but I think it is $15 a day maximum, so that they do not have all of the same interests in ultimate cost reimbursements that we have, but nevertheless, our cost figures will be totally available to the State agency in determining the reasonableness of what they are paying.

NURSING HOME OWNERSHIP AND FHA FINANCING OF NURSING HOME CONSTRUCTION

Senator WILLIAMS. By the way, we asked for a complete list of all the nursing homeowners about two months ago. Has that been assembled yet; do either you or Dr. Land—do you have that yet?

Dr. LAND. Yes, sir; I think the list of all of the nursing homes has been delivered prior to today and we are delivering the first package of ownerships, a listing of the ownerships of nursing homes this afternoon.

Senator WILLIAMS. Does that include all of the nursing homes?

Dr. LAND. In the United States and those jurisdictions that have nursing homes outside the United States.

Senator WILLIAMS. Well, I appreciate your making those available, and we can look them over and discuss them later, because when these hearings are resumed, of course, the administration officials will be back for further discussion.

Now, when you were furnishing and assembling that list, did you assemble information the extent to which these nursing homes are financed by the FHA or some other Government agency?

Dr. LAND. No, sir, we did not do that.

Senator WILLIAMS. Since we will not be resuming these hearings for a couple of weeks or so, until we get rid of the tax bill, could you get that additional information for us from the FHA, so that we would know to just what extent we are financing these nursing homes in the first place, and then we can see how the evaluations appear? The reason I mention that is because I know that one of those in particular to which we referred yesterday was built for around $600,000, and then depreciated down to around $300,000 and it was sold in the transfer of one of these operations for two and a quarter million. Certainly somebody is planning on getting a return of capital back on the two and a quarter, and if it does, it is going to be a sizable operation. I know of 50 specific operations we were interested in examining and we discussed one of them yesterday.

I do not say that we will discuss all of the 50, but they do need to be examined, and I hope you will examine it in the meantime and maybe you can come up with some suggestions as to how to help us, too.

(The material referred to appears as appendix D of this hearing, p. 471.)

REEVALUATION OF FIXED ASSETS

Mr. HESS. Mr. Chairman, on that specific point we have requested a ruling and we received a ruling some time ago from the General Counsel's office on the reevaluation of fixed assets through corporate reorganizations and if you wish we would like to submit it for your consideration, or for the record, whichever you choose.

Senator WILLIAMS. If it is short, just read it. If it is very long, why, you can submit it.

Mr. HESS. It is quite lengthy, sir.

Senator WILLIAMS. Well, then, how about submitting it for the record, and you can just give a brief summary.

(The ruling referred to follows:)

OFFICE OF THE GENERAL COUNSEL, APRIL 29, 1969

REEVALUATION OF FIXED ASSETS THROUGH CORPORATE REORGANIZATION AND/OR VALUATION BY AN APPRAISAL FIRM

Syllabi

In a case where a hospital, operated by a corporation, had rented most of the plant assets used in its operation from a partnership whose members were also the stockholders in the corporation, and a new corporation had been formed to acquire control of the hospital through purchase of its corporate stock and had also purchased the rented plant assets from the partnership and then transferred them to the corporation owning the hospital; held, since there was no sale of assets owned by the hospital corporation, there being only a change of ownership of the stock of the corporation and, accordingly, the established depreciation base of these assets remained in effect, and since the assets formerly owned by the partnership also already had an established depreciation base for the reason that the partnership had been treated as a "related organization" under section 405.427 of Regulations No. 5 and partnership expenses allowed as costs instead of the rental paid for the use of the assets, in contemplation of the regulations the partnership assets already belonged to the corporation; hence, the transfer of these assets by the new corporation to the hospital corporation is not recognizable as a sale for purposes of establishing a new depreciation base. Also, interest on notes given to partnership in connection with purchase of plant assets not reimbursable under principles established in sections 405.419 and 405.427 which are that individuals having a common interest may not be permitted to deal with themselves in such way as to profit from the program beyond costs of operation in furnishing services to beneficiaries. (MEMO GC:HI (Settle) to BHI 4/29/69.)

1861(v)(1), I-9-2-2.

In a case where stock in three proprietary corporations owning a hospital and its equipment had been sold to a newly formed non-proprietary corporation of which the Board of Trustees is composed largely of stockholders of the former corporations and other persons identified with them, and the administration and staff of the hospital remains the same, and, allegedly, the three proprietary corporations were dissolved and all assets were merged into the new entity; held, there was no recognizable sale of assets which would warrant the establishing of a new depreciation base for the hospital assets. Also, the interest on notes given to the former stockholders in the original corporations not allowable as a cost item for the reason that the former stockholders are substantially the same persons having interests in the new corporation. (MEMO GC:HI (Settle) to BHI dated 4/29/69.)

1861(v)(1), IA-9-2-2.

This refers to your memorandum of February 7, 1969, on the above subject, and to the documents which you enclosed for our review.

The questions presented involve a determination of the applicable reimbursement principles as to two provider hospitals. They are considered concurrently for the reason that the facts of the cases are similar in that in each there has been a transfer of ownership of the capital stock in the corporation operating the hospital.

The facts of the *Rancocas Valley Hospital* case are well summarized in your memorandum as follows:

"Rancocas Valley Hospital was a corporation that had operated as a Medicare provider, with Prudential as their fiscal intermediary. It rented property from Medicorp, a partnership, whose members were also the stockholders of the corporation. Prudential disallowed the rent, applying Section 405.427 of SSA Regulation No. 5, allowing the partnership expenses instead.

"In 1968 American Medicorp, Inc. was formed for the purpose of acquiring Rancocas Valley Hospital (and its affiliate, Medicorp) and two other hospitals, one in Pennsylvania and the other in Florida.

"From information secured from the intermediary, it does not appear that there was any substantial common ownership in American Medicorp, Inc., and any of the hospitals, prior to their purchase.

"In order to finance the purchases, American Medicorp, Inc., issued and offered to the public 345,000 shares of its stock at $20 per share. It also issued 52,500 shares as part of the purchase payment of the hospitals.

"The directors and officers of American Medicorp, Inc., as a group (5 persons) prior to the public offering owned 340,500 shares (95.8% of the outstanding shares before public offering) for which they paid $3,405 (1¢ per share). After giving 3,000 shares to the corporation as part of the purchase of the hospitals, and after the public offering, their holding stood at 337,500 shares (45%) which at the offering price to the public of $20 per share would be valuated at $6,750,000, which represents a value increase of nearly 200,000% in approximately a 2 month period.

"Three of the directors are partners in the law firm that represented Parkview (Pa.) Hospital in its sale to American Medicorp, Inc., for which a fee of $97,500 was received.

"The acquisition of the three hospitals was accomplished by a purchase of their capital stock. The assets and liabilities of the leasing partnerships affiliated with two of the hospitals were purchased and transferred to the hospitals which retained their corporate form, becoming subsidiaries of American Medicorp, Inc. The hospitals maintained their some provider status with Medicare without alteration of contract or provider number.

"The officers and directors of American Medicorp have limited experience in hospital management. Each hospital, consequently, has an operating committee, the majority of whose members are the same physicians previously engaged in the management of each hospital.

"American Medicorp, Inc., paid more for the businesses than their book values and charged the excess to various accounts on their consolidated statement, as shown below.

Corporation—Hospital affiliated partnership—Equipment	Parkview Hospital, equipment	Rancocas Medicorp	Golden Isles
Sales price:			
Cash	$1,150,000	$1,475,000	$1,800,000
Notes	800,000	2,575,000	0
Stock—valued at $20/share, offer price	300,000	750,000	0
Total	2,250,000	4,800,000	1,800,000
Book value:			
S/H equity—corporations	270,196	56,387	173,409
Partners' equity—partnerships	49,376	220,237	0
Total	319,572	277,174	173,409
Excess paid over book value	1,930,428	4,522,826	1,626,591
Excess charged to:			
Property, plant and equipment	384,313	320,296	119,978
Excess of cost of investment, over underlying book value	1,557,912	4,176,122	1,506,613
Other miscellaneous accounts	(11,797)	26,408	0
Total	1,930,428	4,522,826	1,626,591

"American Medicorp, intends to have each subsidiary depreciate its portion of the excess charged to 'Property, Plant and Equipment', and amortize its share of the account entitled 'Excess of Cost of Investment Over Underlying Book Value'; these accounts totaling $8,065,234. No appraisal has been made."

We would add to these facts the further comment that apparently the stock in the Rancocas Valley Hospital corporation was acquired on a straight stock exchange basis, 37,500 shares of the American Medicorp stock being exchanged for all of the outstanding capital stock of the Rancocas Valley Hospital Corporation. Also, to clarify another point, virtually all of the plant assets used in the operation of the hospital apparently were owned by the Medicorp partnership. American Medicorp paid the partnership $1,475,000 cash for its equity in these assets plus its note for $2,575,000 bearing interest at 4%. In addition, it assumed Medicorp's mortgage note, and other obligations, totalling $1,186,600. As you

stated, it is reported that the plant assets formerly owned by the Medicorp partnership were sold by American Medicorp to Rancocas Valley Hospital "for the same price that it paid."

It appears to be your view that no sale of assets has occurred which would warrant a revaluation of assets and the establishing of a new depreciation base; that there has been merely a sale of stock. You point out that the Rancocas Hospital has retained its corporate structure, and that the Medicorp partnership which was previously treated as merged for Medicare purposes is now legally merged. Accordingly, you would use the book value of the former stockholder's equity in the Rancocas Corporation, plus the book value of their equity as partners in the Medicorp partnership, as the depreciation base for all of the plant assets now owned by the Rancocas Hospital Corporation. You also state that you are "of the opinion that the interest paid on the notes is for the purchase of the stock and would therefore not be an allowable cost of medical care."

In our opinion the conclusions you have reached on these points are correct. We believe, also, that we are in agreement with you on the rationale, but perhaps we would express it a bit differently.

As we understand it, you have been allowing the Rancocas Valley Hospital Corporation depreciation on its holdings based on the book value of its equity in them. You also have been allowing the costs of the Medicorp partnership, as a related organization, and in that connection have allowed depreciation on the partnership holdings, based on the partnership equity in them. Prior to the acquisition of the Rancocas Hospital stock and the partnership assets, then, there had already been established a depreciation base for all of the assets for Medicare purposes.

On your point that no sale of assets occurred, that there was only a sale of stock, we believe that on the facts of record a sale of assets did occur, the question being whether there was a sale which must be recognized for purposes of establishing a new depreciation base for the assets.

As to the plant assets which have belonged all along to the Rancocas Hospital Corporation, there is, of course, no change. The corporation still owns them; the sale of stock did not affect its ownership; hence, there is no question of there being a change of depreciation base of those assets. The question is as to the plant assets formerly owned by the Medicorp partnership. These assets were undeniably sold by the partners to the American Medicorp Corporation. As to American Medicorp, there was a sale. But when they were in turn transferred by American Medicorp to the old corporation, Rancocas Hospital Corporation, did a sale occur which must be recognized for purposes of establishing a new depreciation base? We think not. The holdings of the group which originally owned the stock in the Hospital Corporation, and were the same group that composed the partnership owning the main hospital plant assets, were, in accordance with Department regulation, treated collectively for purposes of cost reimbursement. In contemplation of the regulations, the partnership assets *already belonged to the corporation.* Therefore, in contemplation of the regulations, no sale of the assets to the corporation could occur. Under the authority of section 1861(v)(1) of the Act, the Secretary has by regulation prescribed the rules to be followed in determining provider costs. Those regulatory rules are exclusive and final. The established depreciation base of the assets formerly owned by the partnership, accordingly, continues to be in effect.

As to the interest expense on the notes given by the Medicorp corporation to the partners in connection with the acquisition of the partnership assets, we agree with you that this is not a reimbursable cost item. Again there is clear direction in the regulations establishing the principles of reimbursement for provider costs. In section 405.419, the principle is established that interest, to be allowable as "proper" interest, must be "paid to a lender not related through control or ownership, or personal relationship to the borrowing organization." This provision in the regulations goes hand in hand with the provisions of section 405.427 which establish the principles for reimbursing providers for services, facilities, and supplies furnished by "related organizations". It is the clear purpose of the regulations that individuals having a common interest not be permitted to deal with themselves in such way as to profit from the program beyond costs of operation in furnishing services to beneficiaries. Although the former partners are no longer connected with the Rancocas Hospital Corporation, they were connected with it, were even its stockholders, at the time the notes were given. We believe, therefore, that the interest is not allowable as "proper interest."

You summarized the facts of the *Cherry Hill Hospital* case as follows:

"Cherry Hill Realty Corporation, and its subsidiaries, Cherry Hill Hospital (the operating company) and Chapel Hill Equipment Corporation (the equipment company) was a proprietary organization, with Blue Cross as its fiscal intermediary, whose ownership has vested in 14 physicians. In Cherry Hill Hospital's cost report for 1966, Blue Cross disallowed the rent, applying Section 405.427 of SSA Regulation No. 5, allowing the operating expenses of the two related corporations instead.

"In January of 1968, Cherry Hill Realty Corporation sold all its stock for $2.400,000 payable in notes, to Cherry Hill Hospital, Inc., a newly formed nonproprietary corporation, which had received tax-exempt status from the Internal Revenue as of December 14, 1967. There was no written agreement between the parties.

"Simultaneously, the three proprietary corporations dissolved and all assets were merged into the new entity.

"The Board of Trustees of the successor corporation is composed of 12 members, including three of the physicians who were stockholders of the former corporation and four other persons previously having business relationships with the former corporation. Only five members of the new board had no relationship with the hospital prior to the change of status. The administration of the hospital remains the same, and all 14 physicians who were owners of the former corporation are still members of the hospital's staff.

"An appraisal performed without approval of Blue Cross, who in turn questioned the expertise of the appraiser, gave a value of $4,250,000 on assets having a gross book value of $2,470,000 and a net book value of $2,170,000. The provider intends to depreciate its assets as the $4,250,000 figure, and supports its revaluation based on the following.

"(1) Approval by the Internal Revenue Service as to their tax-exempt status after an investigation, they claim, implies approval of the sales price; because, if the price would have been inflated, approval would have been denied.

"(2) Acceptance by underwriter of $3,000,000 bond issue, where it is their stated policy that value of the security (the hospital building and equipment) equal 200% of the bond issue."

Although this case is somewhat similar to the Rancocas Hospital case, it has this difference—in Rancocas the original corporation continued in existence and continued to operate the hospital; in the Cherry Hill case it is represented that after the acquisition of the stock of the three original corporations by the new corporation they were dissolved and were merged into the new entity.

First of all, we do not believe that the so-called dissolution and merger can be viewed as a sale of the plant assets to the new corporation. There was a sale of stock, that much is certain; but the transfer of the plant assets owned by the original corporations to the new corporation, or rather, the assumption of ownership by the new corporation, was in no sense a sale. And, even if such a transaction under different circumstances could be viewed as a sale, it could not be so regarded in this case because of the relationship of the parties. As we pointed out in our discussion of the Rancocas case, the regulations show clearly that individuals related by a common interest may not by dealings between themselves realize an advantage under the Medicare program. As you have stated, the new corporation retains the interests of a substantial number of the individuals who were identified with the old corporations. There would not be, under these circumstances, an arms-length transaction from which the program, under Department regulations, could discern a foundation for establishing a new depreciation base.

We may observe, also, that we believe that such a situation as is present in this case, where there has been a transfer of assets by a corporation to another corporation which is under the control of one or more of the stockholders of the corporation making the transfer, would under the Internal Revenue laws be viewed as a reorganization under which no gain or loss on the basis of a sale would be recognized. See Mertens Law of Federal Income Taxation, Vol. 3, Section 20.81 et seq.

We hold a similar view with regard to the interest on the notes payable to the former stockholders in the original corporations. Our comments on the Rancocas case are applicable. The new corporation, because of the fact that the persons identified with it are substantially the same persons who had interests in the old corporations, may not be used as a means of allowing those persons, in effect, to deal with themselves to gain an advantage under the program. We would, accordingly, consider the interest on the notes not to be a reimbursable cost item.

Mr. HESS. I hesitate to summarize it, and if you want it summarized I can ask Mr. Blumenthal to do so; but, when we went into it, it shows that we went into the question of corporate reorganizations and the issue you are raising, and we took the position that the transaction has to be followed through and that we have to get to the actual fair value of the asset. Thus it shows that the value cannot be artificially inflated, and that we do not take the word of the successor corporation.

Senator WILLIAMS. Sure. Well, you can just submit that for the record and we will go into that later.

I think you recognize the problem that is giving us concern: the potential that exists here for greatly inflating these costs.

Unless there is some control and some assurance that the original cost basis will be used as the base for determining these reimbursement rates and, of course, if that is going to be true it will make quite a difference in the plans of some of these people.

There is nothing illegal in having those plans, but I question the wisdom of the Government, and certainly this agency, financing medicare, being a part of a plan which would perpetuate making such arrangements so profitable.

Mr. BALL. We agree with you, Senator, and the ruling and the operational instructions are directed right at your point. Senator, we have the information, also, that you requested yesterday about the administrative expenses of all of the carriers for the various years that you asked for. I just want you to know that we brought that with us today.

Senator WILLIAMS. That is fine, and I would like to have a copy of it if you have an extra copy, and you can just submit that for the record at this point.

(The material referred to follows:)

Administrative costs of part A intermediaries—fiscal year 1966 [1]

Intermediary	*Fiscal year 1966*
Blue Cross:	
Birmingham, Ala	$26,192
Phoenix, Ariz	19,704
Little Rock, Ark	57,627
Los Angeles, Calif	81,998
Oakland, Calif	37,643
Denver, Colo	37,718
New Haven, Conn	17,700
Wilmington, Del	18,571
Washington, D.C	30,281
Jacksonville, Fla	56,290
Atlanta, Ga	5,982
Columbus, Ga	52,551
Rockford, Ill	335
Boise, Idaho	38,326
Chicago, Ill	129,463
Indianapolis, Ind	61,274
Des Moines, Iowa	49,767
Sioux City, Iowa	20,547
Topeka, Kans	36,759
Louisville, Ky	70,822

[1] See footnote at end of table, p. 277.

Administrative costs of part A intermediaries—Fiscal year 1966[1]—Continued

Blue Cross—Continued *Intermediary*	*Fiscal year 1966*
Baton Rouge, La	$54,651
New Orleans, La	52,225
Portland, Maine	20,415
Baltimore, Md	41,419
Boston, Mass	154,904
Detroit, Mich	85,866
St. Paul, Minn	53,696
Jackson, Miss	35,496
Kansas City, Mo	34,600
St. Louis, Mo	67,105
Great Falls, Mont	19,050
Omaha, Nebr	29,310
Concord, N.H	14,777
Newark, N.J	58,058
Albuquerque, N. Mex	7,765
Albany, N.Y	8,945
Buffalo, N.Y	28,671
Jamestown, N.Y	3,563
New York City, N.Y	307,332
Rochester, N.Y	27,933
Syracuse, N.Y	11,665
Utica, N.Y	28,677
Watertown, N.Y	1,346
Chapel Hill, N.C	44,494
Fargo, N. Dak	21,478
Canton, Ohio	16,743
Cincinnati, Ohio	50,172
Cleveland, Ohio	67,335
Columbus, Ohio	28,583
Lima, Ohio	10,230
Toledo, Ohio	11,843
Youngstown, Ohio	5,962
Tulsa, Okla	33,688
Portland, Oreg	31,425
Allentown, Pa	7,132
Harrisburg, Pa	29,727
Philadelphia, Pa	38,305
Pittsburgh, Pa	62,494
Wilkes-Barre, Pa	31,783
Providence, R.I	48,080
Columbia, S.C	47,455
Chattanooga, Tenn	57,201
Memphis, Tenn	22,548
Dallas, Tex	278,000
Salt Lake City, Utah	12,046
Richmond, Va	43,902
Roanoke, Va	10,082
Seattle, Wash	67,482
Charleston, W. Va	15,602
Parkersburg, W. Va	9,683
Wheeling, W. Va	67,328
Milwaukee, Wis	53,781
Cheyenne, Wyo	17,385
San Juan, P.R	25,150
Blue Cross Association	400,467
Total, Blue Cross	3,664,611

[1] See footnote at end of table, p. 277.

Administrative costs of part A intermediaries—Fiscal year 1966[1]—Continued

Intermediary	*Fiscal year 1966*
Commercials:	
Aetna Life	$52,342
Community Health	3,021
Cooperativa, P.R	3,222
Hawaii Medical	19,064
Intercounty	40,687
Kaiser	18,871
Mutual of Omaha	55,256
Nationwide	14,851
N.Y. Department of Health	3,977
Prudential	100,899
The Travelers	137,518
Total, commercials	450,308
Total, Blue Cross and commercials	4,114,919

Administrative costs of Part B carriers, fiscal year 1966[1]

Carrier	*Fiscal year 1966*
Blue Shield:	
Birmingham, Ala	$29,398
Little Rock, Ark	51,836
San Francisco, Calif	145,325
Denver, Colo	54,716
Wilmington, Del	19,536
Washington, D.C	66,270
Jacksonville, Fla	67,187
Chicago, Ill	105,466
Indianapolis, Ind	68,928
Des Moines, Iowa	49,234
Topeka, Kans	32,514
Baltimore, Md	27,519
Boston, Mass	123,235
Detroit, Mich	329,242
Minneapolis, Minn	29,751
Kansas City, Mo	28,405
Helena, Mont	25,376
Concord, N.H	17,071
Buffalo, N.Y	17,884
New York City, N.Y	280,027
Rochester, N.Y	25,483
Fargo, N. Dak	25,663
Cleveland, Ohio	15,283
Camp Hill, Pa	162,296
Hato Rey, P.R	15,068
Providence, R.I	33,968
Columbia, S.C	44,502
Sioux, Falls, S. Dak	20,716
Dallas, Tex	171,500
Salt Lake City, Utah	12,787
Seattle, Wash	148,435
Madison, Wis	78,956
Milwaukee, Wis	44,913
Total, Blue Shield	2,368,490

[1] See footnote at end of table, p. 277.

Administrative costs of Part B carrier, fiscal year 1966[1]—Continued

Carrier	Fiscal year 1966
Commercials:	
Aetna Life	$342,154
Connecticut General	129,803
Continental Casualty	143,210
Equitable Life	163,307
General American	126,968
Group Health Insurance	63,238
John Hancock	116,227
Metropolitan Life	142,212
Mutual of Omaha	102,213
Nationwide Mutual	146,669
Occidental Life	271,986
Pan American Life	80,573
Pilot Life	61,902
Prudential	233,720
The Travelers	312,669
Union Mutual	58,427
Oklahoma Department of Public Works	-------
Nebraska State	8,909
Total, commercials	2,504,187
Travelers (RRB)	105,874
Total, Blue Shield	2,368,490
Total, Blue Shield and commercials	4,978,551

[1] These are costs incurred prior to the July 1, 1966, effective date of the program and include the cost of recruitment, training, systems work, programing, and other tooling-up costs.

TEXAS MEDICAID PROGRAM

Senator WILLIAMS. I would like to ask a couple of questions referring back to the audit report you had on the State of Texas in which the auditor claims that there has been some overpayment as far as the Federal share is concerned. You are familiar with this report, and I will read just a paragraph from page 9:

> The Texas State Department of Public Welfare claims for Federal participation in medical services was based upon premium payments to GHS rather than actual expenditures for medical services provided. During the period September 1, 1967 to June 30, 1968, the Texas State Department of Public Welfare premium payments to the GHS for medical services totaled $32,947,605; however, during this period GHS has disbursed only $18,851,452 for vendors for medical services rendered to Medicaid recipients. Since GHS is a fiscal agent of the Texas Welfare—perhaps, I mean the health insurer—the latter amount should not have been reported as medical service costs. Therefore, the Federal share of medical service costs was overstated by $11,245,911.

Now, would you care to comment on that?

Mr. BALL. Senator, although the Medicare and Medicaid programs are in the same Department, they are completely separate within the Department for administrative purposes between myself, with Medicare and the social security program, and Mary Switzer, who is the Director of the part that deals both with the cash payments in assistance under Medicaid. Dr. Land is her subordinate in the field of medical assistance.

Senator WILLIAMS. Well, that is all right. They can comment.

Dr. Land.

Dr. LAND. Yes, sir. We, as well as the regional office in the Social and Rehabilitation Service, are aware of this audit report. The regional office handles the preparation of the answers for all of the audit re-

ports. The responsibility is delegated to the regional office rather than retained by the central office.

However—to give you some background on this development—we are helping the regional office work with the audit agency. As I mentioned yesterday in my testimony, Texas had approached the regional offices in the development of their plan to try to develop a mechanism by which they could develop the prepayment system, and the contract, and I believe it is mentioned in the audit report, is not in agreement with the regulations for the primary reason of attempting to have an innovation in order to develop a basis for the study of prepayment.

The State agency made some changes after the regional office had approved the original document, according to them, in order to make the agreement more workable.

Now, I do not foresee any problem with getting this particular item straightened out. We hope that it does not straighten out in a fashion that abolishes any attempt to develop prepayment.

As you have mentioned, as you have heard the Under Secretary mention, we are trying to develop some mechanisms of prepayment, but also we do not want to give the insurer extra money.

In other words, a prepayment is valuable when the insurer takes the risk, and we certainly do not want the Government to take the risk.

Senator WILLIAMS. But the Government does take the risk and in this instance this $11 million and a quarter in overpayment, excess payment, as I understand it. It is the basis for a claim for a refund or from prospective payments to the State of Texas; is that not true?

Dr. LAND. Yes, sir.

Senator WILLIAMS. So the insurer can give credit for it.

Now, the question is—what is the Federal-State formula in Texas, 70–30?

Dr. LAND. I think it is 60–40.

Senator WILLIAMS. 60–40?

Dr. LAND. I think it is 60–40.

Senator WILLIAMS. But to the extent of whatever this formula may be, a portion or part of it belongs to the Federal Government; does it not?

Dr. LAND. Yes, sir.

Senator WILLIAMS. And the other percentage belongs to the State of Texas?

Dr. LAND. Yes, sir.

Senator WILLIAMS. Now, the question is: Will we get it?

Dr. LAND. Yes, sir.

Senator WILLIAMS. Can that be emphatic that we will get it?

Dr. LAND. Yes. I do not anticipate any problem with this situation.

Senator WILLIAMS. The reason that I wanted to be sure of that was because, as I saw it, this portion automatically belongs to us and we had a somewhat similar case with the same State before. It was referred to in the Comptroller General's report of January 31, 1967, where at that time the Comptroller General sent the report to the Congress and to your agency, also, and said:

> On the basis of our review we believe that the Department of HEW should have obtained full recovery on behalf of the Federal Government of its equity amounting to about $4 million in a refund paid to the State of Texas from the Group Hospital Services, Incorporated.

Now, that is the same company, the same insurer.

The question is—and the period involved was prior to 1967 because this report was in January 1967—did we recover that $4 million?

Dr. LAND. I am not aware of that situation, Senator.

Senator WILLIAMS. It would be a somewhat comparable situation?

Dr. LAND. I will find out.

Senator WILLIAMS. I mean, the problem is somewhat comparable to this problem; is it not?

Dr. LAND. Yes, it sounds like it is comparable.

Senator WILLIAMS. According to the Comptroller General's report, it has great similarity because he refers to the Federal Government's share of it under our State and Federal matching plan—the fact that a percentage of that belonged to the Federal Government. Do you see any reason why that couldn't have been collected the same as you say in this present case?

Dr. LAND. Well, I am not aware of the circumstances of that particular situation, but I think they sound comparable and that it should have been collected.

Senator WILLIAMS. Perhaps Mr. Ball can comment on that.

Mr. BALL. Senator, I just do not have anything to do with the administration of the assistance program or the medicaid program. I would have to inquire from Miss Switzer's part of the Department.

Senator WILLIAMS. Well, I am just struggling in the dark.

Now, What I want to know is, did we collect it, because I have been advised that we did not. I will accept a correction if we are in error but I would like to know, and if you do not have that answer now I would like for you to furnish it for the record, the date and the circumstances under which this was paid and how it was paid. If this part of the $4 million was not collected, I am wondering why and who is responsible for not having got around to it and now when we do collect some of it, how much interest are we going to get on it for the time it has been delayed, because interest is quite a factor now.

Along with the regular report as to when we will get our part of the $11 million I would like that other information because, as pointed out in these audit reports, as long as this money, this $11 million is allowed in the hands of the insurer, without being claimed by the State of Texas or the U.S. Government, it is growing and they can draw 7 or 8 percent on it and invest the Government funds, for that matter, and get 7 percent and lend it back to us and I am just wondering who owes what.

Dr. LAND. I will submit a memorandum to you tomorrow, Senator, after I look into these facts.

(Following is a letter subsequently received by the committee.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., August 29, 1969.

COMMITTEE ON FINANCE,
New Senate Office Building,
Washington, D.C.

DEAR SIRS: You asked what happened to the original $4 million discussed in the GAO audit of Texas Medicaid. The initial insurance contract between the State and the contractor provided that, within 90 days after the period covered by contract, the contractor was to render a final accounting and repay the State,

upon demand, the excess of premiums received over total claims paid by contractor plus his allowable administrative expenses. Accordingly, the contractor determined the total refund due the State, including earnings on the excess premium payments. With approval of the Department, he repaid the excess funds to the State by offset against premiums payable by the State during the period of a second contract.

As for the Federal medical assistance percentages for Texas, they are:

	Percent
June 30, 1967	67.27
July 1, 1967 to June 30, 1969	67.10
July 1, 1969	66.66

You asked whether the contractual arrangements between the Texas agency and the Group Hospital Service represents health insurance or a fiscal agent relationship. The Administrator for Social and Rehabilitation Service has ruled that the relationship between the Texas agency and the Group Hospital Service is that of a fiscal agent. Therefore, the amounts for administrative costs should have been matched at the administrative rate rather than the Federal medical assistance percentage. We will be taking up with the State agency the matter of excess payments involved.

Your last question concerned interest that would have been earned on amounts paid by the Texas agency to Group Hospital Service, as referred to in the audit agency's report. It does not appear that the Texas agency received any such amounts or has a legal right thereto. In any event, in view of section 203 of the Intergovernmental Cooperation Act of 1968 (P.L. 90-577), it is doubtful that the Federal agency could recover any share of the interest from the State.

Sincerely yours,

JOSEPH MEYERS,
Deputy Administrator.

Senator WILLIAMS. I certainly would appreciate it, and I will not pursue it further, but we are in agreement, complete agreement, and I respect you for your answers that the Comptroller General was correct, that this belonged to us and that this H.E.W. audit report, $11 million, will come back.

Now, do you have other similar circumstances in any of these other audit reports?

OVERPAYMENTS IN OTHER STATES

I have not had a chance to examine them, but have you other situations where there have been similar overpayments or uncollected funds, do you recall?

Dr. LAND. Yes, sir. I recall—and it is not exactly a similar overpayment because the overpayment is to the State and it is in Illinois, and it has to do with whether or not the State mental health hospitals and the State agency charged us too much.

Senator WILLIAMS. Yes, I am familiar with that. I had forgotten it. Go ahead.

Dr. LAND. We also had a situation in California concerning whether or not certain people were declared eligible for care in mental hospitals, as to whether they were, in fact, eligible, which if they were not, would result in an overpayment on our part.

Senator WILLIAMS. And it would be collected, yes. Well, I will not pursue that further and I am glad to note that we are going to get that back.

POOR PERFORMANCE BY CARRIER

Now, just on another point, and I know the hour is late here, but we have discussed the problem that we have had with one of the

carriers, and I know that there are many other examples which could be related concerning this same carrier. I think Mr. Ball, and Mr. Tierney, that you will agree that we are having a little more than perhaps what should be expected in problems and excessive leniency on the part of this carrier, as one of these reports indicates, in making any claim payment regardless of the merits.

Mr. BALL. As Mr. Tierney suggested yesterday, Senator, he had a meeting on the basis of this report that you have there with the top corporate officers of that company. It is a large company, and he met with the top staff, the president and so on, and as he suggested yesterday, they have taken a great many steps to improve their performance, and we will be watching it very closely.

Senator WILLIAMS. Well, in your conversations perhaps it would be helpful if you tell them that they are also being watched from other quarters, too.

Mr. TIERNEY. I think they have that message, Senator.

MEDICARE PAYMENTS FOR EMPTY BEDS

Senator WILLIAMS. I am a little bit concerned, because here is a comment in one of your other audit reports which I did not quite understand. It is one of your reports dated April 1, and it refers to a certain nursing home, which I will not identify.

I quote: "At the time of our visit there were 60 medicare patients and 34 beds were empty in the facility. The administrator related that it was cheaper to keep the beds empty than to fill them with welfare patients because if they did they would lose $7 on welfare patients."

Now, would you explain just how, if you have 147 beds in your operation it is better to keep them idle? Is that due to the arrangements of these payments you make under Part A, assuming the unoccupied bed costs?

Now, could that be true?

Mr. TIERNEY. Well, Senator, I suppose it could be true if the things that he apparently feels are going to work out in the cost settlement actually do work out of a cost settlement.

We are committed under the law and under the regulations to pay the reasonable cost of care in an institution. Now, if the institution is fully staffed up to take care of 120 people and there are only 65 in it, obviously, there are costs on a per diem basis at the end of the year which will be very high. I do not think that it would be in his interest, there would be no reason for him to maintain a full staff for that whole institution.

All he is going to get back is the cost that he incurs, but the cost might be very high to us. Now, the limitations that we would impose on this, Senator, are the limitations of reasonableness, but I think some people have had the feeling, well, that as long as medicare will pick up the cost that they need not be too much concerned about the costs, and this goes through the whole mechanism of cost reimbursement which we have discussed before.

Senator WILLIAMS. This is the point here, and as I understand this particular case, that is the explanation. They have a 147-bed institution and they are putting in 60 medicare patients and they are getting reimbursed for all of their staffing operation regardless, and they do

not have to do but half the work, a little less than half the work, and they cannot lose. On the medicare reimbursement basis they are making money for doing nothing, and they are carrying this to an extreme. Let us carry this to a greater extreme, suppose they have only 30 patients and all are medicare patients.

Do we under Title A, if it is a certified and approved institution, pick up all of the costs?

Mr. TIERNEY. I think the cost in such a situation, again assuming that it is fully staffed for 147 and you only have 8 or 30 or whatever you said, Senator, would be highly unreasonable.

Now, under the law we have this general provision that we will pay the reasonable costs. We have been working, Senator, toward the development of an assumption of occupancy in determining reasonable cost and I think, frankly, our General Counsel feels that we have to have legislative authority to impose that kind of limitation. He does not feel under the present law that we can just say we do not care what your costs have been, we are going to assume what they would have been had you been 90 percent occupied.

But, that kind of an approach would give us a lot more direct pressure on the situation than going through this thing of what is reasonable and what is not reasonable.

Senator WILLIAMS. Well, perhaps you will get some legislation if necessary. I am just wordering why we have not acted sooner, because carrying this to an extreme, as I understand it, they can go along, and in this instance, this particular carrier, as this report said, is very lenient and does not seem to care—after all, it is not his money, and so they just go on and pay it—and as long as this is certified as acceptable from medicare they can fill it to 10 percent and collect the whole 100 percent of costs.

Now, I think that if they are turning down patients that in itself should be evidence that there is something wrong, and yet, this particular home, as I understand it, is still drawing that money.

Now, I wish you would check this. When you are back here again, and these hearings will be resumed, I more than likely will be raising that same question as to just what has been done in the meantime and where it stands.

Mr. TIERNEY. I will have an answer, Senator.

PAYMENTS FOR UNNECESSARY PHYSICAL THERAPY

Senator WILLIAMS. This is an entirely different area from the one we discussed yesterday, but the same carrier is involved. It seems that this physical therapy business has developed into somewhat of a racket, and I am just wondering if the carrier and perhaps somebody in the administration doesn't need a little therapeutic treatment. I noticed here one particular case that they cite in one of these nursing homes where the patient is 80 years old, and had congestive heart failure.

On March the 17th the physician stated that she be kept at minimum activity and for the patient to be evaluated by the orthopedist. On March the 22d the orthopedist stated that he did not feel that the patient was ready for ambulation.

On the 28th the attending physician ordered full and complete bed rest for a few days, yet physical therapy charges were there for every one of the days right straight on through.

Now, you cannot say that physical therapy was ordered in that case because it was specifically rejected.

Mr. TIERNEY. Senator, we agree entirely. This was our report—the report of our team—and this is how we got the whole thing on the table with this carrier and this intermediary.

POOR PERFORMANCE BY ANOTHER CARRIER DOCUMENTED

Senator WILLIAMS. Well, I appreciate that and I will not pursue it, but as I say, I think that the carriers should be on notice and advised that we are checking and lest they think that we are picking on this one carrier alone, I will refer to your report here of March 8, which included another carrier and I will just read a few of the notations regarding this other carrier here.

"The interim increases are not properly documented, No. 1. Two, current financial computations are loaded in favor of the provider.

"Substantial payments have been made for physical and occupational therapy not related to the patient's condition, and that there is still therapy being scheduled for patients without regard to medical necessity."

This referred to another geographical area and another series of nursing homes in which this was being done.

Continuing with the report they referred to rate increases and in one of these nursing homes, for example, and this is one in New York City, the routine service rate was $32.50 a day effective April 1, 1968 and it was increased four times to the present rate of $52, effective April 1, 1969. No examination was made by the intermediary as to why the rate was raised; the home just decided they wanted more money and asked for it. I wonder why they stopped at $52.

Now, is there not some way that we can check this? They point out here that the private patients in there, the private patients were paying substantially less than this medicare rate at the time, and yet as I understand it, this same nursing home is still on your approved list.

Mr. TIERNEY. I am not aware of that nursing home. I do know that we have called this same type of situation to the attention of this intermediary.

I might say this, Senator. We are not allowing either of these intermediaries to take on any more business. It is really a question of settling up their past business, but in every one of these situations we totally agree with you, Senator, that they have not done an effective job of following the regulations.

INTERMEDIARY COMPETITION FOR HANDLING NURSING HOME BUSINESS

Senator WILLIAMS. In selecting the intermediary for this particular nursing home, can they, did they have a choice in selecting who was going to be the intermediary?

Mr. TIERNEY. Under the Part A portion of the legislation, Senator, an institutional provider who is reimbursed on a cost basis—either a

hospital or ECF—has the right to either individually or through an association to nominate its fiscal intermediaries.

So, that is a part of the law, Senator, that they have that right. They can elect, if they so choose, to deal directly with the Government.

Now, the Secretary, however, is not bound by that nomination. He is bound to go along with them unless the finds that it would not be in accordance with effective and efficient administration.

Senator WILLIAMS. I think you are correct that it is a part of the law, but there is a question in my mind. If those who are going to be paid these rates have a right to shop around for an agent who is going to handle it, does this not open itself up to a situation where you or I as intermediaries would be shopping around, and I will be a little more lenient if you will let me handle it, does this not open up somewhat of an encouragement, a financial encouragement to the carriers to be lenient in those payments so that the nursing homes or the hospitals, whatever may be involved will use them and select them?

Mr. TIERNEY. Senator, I think that is a possibility and we have had allegations on both sides of this sort of thing. One company alleges that another intermediary is telling the people dealing with our company, that if they go over to them that they will do better and the other company is saying the same. There has been serious consideration given, Senator, to eliminating this nominating procedure and having a direct appointment.

Senator WILLIAMS. Well, that bothers me. I have received the same complaint to the effect that some institutions may claim they are going to change intermediaries because they would get better treatment. The intermediary claims that if they do not give the institution good treatment they might lose that business and I wonder if maybe a correction in the law is needed. Perhaps you could be thinking about that. Would this switching ability not be an incentive for inefficiency—it is just not quite cricket.

Mr. TIERNEY. I agree, Senator; we do not allow an institution to just change intermediaries willynilly whenever they want to. They must demonstrate that the existing intermediary is not doing an effective job.

But, I am not arguing, Senator. Underlying the whole issue there may be some incentive for less stringent application of the regulations.

Senator WILLIAMS. On the other nursing homes, other than that one audit report placed in the record which we discussed yesterday, I am withholding names. We are not going to identify the carriers, although I think that it should be made clear that as these hearings proceed more than likely some of these names will be disclosed, at which time they will be given a chance to explain their side. There are two sides to every question, and in all fairness we want them to have their chance. I think that those who are working with this program who are tentatively under criticism at this time, whatever segment they may be, can be sure that they will get an opportunity to present their case; but at the same time we do expect them to present it and explain some of the things that have happened.

PHYSICIAN FEE RAISING JUST PRIOR TO MEDICARE

The staff just handed me this. There has been a report that doctors began increasing their fees just before medicare became effective in order to fix a high base for medicare reimbursement, and that they are submitting bills on which medicare pays 80 percent and then they do not bother to try to collect the other 20 percent from the patient.

In other words, they are getting 100 percent of their payment from medicare originally. Now, do you know anything about whether this is true, or not?

Mr. BALL. On the first part, Senator, in my opening statement that we put in the record I did go into the question of the effect of medicare on the sharp increase in physicians' fees when medicare came into effect.

It is my opinion that the fact that this program was going into effect did cause large numbers of physicians to revise their schedule of charges to patients generally in order to have a base for the operation of this program.

So, on the first part, it is my opinion that this did happen, to a considerable degree.

I have heard reports that it is fairly common in dealing with patients who have very low incomes for the physicians not to attempt to collect that 20-percent coinsurance. We have not done a study on that and I do not have any way that I can document it factually. I would suspect that it would be true for many of the low-income patients.

HEW FREEZE ON PHYSICIAN FEES

Senator WILLIAMS. Now, the department, as I understand it, has issued a statement tentatively freezing payments at the January 1 level. Is that correct?

Mr. BALL. In the medicare program we issued a general rule to carriers that they could not recognize the increases in physicians' fees for medicare purposes except in a very unusual, especially justified, specific instance, and that any change in the determination of prevailing changes would have to be submitted to Social Security for prior approval, and we have had no such change. I do not like to characterize it as a complete freeze, Senator, but it is very close.

Senator WILLIAMS. It has been suggested to the committee that this, in effect, freezes them at a very high level. Do you think that is valid?

The suggestion has also been made that the doctors who have been taking advantage of Medicare in raising their charges substantially are frozen at a high level, whereas the ones who have not raised charges and have been going along at a reasonable level are the ones who are penalized.

Mr. BALL. Your latter point is the reason that we did not want to issue an absolute freeze. We would accept and the carrier would accept as justification for allowing increased charges in the case of a particular physician, a demonstration that he had, for example, not raised his fees since before medicare, so we would try to make some equitable adjustment there.

On the matter of this freeze being at quite a high level, I think that it is true. But I think it is only fair to point out that while in my judgment physicians' fees, are rising out of proportion to other factors, these increases reflect in some portion increases that can be justified on the bases of increases in wages and the cost to the physician of doing business. I think if we hold this now where we are, largely throughout this next fiscal year—1970—which is the year to which the $4 rate applies, that will have had a very significant dampening influence.

Senator WILLIAMS. We are going to adjourn the hearing at this time, and as you have been notified, they will be resumed at a later date. In the meantime we thank you for your cooperation. At the same time we want to emphasize that we recognize that there is much good in these programs.

We are not trying to discredit the programs themselves, but it is most essential that we point out, expose, and eradicate whatever abuses there may have been and make sure that whatever benefits are in the program go to the patients for whom it was intended.

We thank you very much.

(Thereupon, at 4:15 p.m., the hearing was adjourned sine die.)

APPENDIX A

Medicare Payments for Services of Supervisory and Teaching Physicians at Cook County Hospital, Chicago, Ill. (Report to the Committee on Finance by the General Accounting Office)

REPORT TO THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

Medicare Payments For Services Of Supervisory And Teaching Physicians At Cook County Hospital, Chicago, Illinois B-164031(4)

Social Security Administration
Department of Health, Education,
and Welfare

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(4)

Dear Mr. Chairman:

The General Accounting Office has made a review of Medicare payments for services of supervisory and teaching physicians at Cook County Hospital, Chicago, Illinois. The review was made in accordance with your request of April 28, 1969.

Our review was limited to obtaining factual information pertaining to the specific matters on which such information was requested. In accordance with your request, we did not develop overall conclusions with respect to legal or policy questions relating to matters covered during our review.

Pursuant to agreements reached with members of the Committee staff, copies of this report are being sent today to the Secretary of Health, Education, and Welfare and to other appropriate officials of the Department of Health, Education, and Welfare; the Director of the Cook County Hospital; the president of Illinois Medical Service; and the president of The Associated Physicians of the Cook County Hospital.

We plan to make no further distribution of this report unless copies are specifically requested, and then we shall make distribution only after your agreement has been obtained or public announcement has been made by you concerning the contents of the report.

Sincerely yours,

Comptroller General
of the United States

The Honorable Russell B. Long
Chairman, Committee on Finance
United States Senate

COMPTROLLER GENERAL'S REPORT TO CHAIRMAN, COMMITTEE ON FINANCE UNITED STATES SENATE

MEDICARE PAYMENTS FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS AT COOK COUNTY HOSPITAL, CHICAGO, ILLINOIS
Social Security Administration
Department of Health, Education, and Welfare
B-164031(4)

D I G E S T

WHY THE REVIEW WAS MADE

In accordance with a request, dated April 28, 1969, from the Chairman, Committee on Finance, United States Senate, the General Accounting Office (GAO) reviewed selected Medicare payments for physicians' services made to the Associated Physicians of the Cook County Hospital (APCCH), Chicago, Illinois. The Chairman advised GAO that the Committee did not intend that GAO develop overall conclusions relating to any legal or policy questions which might arise during the review. The Committee has also requested GAO to limit the distribution of the report prior to its release by the Committee.

Medicare is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW). Illinois Medical Service (Blue Shield) has been operating under a contract with SSA to make payments of Medicare claims for physicians' services in several counties in Illinois, including Cook County.

In accordance with certain SSA regulations, issued in August 1967, payments under the supplementary medical insurance portion (part B) of the Medicare program could be made for the professional services rendered to Medicare patients by supervisory or teaching physicians in a hospital in cases where the physicians are the patients' attending physicians and provide personal and identifiable direction to interns and residents who are participating in the care of their patients.

FINDINGS AND CONCLUSIONS

From April 1968 to April 15, 1969, when, at the direction of SSA, Blue Shield suspended making payments of APCCH claims, APCCH had received about $1.6 million in payments under part B of the Medicare program for the services of attending physicians.

The GAO review of patient medical records of Cook County Hospital indicated that the professional services billed by APCCH and paid by Blue Shield had been furnished, in almost all cases, by residents and interns

at the hospital and showed only limited involvement of the attending physicians in whose names the services had been billed.

The GAO review of the hospital medical records applicable to selected Medicare claims for attending physicians' services showed that:

--For 60 of the 72 initial visits for which billings had been made, the medical records supporting the specific services billed disclosed no involvement of any attending physicians, although the SSA regulations provided that the attending physicians should review the patients' histories and physical examinations and personally examine the patients within reasonable periods after admission. (See p. 29.)

--For 129 of 747 follow-up visits billed, no notations had been made by any physicians, including residents or interns, to indicate that physicians had seen the patients. For the remaining 618 visits, which were supported by physicians' notations, attending physicians had been identified as involved in providing the services for only 35 visits and residents and interns had been identified as providing the services for nearly all the remaining visits. (See p. 31.)

--The medical records applicable to 38 consultations for which the Medicare program had been billed disclosed no involvement of the attending physicians in whose names the services had been billed. (See p. 34.)

--Hospital records in nine of 18 cases involving charges for operating room surgery did not indicate that attending physicians had been present during the operations. (See p. 37.)

--Hospital records in 31 of 39 cases involving charges for minor surgical procedures did not indicate that attending physicians had been specifically involved. (See p. 40.)

Officials of APCCH and Cook County Hospital advised GAO that generally the services were provided to the patients under the direction of attending physicians responsible for the patients care but that evidence of such direction was not incorporated into the patients' medical records.

RECOMMENDATIONS OR SUGGESTIONS

Although in April 1969 SSA issued new and more comprehensive guidelines which were intended to clarify and supplement the criteria for making payments for the services of supervisory or teaching physicians, GAO suggested that SSA inquire further into the propriety of the charges being allowed when the circumstances outlined above existed at hospitals.

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW pointed out that SSA, by letter dated April 9, 1969, had directed Blue Shield to suspend further payments to APCCH. HEW stated that it would inquire further into the specific circumstances described by GAO. (See p. 68.)

Tear Sheet

Contents

ABBREVIATIONS

APCCH	The Associated Physicians of the Cook County Hospital
CRVS	California relative value studies
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
JCAH	Joint Commission on Accreditation of Hospitals
PHS	Public Health Service
PSF	Physicians' and surgeons' fund
RRB	Railroad Retirement Board
SSA	Social Security Administration

COMPTROLLER GENERAL'S REPORT TO CHAIRMAN, COMMITTEE ON FINANCE UNITED STATES SENATE

MEDICARE PAYMENTS FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS AT COOK COUNTY HOSPITAL, CHICAGO, ILLINOIS
Social Security Administration
Department of Health, Education, and Welfare
B-164031(4)

D I G E S T

WHY THE REVIEW WAS MADE

In accordance with a request, dated April 28, 1969, from the Chairman, Committee on Finance, United States Senate, the General Accounting Office (GAO) reviewed selected Medicare payments for physicians' services made to the Associated Physicians of the Cook County Hospital (APCCH), Chicago, Illinois. The Chairman advised GAO that the Committee did not intend that GAO develop overall conclusions relating to any legal or policy questions which might arise during the review. The Committee has also requested GAO to limit the distribution of the report prior to its release by the Committee.

Medicare is administered by the Social Security Administration (SSA), Department of Health, Education, and Welfare (HEW). Illinois Medical Service (Blue Shield) has been operating under a contract with SSA to make payments of Medicare claims for physicians' services in several counties in Illinois, including Cook County.

In accordance with certain SSA regulations, issued in August 1967, payments under the supplementary medical insurance portion (part B) of the Medicare program could be made for the professional services rendered to Medicare patients by supervisory or teaching physicians in a hospital in cases where the physicians are the patients' attending physicians and provide personal and identifiable direction to interns and residents who are participating in the care of their patients.

FINDINGS AND CONCLUSIONS

From April 1968 to April 15, 1969, when, at the direction of SSA, Blue Shield suspended making payments of APCCH claims, APCCH had received about $1.6 million in payments under part B of the Medicare program for the services of attending physicians.

The GAO review of patient medical records of Cook County Hospital indicated that the professional services billed by APCCH and paid by Blue Shield had been furnished, in almost all cases, by residents and interns

at the hospital and showed only limited involvement of the attending physicians in whose names the services had been billed.

The GAO review of the hospital medical records applicable to selected Medicare claims for attending physicians' services showed that:

--For 60 of the 72 initial visits for which billings had been made, the medical records supporting the specific services billed disclosed no involvement of any attending physicians, although the SSA regulations provided that the attending physicians should review the patients' histories and physical examinations and personally examine the patients within reasonable periods after admission. (See p. 29.)

--For 129 of 747 follow-up visits billed, no notations had been made by any physicians, including residents or interns, to indicate that physicians had seen the patients. For the remaining 618 visits, which were supported by physicians' notations, attending physicians had been identified as involved in providing the services for only 35 visits and residents and interns had been identified as providing the services for nearly all the remaining visits. (See p. 31.)

--The medical records applicable to 38 consultations for which the Medicare program had been billed disclosed no involvement of the attending physicians in whose names the services had been billed. (See p. 34.)

--Hospital records in nine of 18 cases involving charges for operating room surgery did not indicate that attending physicians had been present during the operations. (See p. 37.)

--Hospital records in 31 of 39 cases involving charges for minor surgical procedures did not indicate that attending physicians had been specifically involved. (See p. 40.)

Officials of APCCH and Cook County Hospital advised GAO that generally the services were provided to the patients under the direction of attending physicians responsible for the patients care but that evidence of such direction was not incorporated into the patients' medical records.

RECOMMENDATIONS OR SUGGESTIONS

Although in April 1969 SSA issued new and more comprehensive guidelines which were intended to clarify and supplement the criteria for making payments for the services of supervisory or teaching physicians, GAO suggested that SSA inquire further into the propriety of the charges being allowed when the circumstances outlined above existed at hospitals.

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW pointed out that SSA, by letter dated April 9, 1969, had directed Blue Shield to suspend further payments to APCCH. HEW stated that it would inquire further into the specific circumstances described by GAO. (See p. 68.)

INTRODUCTION

Pursuant to a request, dated April 28, 1969, from the Chairman, Committee on Finance, United States Senate, the General Accounting Office has reviewed selected Medicare payments to APCCH.

The Chairman requested that we review:

1. The circumstances surrounding the admission of Medicare patients to Cook County Hospital.

2. The extent to which the services paid for with Medicare funds had been performed by supervisory or teaching physicians and the extent to which such services had been performed by residents and interns.

3. The extent to which the services for which payments had been made had been performed by salaried and nonsalaried physicians and whether the hospital or the physicians had been otherwise compensated for such services.

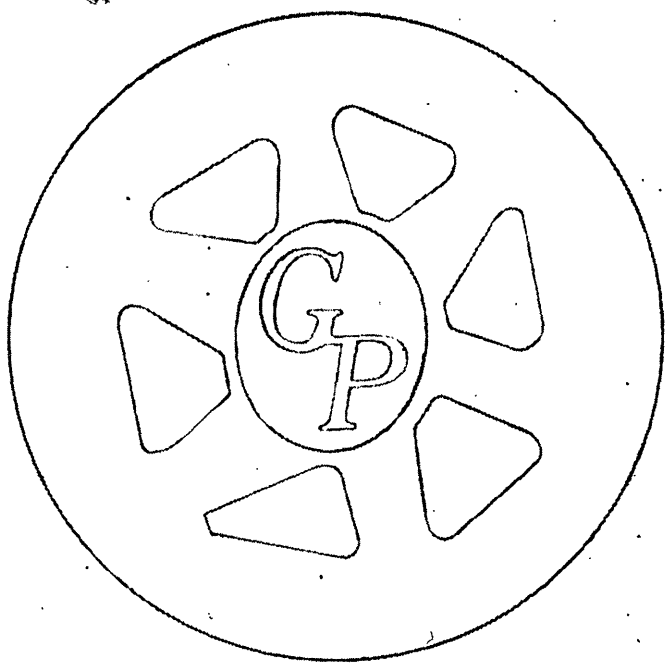
4. The relationship between APCCH and the physicians.

5. Information as to whether Medicare patients had been billed for deductibles and coinsurance, whether they had requested that Medicare payments be made on their behalf, and whether they had received notification of payments made on their behalf.

6. The basis for arriving at the amounts of the reasonable charges for the services.

7. Information as to whether other medical insurance programs or other patients had made payments for services performed by the salaried or nonsalaried physicians at Cook County Hospital in amounts comparable to those paid from medicare funds under comparable circumstances.

We were advised by the Chairman that the Committee did not intend that we should develop overall conclusions relating to any legal and policy questions which might arise during the review. The scope of our examination is set forth on page 69.



32-108 O - 69 - 20

DESCRIPTION OF PERTINENT FEATURES

OF THE MEDICARE PROGRAM

Title XVIII of the Social Security Act (42 U.S.C. 1395), enacted on July 30, 1965, established the Medicare program, effective July 1, 1966, to provide two basic forms of protection against the costs of health care to eligible persons over age 65. One form, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services, as well as posthospital care in an extended-care facility or in the patient's home. This form of protection is financed by a special social security tax paid by employees and their employers and by self-employed persons.

The second form of protection is a voluntary program, designated as Supplementary Medical Insurance Benefits for the Aged (part B), and covers physicians' medical and surgical services, including consultations and home, office, and institutional visits, as well as other services ordinarily provided as part of a physician's service, such as diagnostic tests, medical supplies, and drugs which cannot be self-administered. Medical services rendered by hospital-based physicians and specialists, such as radiologists and pathologists, are covered by the medical insurance program (part B).

Part B is financed, in part, from the proceeds of premiums collected from each participating beneficiary who has elected to be covered by the program. The premiums are matched by equal amounts appropriated from the general revenues of the Federal Government. Effective April 1, 1968, the monthly premium rate was increased from $3 to $4. The beneficiary is responsible for the first $50 for covered services in each year. Eighty percent of the reasonable charges for covered services in excess of $50 in each year is paid under part B of the Medicare program.

PAYMENTS FOR SERVICES ON THE BASIS OF REASONABLE COSTS AND REASONABLE CHARGES

Under the hospital insurance program (part A), services furnished to beneficiaries by hospitals, extended-care facilities, and home health agencies are paid for on a "reasonable cost" basis, as required by section 1814 of the Social Security Act. Payment is made directly to these institutions, also known as providers, by fiscal intermediaries operating under contracts with SSA to administer the hospital insurance program. Reimbursement on the basis of reasonable cost provides for payment of all direct and indirect costs related to the care furnished to Medicare beneficiaries.

Under the medical insurance program (part B), payments for physicians' services are to be made on the basis of "reasonable charges," as required by section 1842 of the Social Security Act. The organizations designated by contract with HEW to make such payments are referred to as carriers. In determining the reasonable charges, the carriers are required to take into consideration the customary charges made by physicians for their services, as well as the prevailing charges in the same locality for similar services.

In regulations promulgated to implement the reasonable charge criteria set forth in the Medicare law, SSA defined "customary charge" as the uniform amount that a physician charges, in the vast majority of cases, for a specific medical procedure or service.

SSA regulations define "prevailing charges" as those which fall within the range of charges most frequently and most widely used by physicians in a locality for a particular medical procedure or service. SSA regulations state also that, except for unusual circumstances, the upper limit of the range of prevailing charges represents an overall limitation on the charges which a carrier should accept as reasonable for a given medical procedure or service.

In other words, under part B of the Medicare program, the charge to be allowed should not exceed either

(1) the individual physician's customary charge for the service rendered or (2) the upper limit of the prevailing charges in the area. Furthermore, the reasonable charge cannot exceed the actual charge made by the physician in a particular case.

PAYMENTS FOR SERVICES OF SUPERVISORY OR TEACHING PHYSICIANS, RESIDENTS, AND INTERNS

SSA regulations provide that the reasonable charges for professional services rendered to Medicare patients by supervisory or teaching physicians in a hospital, in cases where the physicians provide personal and identifiable direction to interns and residents who are participating in the care of their patients, are covered under part B of the Medicare program. The reasonable costs of medical services provided in a hospital by residents and interns under an approved training program are covered under part A of the program.

The following SSA regulations,[1] issued on August 31, 1967, describe the circumstances under which payments will be made for services furnished by supervisory or teaching physicians, as follows:

> "(b) Payment on the basis of reasonable charges is applicable to the professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient. In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician. A charge should be recognized under Part B for the services of an attending physician who involves residents

[1]The SSA regulations were published in February 1967 in the Federal Register as a proposed rule.

and interns in the care of his patient only if his services to the patient are of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients. The carrying out by the physician of these responsibilities would be demonstrated by such action as: Reviewing the patient's history and physical examination and personally examing the patient within a reasonable period after admission; confirming or revising diagnosis; determining the course of treatment to be followed; assuring that any supervision needed by the interns and residents was furnished; and by making frequent reviews of the patient's progress.

"(c) Charges for such services of the attending physician may be billed either directly by him or by the hospital under arrangements between the physician and the hospital. [note 1.] In either case, the amount payable under the program for such service may be determined in accordance with the same criteria for the determination of reasonable charges as are applicable to the services which the physician renders to his other patients ***."

In April 1969, SSA issued new and more comprehensive guidelines (see app. VII) which, according to SSA, were intended to clarify and supplement the criteria for making payments for services of supervisory or teaching physicians. SSA stated that the new guidelines were found to be necessary because there appeared to be a serious need for a better and more uniform understanding of the conditions under which such payments could be made. Some of the more important provisions of the new guidelines are as follows:

---

[1]SSA instructions issued in April 1967 permitted organizations of teaching physicians to bill for professional services furnished to medicare patients, provided that the individual physicians had authorized such organizations to bill on their behalf.

"A. Conditions Which Must be Met for a Teaching Physician to be Eligible for Part B Reimbursement as an Attending Physician

The physician* must be the patient's 'attending physician.' This means he must, as demonstrated by performance of the activities listed below, render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized; his services to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients.

"1. To be the 'attending physician' for an entire period of hospital care, the teaching physician must as a minimum:

a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

b. personally examine the patient; and

c. confirm or revise the diagnosis and determine the course of treatment to be followed; and

---

"* The term 'physician' does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff. For example, a senior resident who is referred to as an 'assistant attending surgeon' or an 'associate physician' would still be considered a resident since the senior year of the residency is essential to completion of the program."

d. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and

e. be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an 'attending physician' his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and

f. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization."

* * * * *

"3. Performance of the activities referred to above must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician.

"4. The services of a teaching physician while visiting patients during grand rounds is basically teaching and does not contribute to an 'attending' relationship with any of the patients visited."

11

METHODS OF PAYMENT FOR MEDICAL SERVICES

Under part B of the Medicare program, payments in excess of the $50 deductible for covered services for a beneficiary, may be made either to a physician (assignment method) or to the beneficiary. The choice is a matter of agreement between the physician and the beneficiary. If the physician agrees to take an assignment, he agrees also that the reasonable charge determined by the carrier will be the full charge and that the beneficiary will be billed for no more than 20 percent of the reasonable charge.

If an assignment is not made and the beneficiary applies for payment, his claim must be supported by an itemized bill from the physician and the carrier can pay the beneficiary 80 percent of the reasonable charges. Under this method, the payment of the physician's fee becomes a matter between the physician and the beneficiary. All payments for services of supervisory or teaching physicians at Cook County Hospital were made to APCCH under the assignment method.

CARRIERS' ROLE IN ADMINISTERING PART B OF MEDICARE PROGRAM

To provide for the administration of benefits under part B, the Congress authorized the Secretary of HEW to enter into contracts with carriers which are (1) to make determinations of the rates and amounts of payments on a reasonable-charge basis and (2) to receive, disburse, and account for funds expended in making such payments.

The reports of the House Ways and Means Committee and the Senate Finance Committee on the bill (H.R. 6675) that became the Medicare law expressed the view that medical benefits under part B should be administered by private carriers because private insurers, group health plans, and voluntary medical insurance plans had had experience in reimbursing physicians. Both Committee reports also expressed the intent that the Secretary of HEW, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other

geographical basis, to permit comparative analysis of their performance.

As of June 30, 1968, SSA, acting under delegation of authority from the Secretary, had entered into contracts with 33 Blue Shield organizations, 16 commercial insurance companies, and one State agency to act as carriers under the supplementary medical insurance program. During fiscal year 1968, benefit payments made by carriers under part B of the Medicare program amounted to about $1.3 billion, of which over 90 percent was for physicians' services. Administrative costs of the carriers for making such benefit payments amounted to about $100 million.

In July 1966, SSA entered into a contract with Illinois Medical Service, a Blue Shield organization, to act as carrier for part B of the Medicare program in Cook, Du Page, Kane, Lake, and Will Counties in the State of Illinois. The contract was for the period February 11, 1966, through June 30, 1967, and it was automatically renewable for successive periods of 1 year, unless either Blue Shield or the Secretary gave written notice of intention not to renew.

During fiscal year 1968, Blue Shield made Medicare part B benefit payments amounting to about $38 million and incurred expenses of about $3 million in administering the program.

The Travelers Insurance Company, operating under a contract with the Railroad Retirement Board (RRB), acts as the nationwide part B carrier for RRB beneficiaries and, accordingly, administers a small portion of the part B Medicare program in the same geographical area covered by Blue Shield. Because, on a nationwide basis, the Medicare payments made on behalf of RRB beneficiaries represent less than 5 percent of the total payments, we did not include in our review any payments made by Travelers to APCCH.

MEDICAL CARE

IN COOK COUNTY HOSPITAL

Cook County Hospital provides general, short-term medical care, primarily for residents of Cook County. It is a large, old hospital with about 2,500 beds. The overall administrative direction of the hospital is provided by a hospital director who is responsible to the Cook County Board of Commissioners. The cost of the hospital's operations is funded through appropriations by the Cook County Government, and all revenues received by the hospital are deposited in the county's general fund.

The hospital provides a full range of medical services, including the usual services in medicine, surgery, gynecology, obstetrics, and pediatrics. In addition, it has a burn unit and a trauma unit which provide specialized care beyond that normally furnished by a general hospital. In 1968, the hospital reported about 699,000 patient-days, of which about 97,000, or 14 percent, were attributable to patients 65 years of age or over. The costs for the hospital, including the related School of Nursing and the Fantus Outpatient Clinic, during this period were about $41 million.

According to a December 1967 report by the Task Force on Health and Hospital Services, which was appointed by the Citizens Committee on Cook County Government, the Cook County Hospital is open to all residents of the county, but it is basically an institution for the medically indigent. The report stated that probably less than 10 percent of the hospital's patients had sufficient income or insurance to cover their full hospital costs.

The hospital reported in November 1968 that all 2,500 hospital beds and the Fantus Outpatient Clinic were used for teaching. The five Chicago area medical schools conduct teaching programs at Cook County Hospital. The hospital director stated, however, that no formal agreements existed between the hospital and the medical schools. Four of the schools assigned junior-year students and senior-year students to the wards and clinics of the hospital.

The schools assign full-time faculty members to supervise the students, and residents and interns also supervise the students. The hospital also reported that its internship and residency programs were fully accredited by the Council on Medical Education of the American Medical Association and by such specialty boards as the American Board of Surgery and the American Board of Anesthesiology.

The hospital further reported in November 1968 that all the full-time staff and virtually all the voluntary attending staff held faculty positions in one of the Chicago medical schools. The hospital's office of medical education conducts an educational program for the Cook County Hospital internship. Each division and department of the hospital conducts its own educational program for its residents.

Medical care in the hospital is largely dependent upon the staff of residents and interns who are taught and supervised by a staff of attending physicians. A vast majority of the attending physicians voluntarily donate their services on a part-time basis, whereas other attending physicians are paid salaries by the hospital for various duties.

Most of the attending physicians at Cook County Hospital are members of APCCH and have authorized that organization to bill and collect from the Medicare program fees for services which they provide to patients in the hospital. As of April 30, 1969, APCCH had billed the Medicare program about $3.5 million for services provided subsequent to July 1966 by these supervisory and teaching attending physicians to Medicare patients in Cook County Hospital and had been paid about $1.6 million. All of these payments were made by Blue Shield, except about $60,000 which was paid by The Travelers Insurance Company for services furnished to RRB beneficiaries.

MEDICARE PAYMENTS FOR SERVICES OF SUPERVISORY AND TEACHING PHYSICIANS AT COOK COUNTY HOSPITAL

This report includes information responsive to the request made by the Chairman in his letter dated April 28, 1969. For ease in identifying the information furnished in response to the specific items included in the request, we have noted these items under the various sideheadings in the report and have cross-referenced the Chairman's letter, which is included as appendix I beginning on page 73, to the appropriate pages of this report. In addition, the comments of HEW, Blue Shield, Cook County Hospital, and APCCH are included as appendixes III through VI, respectively.

NATURE OF APCCH (Item 4)

APCCH was incorporated in Illinois on December 8, 1967, as a not-for-profit corporation. The stated purposes for which the corporation was organized are:

> "*** to carry on and promote medical and scientific education and research; to educate and train doctors, nurses, technicians and other persons to the extent related or incident to modern hospital and medical care and services; to promote improved and expanded medical treatment and hospital facilities; to receive and promote the making of gifts, donations and bequests and devises of monies and properties of every kind and nature to, and for the use and benefit of, the corporation; to apply for, receive and acquire grants of assistance, property and services, of any kind, from any governmental or public agency; and to conduct all lawful activities incident to or desirable in connection with the foregoing purposes; provided, however, that no part of the activities of the corporation shall be carrying on propaganda or otherwise attempting to influence legislation."

The authority of APCCH to bill in the names of attending physicians is derived from the assignment each physician makes at the time he applies for membership. The assignment, which may be revoked by written notice, provides as follows:

> "The undersigned further hereby assigns, transfers and sets over to the Associated Physicians of the Cook County Hospital, for distribution for the benefit of medical and scientific education and research, and other purposes defined in the Articles of Incorporation, as determined by the Board of Directors of the Associated Physicians of the Cook County Hospital pursuant to the By-Laws of the Association, all of his right, title, and interest in and to professional fees for professional services rendered to patients at the Cook County Hospital in the course of his responsibilities as a member of the Attending Staff of the Hospital; these are fees which may become payable to him (1) under the provisions of Title XVIII Part B and Title XIX of the Health Insurance for the Aged Act (P.L. 89-97, 1965); (2) third party reimbursements; and (3) direct payments. This assignment is conditional upon the agreement of the Associated Physicians of the Cook County Hospital to indemnify and save the undersigned harmless from any claim against the undersigned by or on behalf of the Internal Revenue Service, or other taxes on or with respect to professional fees covered by this assignment."

We were informed by the hospital director that, as a matter of policy, attending physicians were not permitted to individually bill patients for professional services provided at Cook County Hospital. The executive staff, however, has authorized two physicians' organizations to bill for such services. Such an authorization was granted to APCCH about a month before its incorporation. A previous authorization was granted to the physicians' and surgeons' fund (PSF) in May 1959. The PSF which bills private insurance companies for physicians' services, is discussed in greater detail beginning on page 63.

APCCH membership, as of May 1969, consisted of 512 of the 612 attending and consulting physicans on the hospital staff. APCCH presently has billed only for physicians' services provided to hospital patients covered under part B of the Medicare program; however, the APCCH administrator informed us that APCCH intended, in the near future, to bill all patients and/or their third-party insurers for such services.

Our test review of selected Medicare billings (see p. 69) showed that in each case the attending physician, in whose name the billing had been made, was a member of APCCH. To test whether attending physicians who were not members of APCCH were also billing for their services to Medicare patients treated at the hospital, we submitted the names of 12 such physicians to Blue Shield for screening against its payment files. This test did not disclose any payments to these physicians for services at Cook County Hospital.

Expenditures of APCCH

As cited above, the APCCH articles of incorporation provide, in general, that expenditures be made for medical and scientific education and research. The articles provide also that no part of APCCH's income be distributable to its members, directors, or officers; provided, however, that reasonable compensation for services rendered not be deemed a distribution of income. Further, the articles provide that no part of the net earnings of APCCH inure to the benefit of any member or individual but that all net profits and net gains arising from the operation and conduct of APCCH be devoted exclusively to furthering the purposes of APCCH.

According to financial data provided to us by APCCH for the period from incorporation to April 30, 1969, a total of about $3.5 million had been billed under Medicare, of which about $1.6 million had been received. Of the total amount received, $1,600,476 was for physicians' services provided to Medicare patients and $7,865 was from return on investments of those funds. The status of the amounts received as of April 30, 1969, was reported by APCCH, as follows:

Total cash received		$1,608,341
Cash in bank and on hand	$ 9,755	
Marketable securities, at cost	1,110,301	
		1,120,056
Cash expenditures		$ 488,285

Of the cash expenditures totaling $488,285, $392,694 was for APCCH's operating expenses and for fixed assets and $95,591 was for various purposes authorized by five separate appropriations.

The nature and status of the APCCH appropriations, all of which, the APCCH Administrator stated, were in support of patient care and/or education in health services at the hospital and in the community, as of April 30, 1969, were as follows:

Net appropriations to	Total	Expended	Unexpended
Scholarship and education	$ 128,977	$30,416	$ 98,561
House staff development	200,878	22,944	177,934
Hospital director's emergency fund	203,952	18,958	184,994
Scientific research	200,000	-	200,000
Department development	300,000	23,273	276,727
Total	$1,033,807	$95,591	$938,216

In addition, APCCH has reserved $126,576 to a building fund for new physical plant facilities for the hospital, but no funds have yet been expended for this purpose. The reserve is controlled by the board of directors of the APCCH, and expenditures will require membership authorization on the basis of specific building plans which may be developed in the near future.

Operating expenses were incurred mainly for salaries, including those paid to medical and dental students who abstracted data from hospital patient medical records for the purpose of making Medicare billings. The APCCH controller told us that no payments had been made from its fund to member physicians, and our test review of payrolls did not disclose any such payments to member physicians. The APCCH financial data showed that a portion of the funds appropriated to the hospital director's emergency fund had been applied to salaries and salary supplements of hospital employees, excluding physicians.

NATURE OF SERVICES FURNISHED (Items 1 and 2)

Our review of individual medical records at Cook County Hospital indicated that the professional services for which billings had been made by APCCH in the names of attending physicians and for which payments had been made by Blue Shield generally had been furnished by residents and interns. The billings and payments reviewed had been made prior to SSA's issuance in April 1969, of clarifying guidelines and supplementary criteria. (See p. 9.)

Our findings with regard to the furnishing of services by residents and interns have been confirmed by statements obtained from hospital officials, by transcripts of recent Cook County hearings into the operations of APCCH, and by reports of others who had made reviews at the hospital. This information indicated that direct and identifiable patient care at the hospital had been provided primarily by residents and interns, whereas the role of an attending physician primarily had been to provide overall direction and supervision. We were informed by hospital officials that, under the foregoing circumstances, individual medical records would not fully reflect the actual involvement of the attending physicians in the care of individual patients.

Further, because the hospital did not maintain time records showing when the attending physicians were on duty at the hospital, it generally was not possible for us to determine whether the physicians in whose names the services had been billed had been physically present at the hospital at the time the specific services were furnished.

General policies governing patient care

According to the bylaws adopted by the medical staff of the hospital on May 29, 1964, all patients are to be attended by members of the attending staff and patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the medical staff. The attending medical staff consists of voluntary physicians and the permanent staff, all of whom have been appointed by the Cook County Board of Commissioners.

32-108 O - 68 - 21

Residents and interns are not members of the medical staff. As of May 1969, there were 612 physicians on the medical staff, of whom 87 were full-time permanent staff, 13 were part-time permanent staff, and 512 were voluntary physicians. At that time, there were 143 interns and 318 residents on the hospital house staff.

The hospital's patient-care program was described by the hospital director in a statement to us, as follows:

> "1. All patients are assigned an interne, [sic] one or more residents and one or more attending physicians on admission to the hospital.
>
> "2. The care of the patients is the ultimate responsibility of the attending physician(s) to whom they are assigned.
>
> "3. Where more than one attending physician is responsible for the patient, they will of necessity share with one another, both the supervision of the house staff [residents and interns] in patient care and their own personal involvement in the diagnosis and treatment of the patient."

The hospital director described the delivery of patient care by the attending staff, residents, and interns and the patient's identification of his doctor in testimony before the Cook County Board Ad Hoc Committee re: Associated Physicians, on May 15, 1969, as follows:

> "Now, I'd be the first to say that the vast majority of our voluntary staff members, those who come in voluntarily and contribute their time, that there would be difficulty in the patient identifying just exactly which of those men were their personal physician; it is unlikely that the

vast majority of our patients could do that. [Note 1.] Nevertheless by virtue of the organized programs which we have, it is possible for three or four of these voluntary staff physicians, backed up by full-time staff physicians, to come in and supervise the residents, one being present at the time to check the initial examination of the patient and the initial plan of treatment, and, perhaps, another one being present at the time that that patient undergoes a therapeutic procedure, such as an operation or the like, and I believe this is at the present time an acceptable physician-patient relationship in the teaching setting with interns and residents, but it is going to be increasingly under scrutiny and it may be more difficult to document to the satisfaction of all the parties concerned."

Other authorities, which had previously indicated that medical care depended largely upon the intern and resident staff and that ward supervision and medical care depended primarily upon a system of voluntary and/or permanent attending physicians, were the Task Force on Health and Hospital Services of the Citizens Committee on Cook County Government in December 1967 and Albert W. Snoke, M.D., consultant to the Cook County Board of Commissioners in September 1968. Also, the hospital's November 1968 brochure dealing with its intern and residency programs described the large measure of responsibility for patient care which had been given to the hospital's house staff.

The hospital director advised us that the adequacy of the supervision and direction provided by attending physicians to the house staff was evidenced by the full approval

---

[1]The Director indicated in a separate statement to us that, in the case of the permanent staff, more patients were aware of the role of an attending physician in their care, although they still identified the intern or resident as their doctor.

of the hospital internship and residency programs and by certain favorable comments regarding medical care that were included in the February 1968 report on the hospital, issued by the Joint Commission on Accreditation of Hospitals (JCAH).

Regarding comments by JCAH, the director noted that it had reported that the medical and surgical staffs were excellent and were doing their best to provide high-quality patient care. He noted also that JCAH had reported that the teaching of internal medicine to medical students, interns, and residents was well organized and supervised and that the division of surgery staff was doing its best to do excellent teaching and to carry on research. JCAH also noted that the hospital medical program had been hampered by poor physical facilities and an insufficient number of nurses.

A system of accounting for the time devoted by the attending staff to patient care was not maintained by the hospital, and the amount of time apparently differed for each physician. For the permanent staff, the director of the division of medicine estimated that most members of the division staff worked between 40 and 48 hours a week, of which up to 15 hours were devoted directly to patient care or direction of interns and residents and the remainder was devoted to administrative and teaching duties. The director of the division of surgery estimated that most physicians in his division maintained a 60-hour workweek, of which 20 hours were devoted to patient care and 40 hours to administrative and teaching duties.

The Cook County Civil Service Commission announcement stated that the voluntary staff would have to spend 20 hours a month at the hospital. Estimates of time donated by the voluntary staff made by various physicians working at the hospital or familiar with its operation were generally consistent with, or higher than, the Cook County Civil Service Commission requirement. The maximum estimate was about 60 hours a month.

Basis for APCCH charges

The financial statements of APCCH show that, as of April 15, 1969, when, at the direction of SSA, Blue Shield suspended the processing of the APCCH Medicare claims, APCCH had received about $1.6 million in payments under part B of the Medicare program. We made a detailed review of selected payments to APCCH for services which it claimed had been provided to 75 Medicare beneficiaries. Payments made in the cases selected totaled about $10,800, and such payments were made by Blue Shield during the period from April 1968 to January 1969. As discussed on page 69, our selection was made from a listing furnished by SSA, which it prepared from its 5-percent sample of bills paid by Blue Shield to APCCH.

The APCCH billings were made only for medical and surgical care provided to patients in the hospital. Billings were not authorized by Blue Shield for outpatient care or for various ancillary services, such as pathology and radiology.

The payments which we reviewed were for services furnished to the 75 Medicare beneficiaries from July 1966 through November 1968. The nature and number of services, as well as the amounts billed by APCCH and allowed by Blue Shield, are summarized in the following table.

Type of service	Occasions of service	Amount billed by APCCH	Amount allowed by Blue Shield
Medical services:			
Initial visits	72	$ 1,835	$ 1,793
Daily medical care	747	5,341	5,334
Consultations	38	1,008	938
Other	9	63	59
Total medical	866	8,247	8,124
Surgical services:			
Requiring use of operating room	18	6,149	5,544
Other	39	1,408	1,198
Total surgical	57	7,557	6,742
Total	923	$15,804	14,866
Less deductibles and coinsurance			4,058
Total payments reviewed			$10,808

According to the hospital's procedures, the attending physicians in whose names the billings were made should have been assigned to the patients at the time they were admitted to one of the hospital wards. When patients received additional specialized services, such as surgery, from other attending physicians, the billings were made in the names of the attending physicians responsible for those services.

The APCCH bases for billing for physicians' services provided to Medicare patients were the SSA regulations, cited on page 8 of this report, and agreements negotiated with the carrier, which, the APCCH administrator stated, included the APCCH principles and procedures for billing adopted in March 1968. The APCCH billings relate to services dating back to July 1966, when the Medicare program went into effect; and the data supporting the billings for periods prior to March 1968, when the APCCH began processing claims, was derived from patient-care data accumulated by the hospital and PSF. The APCCH administrator advised us that almost all the prior billings had been further verified by a review of the patients' medical records by the APCCH staff.

With respect to documentation procedures followed after March 1968 by APCCH in billing for the services of attending physicians, our review showed that, as a matter of practice, the staff of APCCH reviewed the hospital medical records and extracted from those records the evidence of the specific services provided to Medicare beneficiaries by interns, residents, or attending physicians. On the basis of that evidence, the APCCH staff prepared the Medicare billing forms (Form SSA-1490, Request for Medical Payments), in the name of the attending physicians and forwarded the bills to Blue Shield for payment. In other words, the individual attending physicians in whose names the services were billed did not, themselves, develop or submit the bills for their services.

The APCCH principles and procedures for billing the part B carriers, which are referred to above, were approved by the executive staff of the hospital on April 9, 1968. These principles and procedures, which are set

forth in appendix VI, were submitted to Blue Shield and to the SSA Regional Office in March 1968. The principles and procedures included the following guidelines as to how the hospital's medical records should be maintained to support the billings.

"1. As of the effective date of the approval of these Principles and Procedures by the Executive Staff of Cook County Hospital all patients' charts will include the following information essential for billing requests for reimbursement for services rendered to Medicare and Medicaid qualified patients:

a. A note signed by the attending physician or his designate within a reasonable period after admission indicating that the attending physician reviewed the patient's history and physical examination, his personal examination of the patient, confirmation or revision of the diagnosis, and determination of the course of treatment.

b. The operative note must include the name of the attending physician personally supervising in the case of a major procedure, or personally authorizing or directing other procedures.

c. In cases involving extended treatment in the Hospital, frequent progress notes, by the attending personally, or for him by interns and residents assisting in the care of his patient, should indicate when the patient's progress has been reviewed personally by the attending, and when he has given directions changing the course of treatment.

d. Requests for consultations should indicate that they are at the direction or

with the authorization of the attending physician responsible for the care of the patient.

e. Consultation notes should indicate the name of the attending physician responsible for the consultation.

f. Discharge note should be initialed by the attending physician.

"2. With respect to the back-log of Medicare cases which may lack written confirmation of the explicit participation of the attending physician in accordance with the above procedure, and, subject to the concurrence of the Director of the Division concerned, it will be assumed that the care of the patient has been under the personal direction of the attending physician (a) indicated in the patient's chart, or (b) the attending physician assigned responsibility for patient care in the area in which services were rendered. With respect to surgical procedures, it will be assumed, with the concurrence of the Director of the Division concerned, that the attending physician indicated on the Operating Room Log Book provided personal supervision in the case of major procedures, and gave his personal direction in other cases."

Of the total amount ($14,900) of allowed charges reviewed by us, about $4,600, or about 30 percent, was applicable to services rendered after the effective date of the APCCH principles and procedures.

Inasmuch as the basic source for the billings prepared by the staff of APCCH had been the hospital medical records, we reviewed the same source data applicable to the 75 Medicare beneficiaries included in our sample of cases selected for review. We attempted to ascertain (1) whether the services actually had been provided and (2) the extent to which the attending physicians had been involved in providing such services.

Further, because of the technical nature of the data being considered, we requested that SSA make Public Health Service (PHS) physicians available during our review, to provide us with professional assistance. These physicians examined the medical records pertaining to 47 of the 75 beneficiaries, to determine whether the services for which billings had been made were compatible with the services shown on the records.

Our findings with respect to each type of medical and surgical services included in our review are discussed in the following sections of this report and are summarized in appendix II.

Initial visits

When a Medicare beneficiary was admitted to the hospital and was assigned an attending physician, the Medicare program was generally billed by APCCH for an initial visit which consisted of the development of a patient history, a physical examination, and a diagnosis. For billing purposes, this service was usually classified "routine" and a charge of $21 was made; however, in 13 of 72 instances, the initial visits were classified "intensive" and charges of $42 each were made.

Although the APCCH principles and procedures contained some criteria for making these classifications, the difference between a routine initial visit and an intensive initial visit represented primarily a value judgment by the APCCH staff reviewing the hospital's medical records for the purpose of developing bills. The PHS physicians assigned to assist us in our review examined the medical records for seven of the 13 initial visits that were classified as intensive and took no exceptions to the classifications.

We found evidence in six of the 72 cases that, in addition to the services provided by residents and/or interns, the attending physicians in whose names the services had been billed had been personally involved. In six additional cases, attending physicians other than those identified on the bills had been specifically

identified as having been involved in the services provided. In the remaining 60 cases, the medical records supporting the specific services billed disclosed no personal involvement or identification of any attending physician. In these 60 cases, the medical records generally showed that the services had been provided by residents, interns, and/or medical students.

The number and type of medical personnel identified as being involved in providing the specific services relating to initial visits are summarized in the following table. In most cases, more than one individual was identified as being involved in providing the same service. Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

	Total	Medical records reviewed by PHS physicians and GAO	Medical records reviewed by GAO only
Occasions of service:			
Billed	72	46	26
Not furnished	1	1	-
Furnished	71	45	26
Medical personnel identified with record of service:			
Attending physicians:			
Same as identified on bill	6	5	1
Other	6	4	2
Residents	54	39	15
Interns	65	43	22
Medical students	10	4	6
Records not signed or signature not identifiable	4	3	1
Total	145	98	47

The medical records supporting 29 initial visits made after April 1, 1968, were reviewed by the PHS physicians. In only three of these cases was the attending physician

named on the billing specifically identified with the service, although the APCCH principles and procedures provided that, within a reasonable period after admission, the patient's charts should include a note to the effect that the attending physician had reviewed the patient's history and physical examination and had confirmed or reviewed the diagnosis. Further, in one of the 29 cases reviewed by the PHS physicians, the medical record showed that the services comprising an initial visit had not been provided. In this particular instance, the patient had been discharged from the hospital for transfer to an extended-care facility. The transfer was not accomplished, however, and the patient was readmitted to the hospital on the same day.

Daily medical care

After a Medicare beneficiary's first day in the hospital (which is covered by the initial visit), APCCH, in accordance with its principles and procedures for billing, generally billed for follow-up visits for each day of hospitalization, unless such services were covered under the fees billed for surgery. APCCH billed for daily follow-up visits for 65 of the 75 Medicare beneficiaries included in our review. Usually the follow-up visit was classified "routine" and the daily charge was $7; however, 12 of the 747 follow-up visits applicable to the 65 beneficiaries were classified "intensive" and the daily charge was $14.

Our review of hospital medical records prepared by physicians (attending physicians, residents, or interns) showed that, for 129 of the 747 daily follow-up visits billed, no notations had been made by any physicians, including residents or interns, to indicate that physicians had seen the patients. We found that, for the remaining 618 daily follow-up visits, which were supported by physicians' notations, the records for only eight visits showed notations that the attending physicians in whose name the bills had been rendered had been involved. There were 27 visits where other attending physicians had been involved in providing daily follow-up care. For the remaining 583 daily follow-up visits which were supported by physicians' notes, such notations generally identified residents and/or interns as having been involved in providing the care.

Our findings with respect to the review of medical records supporting charges for daily follow-up visits are summarized in the following table. For many daily follow-up visits, the records showed that more than one resident and/or intern had been involved. Therefore, the number of medical personnel identified with the services exceeds the total occasions of service billed.

	Total	Medical records reviewed by PHS physicians and GAO	Medical records reviewed by GAO only
Occasions of service:			
Billed	747	408	339
Not supported by physicians' notations	129	73	56
Supported by physicians' notations	618	335	283
Medical personnel identified with record of service:			
Attending physicians:			
Same as identified on bill	8	5	3
Other	27	15	12
Residents	329	196	133
Interns	313	113	200
Medical students	58	22	36
Records not signed or signature not identifiable	24	16	8
Total	759	367	392

As indicated by the foregoing table, for those medical records reviewed by the PHS physicians, there were 73 follow-up visits for which no physicians' notations were found; however, we were advised by the PHS physicians that

there had been only 12 daily visits billed in cases where all the patients' medical records, including those not customarily prepared by physicians--such as nurses' notes and laboratory reports--revealed no medical services at all. For four of these 12 visits, the patient was not even in the hospital. We were advised by the hospital director, however, that a physician's entry on a patient's chart was not required for each consecutive day of hospitalization and that therefore the absence of a physician's notation would not necessarily mean that the patient had not been seen by a physician.

Consultations

APCCH billed for consultations when the medical records indicated that one division (e.g., medicine) had received medical advice from another division (e.g., surgery) or from a subspecialty within the same division. Consultations were classified "limited," "complete," or "follow up." In the cases reviewed by us, APCCH had billed for 38 consultations, of which 17 had been classified as limited and billed at $21 each, 12 had been classified as complete and billed at $49 each; and nine had been classified as follow up and billed at $7 each.

Although the APCCH principles and procedures contained some criteria for making these classifications, the difference between a limited consultation and a complete consultation represented primarily a value judgment by the APCCH staff reviewing the hospital's medical records for the purpose of developing bills. The PHS physicians assigned to assist us in our review examined the medical records for nine of the 12 consultations that had been classified as complete and took exception to only one classification which they considered to be limited.

Our review of hospital regulations and of the APCCH principles and procedures provided some guidelines as to the involvement of attending physicians in consultations. For example, the bylaws and rules and regulations of the medical staff of Cook County Hospital, adopted in May 1964, provide, with respect to consultations, that:

"A satisfactory consultation includes examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record ***." (Underscoring supplied.)

As indicated on page 27, the APCCH principles and procedures provide that (1) requests for consultations should indicate that they are at the direction, or with the authorization, of the attending physician responsible for the care of the patient and (2) consultation notes should indicate the name of the attending physician responsible for the consultation.

Our review of the medical records applicable to the 38 consultations for which billings had been made did not disclose any instance in which the attending physician in whose name the service had been billed had been shown as having been involved in providing the service. In three cases, we found that four attending physicians, other than those identified on the bills, had been specifically identified as having been involved in the services provided. In the remaining 35 cases, the medical records indicated that the services generally had been provided by residents.

The number and type of medical personnel identified as having been involved in providing the specific services relating to consultations are summarized in the following table. In some cases, more than one individual was identified as having been involved with the services provided. Therefore the number of medical personnel identified with the services exceeded the total occasions of service billed.

	Total	Medical records reviewed by PHS physicians and GAO	Medical records reviewed by GAO only
Occasions of service billed and furnished	38	28	10
Medical personnel identified with record of service:			
Attending physicians:			
Same as identified on bill	-	-	-
Other	4	4	-
Residents	32	24	8
Interns	1	1	-
Medical students	1	1	-
Records not signed or signature not identifiable	5	3	2
Total	43	33	10

Because the medical records did not include the required written consultation opinions signed by the attending physicians, we asked the APCCH staff members how they had been able to identify an attending physician for billing purposes. We were advised that the identification had been based on the organizational unit involved in the consultation and that, on such basis, the name of an attending physician assigned to the specific unit had been selected at random.

Other medical services

In nine instances, APCCH billed Medicare for minor medical procedures, such as measuring the patients' blood circulation times. Our review of the medical records disclosed no record of involvement of attending physicians in any of these instances.

The number and type of medical personnel identified as having been involved in providing these miscellaneous services are summarized as follows:

	Total	Medical records reviewed by PHS physicians and GAO	Medical records reviewed by GAO only
Occasions of service billed and furnished	9	4	5
Medical personnel identified with record of service:			
Attending physicians:			
Same as identified on bill	-	-	-
Other	-	-	-
Residents	4	2	2
Interns	3	2	1
Medical students	2	-	2
Total	9	4	5

Operating room surgery

For 14 of the 75 Medicare beneficiaries included in our review, APCCH had billed for 18 surgical procedures which had required the use of the hospital's operating rooms. Of these 18 operations, six were transurethral resections of the prostate, four were amputations, two were cystotomies, and the remainder were various other procedures, including two which the hospital director considered major operations. The charges allowed by Blue Shield for these 18 surgical procedures ranged from $44 to $660.

Our review of the hospital's operating room records showed that, for 16 procedures, the surgery actually had been performed by residents who, in some cases, had been assisted by interns and that, for two procedures, the

medical personnel performing the surgery could not be identified from the available records.

The SSA regulations dealing with reimbursement for services of attending physicians who supervise interns and residents provide, in part, that:

> "In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician ***."

The hospital records which would normally indicate the presence of the attending physicians could not be located for three of the 18 procedures. We found that, in the 15 instances where the pertinent hospital records were available, the attending physicians in whose behalf the service had been billed were shown as having been present in the operating room during the surgery in two instances. In four additional instances, attending physicians, other than those identified on the bills, were shown as having been present in the operating room. In the remaining nine instances, the records did not indicate that attending physicians had been present.

Our findings relating to the services involving operating room surgery are summarized in the following table. In some instances, more than one individual was identified with the surgery performed. Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

32-108 O - 69 - 22

	Total	Operating records reviewed by PHS physicians and GAO	Operating records reviewed by GAO only
Occasions of service billed and furnished	18	11	7
Surgery performed or assisted in by:			
Attending physicians	-	-	-
Residents	18	11	7
Interns	2	-	2
Not known	2	1	1
Total	22	12	10
Attending physicians present at surgery:			
Same as identified on bill	2	1	1
Other	4	4	-
None present	9	4	5
Not known	3	2	1
Total	18	11	7

Because the SSA regulations appeared to stress the personal supervision of attending physicians in cases involving major surgical procedures, we requested the views of the hospital director and of the director of surgery regarding the need for the attending physicians to be present during surgery.

With respect to the specific procedures included in our review, the hospital director advised us that (1) where the hospital records did not show the presence of an attending physician during a prostate operation, the records were incomplete because, under the hospital's procedures, an attending physician must be present on such occasions, (2) the presence of an attending physician

during an amputation was not necessary, because experience had shown that the resident staff could perform the procedure properly, and (3) for the two procedures which, in his judgment involved major surgery, the attending physicians named on the billings had been present.

By letter, dated June 6, 1969, to the hospital director, the director of surgery stated that:

> "*** Whether the attending physician responsible for the care of the patient is present in the operating room and actually assists in the performance of surgery, or is 'scrubbed' and present in the operating room in order to provide active assistance if required, or if he is in the operating room but not 'scrubbed' in order to be immediately available for consultation and guidance, or whether, after having given his direction to the resident surgeon with respect to the surgical procedure, he is available within the hospital for consultation or assistance in the case of development of an emergency . . . in each of these varying situations the attending physician responsible for the care of the patient, who has given his direction to the resident surgeon assisting the care of his patient, is the individual who is both ethically and legally responsible for the patient care being rendered."

As indicated on page 21, because the hospital did not maintain records showing when the attending physicians were on duty at the hospital, it generally was not possible for us to determine whether the physicians in whose names the services had been billed had been physically present at the hospital at the time the surgery was performed.

Other surgical services

In addition to billing for the surgical procedures which required the use of the hospital's operating rooms, APCCH billed for 39 other surgical services furnished to

beneficiaries included in our review. These services generally involved spinal taps and two types of cystoscopies which were usually billed at rates of $22 and of $44 or $82.50, respectively. The PHS physicians assigned to assist us in our review examined the hospital's medical records applicable to 31 of these surgical procedures and found that, in two instances, these records supported a lower valued cystoscopy than that which had been billed by APCCH.

Our review of the hospital's medical records applicable to the 39 procedures showed one instance where the attending physician in whose name the service had been billed had been personally involved. In seven additional cases, attending physicians other than those identified on the bills had been specifically identified as having been involved in the services provided. In the remaining 31 cases, the hospital records did not indicate that attending physicians had been specifically involved.

The number and type of medical personnel identified as having been involved in providing the specific services relating to these surgical procedures are summarized in the following table. In some cases, more than one individual was identified as having been involved in providing the same service. Therefore the number of medical personnel identified with the services exceeds the total occasions of service billed.

	Total	Medical records reviewed by PHS physicians and GAO	Medical records reviewed by GAO only
Occasions of service billed and furnished	39	31	8
Medical personnel identified with record of service:			
Attending physicians:			
Same as identified on bill	1	-	1
Other	7	5	2
Residents	18	13	5
Interns	13	11	2
Medical students	3	3	-
Records not signed or signature not identifiable	3	1	2
Total	45	33	12

We were advised by the hospital director that a cystoscopic examination was a minor diagnostic procedure performed routinely by residents and that attending physicians were called upon for advice and assistance only when necessary.

Hospital, APCCH, and
Blue Shield comments

The hospital director acknowledged that, in many instances, the supervision and direction to interns and residents by attending physicians were poorly documented in the medical records but stated that this did not mean that the supervision and direction had not been provided. He stated further that, in many private hospitals, the only notation in a hospital chart to indicate that a physician had visited a patient or had performed a procedure was that which appeared in the nurses' notes. According to the director, Cook County Hospital does not have enough nurses to provide this documentation and it is not realistic to expect that this be done by the physicians.

The APCCH administrator stated that 11,966 beneficiary claims had been submitted to Blue Shield during the 8-month period from which we selected 75 beneficiary claims for review. He questioned, therefore, whether such a small sampling of claims processed could produce statistics upon which to base a valid judgment of the billing procedures of APCCH.

The APCCH administrator stated also that, prior to April 1969 when SSA issued new guidelines, there were no SSA or Blue Shield requirements that billed services provided to beneficiaries be documented, in part, by notes and orders in the patients' records that were either written by or countersigned by the supervising physicians.

Regarding the standards for documenting patients' records included in the APCCH principles and procedures for billing, the APCCH administrator stated that, although the implementation of those provisions was considered to be a highly desirable goal, it was not considered by him to be a precondition for requesting reimbursement under the Medicare program.

He stated further that, due to circumstances which could not rapidly be remedied, there was a serious lack of recording in the patients' medical records of the actual participation by attending physicians in their direction

and supervision, and even in their personal rendering, of patient care. He added, however, that he did not consider the absence in the patients' records of notes and orders written or countersigned by the attending physicians to detract from the validity of the right of APCCH to receive reimbursement for the services of the attending physicians responsible for the care of the patients.

Regarding the absence of notations by physicians, including residents and interns, for each day of medical care billed, the APCCH administrator stated that there was no requirement in the Federal regulations, SSA guidelines, or APCCH agreements with Blue Shield for a written record in the patient's chart to substantiate daily follow-up visits. He added that it was an established routine at the hospital that every patient was seen daily by an attending physician or by a resident or intern assisting in the care of the patient under the physician's direction. The failure to record the visit, he stated, was not indicative that the service had not been performed.

Regarding billings for surgery performed in operating rooms, the APCCH administrator stated that the billings had been in accordance with the APCCH principles and procedures and with agreements with Blue Shield. That is, a surgical procedure was billed in the name of the attending physician who personally supervised the procedure in the operating room or who gave his personal direction to the resident performing the procedure; this would be the attending physician named in the operating note on the hospital chart, or, in the absence of an indication on the chart, the attending physician named in the operating room record of the hospital. The latter record, he stated, showed the name of the attending physician responsible for the supervision of each surgical procedure, and this information was usually

also contained in related records of the anesthesiology department.[1]

Blue Shield did not comment directly on this section of the draft report because, the vice president of the Government Contracts Division stated, the time allowed for comment did not permit a detailed examination of the specific Medicare claims included in our review. He noted, however, that in January 1969 all APCCH claims had been assigned to one claims examiner, a registered nurse with special qualifications, for screening and evaluating the claims.

He stated also that, in a further effort to ensure proper adjudication, APCCH subsequently had been required to submit additional supporting data from the medical records, to assist the claims examiner in evaluating the representations made in the claims filed by APCCH. He also noted that Blue Shield had refused to make payment for the professional services of the so-called hospital-based physicians, e.g., the pathologist, radiologist, anesthesiologist, and physiatrist.

---

[1]The objective of our review of medical records documenting surgical procedures was twofold: (1) to identify the physician(s) who had actually performed the operations and (2) to identify any other attending physicians who actually had been present in the operating rooms at the time of the operations. We reviewed the medical records cited by the APCCH administrator; however, we were informed by responsible hospital officials that the operating room records would not provide the information cited in (2) above. For this information, they referred us to records of the anesthetists, which we reviewed, and the data extracted therefrom was used in compiling the statistics shown on page 38 of this report.

CHARGES BY ATTENDING PHYSICIANS EMPLOYED BY COOK COUNTY HOSPITAL AND BY VOLUNTEERS (Item 3)

The salaries of physicians on the hospital's permanent staff have been claimed by the hospital for reimbursement by the intermediary, the Blue Cross Association (Blue Cross), under part A of the Medicare program, and some of the same physicians have authorized APCCH to bill Blue Shield for their professional services under part B of the program. Subject to audit, Blue Cross has agreed to reimburse the hospital for the Medicare share of the physicians' salaries under part A and has made interim payments to the hospital on the basis of a provisional per diem rate applicable to Medicare patients. Blue Shield has accepted the part B claims and has made payment to APCCH on the basis of a negotiated schedule of fees for specific services.

The hospital has claimed reimbursement for the salaries of these physicians on the basis that they were paid salaries for administrative and supervision duties and not for patient care. APCCH has charged for the services of these physicians on the basis that they also provided direct patient care or provided personal and identifiable direction to residents and interns involved in the care of their patients.

In addition to the physicians on the hospital permanent staff, there were about 512 voluntary physicians on the medical staff in May 1969. These volunteers were not salaried, and therefore no costs applicable to their services were chargeable under part A. About 389 of the volunteers were involved in practicing medical specialties applicable to the aged and also were members of APCCH. Accordingly, their services were potentially billable under part B. Our sample inquiries with respect to these volunteers showed that they had not been otherwise compensated for their services at the hospital.

Salaried physicians

The services of 49 of the 100 physicians on the salaried, permanent staff in May 1969 were potentially

billable by APCCH under part B. From SSA's viewpoint, a basic question regarding these physicians is whether Medicare funds may be used to pay for their services under the methods of payment agreed upon by Blue Cross for part A costs and by Blue Shield for part B charges.

The question arises because there is some conflicting evidence as to whether these physicians' salaries are paid for only administrative and supervisory duties or for patient care. If the intermediary had held that the salaries were paid to physicians for their patient care, as well as for their other duties, their compensation would have been apportioned between parts A and B of the program. Consequently, the basis for charges under part B would have been different; the basis would have been that portion of their salaries attributable to patient care rather than the schedule of fees which had been used. We believe that charges based on salaries would have been significantly less than those based on the fee schedule.

In May 1969 there were 100 full- and part-time physicians on the permanent staff. The annual salaries paid to these physicians ranged from $6,000 for a part-time physician to $40,000 for the full-time hospital director; most full-time physicians' salaries ranged from $20,000 to $25,000 annually. Medicare billings could not be made in the names of 51 of these physicians because (1) they, e.g., pediatricians, did not care for the aged, (2) they were not members of APCCH and, under the rules of the hospital, were not permitted to bill individually, or (3) if they were members, they practiced ancillary medical specialties, e.g., radiology or pathology, for which they had not been reimbursed under part B because Blue Shield and APCCH had not reached an agreement under which charges for these services were allowable.

The remaining 49 physicians were members of the attending medical staff and were engaged in practicing medical or surgical specialties applicable to the aged. They were also members of APCCH and, as a result, billings could be made in their names under part B. The APCCH administrator, in June 1969, estimated that about 28 percent of the APCCH

billings was attributable to members assigned to the permanent staff. The estimate was based on a survey of 3,500 cases, or between 20 and 25 percent of the total cases then billed.

Our review of 75 Medicare patient cases showed that billings had been made in the names of 57 different physicians and that 14 of these 57 physicians, or about 25 percent, were assigned to the permanent staff. Further, $5,127, or about 34 percent of the total of $14,866 in charges allowed by Blue Shield on those claims, was for the services of the permanent staff.

Our analysis of data obtained in reviewing the 75 Medicare patient cases, covering the period from July 1966 through November 1968, showed that Blue Shield had allowed an average $13.37 under part B for physicians' services for each patient-day of hospitalization. At the time of our field review, the reasonable costs for Cook County Hospital under part A of the Medicare program had not been finally determined by the fiscal intermediary for the fiscal years ended on November 30, 1966, 1967, and 1968. We estimate that, for these years, an average $1.40 a patient-day was claimed by the hospital under part A for salaries paid to all physicians on the permanent staff.

In addition, an average $2.11 a patient-day was claimed by the hospital under part A for salaries paid to interns and residents. In other words, the "reasonable cost" under part A applicable to the hospital's medical personnel usually providing patient care, as previously described on page 21, was $2.11 a patient-day, whereas the "reasonable charge" made under part B, primarily for supervising those persons, was $13.37 a patient-day.

In October 1968, the intermediary for part A, Blue Cross, and its subcontractor, Hospital Service Corporation, accepted, subject to audit, the hospital's claim for reimbursement under part A for salaries paid to physicians assigned to the permanent staff.

In making its acceptance, Blue Cross agreed with the hospital that, technically, the salaries paid to these

physicians were for administrative and supervision of personnel duties and therefore were allowable under part A. This agreement was reached after rather extensive inquiries had been made by Blue Cross, which included obtaining a statement from the hospital administrator and certifications from the directors of all but one of the hospital divisions that the salaried staff in their divisions were paid for such administrative and supervisory duties and not for patient care. The certification read as follows:

> "This is to certify that each individual understands that his Civil Service status and requirements of the statutes of the State of Illinois preclude his receiving any salary from the County for the care of patients, and that such salary as he does receive is exclusively for the above enumerated administrative services. This is true in all cases without exception."

This certification was apparently requested by Blue Cross to assure itself, in view of other somewhat conflicting evidence, that members of the permanent staff were not paid for attending patients in the hospital. In particular, the bylaws of the medical staff of the hospital, adopted in May 1964, provided as follows:

> "*** The Attending Medical Staff will consist of voluntary physicians *** and the permanent staff who have been appointed by the governing body to attend patients in the hospital."

One division director would not sign the certification. The director of the division of laboratory sciences told us that he would not do so because of the provision in the bylaws cited above. The head of the hospital's governing body, the president of the Cook County Board of Commissioners, told us that, in his opinion, the physicians who were salaried by the hospital were compensated to attend patients and to perform administrative and supervisory duties.

The apparent bases underlying the certification were that (1) members of the permanent staff in whose names billings were to be made had been appointed to the medical staff as attending or associate attending physicians, (2) the latest civil service announcements calling for hospital attending physicians, issued in April and May 1966, had specifically provided that the positions offered no compensation, and (3) hospital attending physicians either had been appointed as a result of those or prior announcements or had been temporarily appointed consistent with announcements issued by the president of the Cook County Board of Commissioners.

The Illinois statute referred to in the above certification was "An Act Concerning the Classified Service of the County of Cook," approved in 1905 and last amended in 1951 (section 1144 of chapter 34 Illinois revised statutes). The act provided for the appointment, employment, and removal by the Board of Commissioners of Cook County of all physicians and surgeons in conformity with rules prescribed by the Cook County Civil Service Commission. The act further specified that the board "may provide that all such physicians and surgeons who serve without compensation" be appointed for a term to be fixed by the board.

In replying to our inquiry on June 9, 1969, the chairman of the Cook County Civil Service Commission stated that the term "attending physicians" used in the 1966 announcements should be considered to be the same as the term "voluntary attending staff," as defined in the commission's laws and rules of 1969. The rules provide that such physicians or surgeons serve without compensation. The chairman stated also that:

> "*** the hospital staff is divided into different categories among which is the Voluntary Physician who is also referred to as an Attending Physician. The Attending Staff also includes the full-time paid physicians. In some instances, I believe, an individual may hold status in both categories."

In an attempt to further clarify whether members of the permanent staff were paid to care for hospital patients, we asked the Cook County Civil Service Commission and the Cook County Position Classification Agency to provide us with position announcements and job descriptions for the salaried physicians' positions included in the annual appropriation bill of Cook County for fiscal year 1969.

These efforts did not produce conclusive results, because both agencies had relatively little data applicable to the physicians in the divisions of medicine and surgery and nearly all the APCCH bills were applicable to positions assigned to these divisions. Available job descriptions, some published in 1966 and others not dated, covering eight of the 49 types of salaried positions included in the appropriation bill, tended to support the view that these physicians were paid to care for patients and to perform certain departmental administrative duties and/or to teach residents and interns and supervise their care of patients.

For example, of eight job descriptions we reviewed, four stated that the physicians would assist the division director in administration and teaching and in the supervision of inpatient and outpatient care. One job description stated that the incumbent was to administer the department, supervise the care of patients, and direct and conduct teaching of residents and interns and supervise their care of patients. One job description stated that the physician was to supervise the diagnosis and treatment of certain illnesses. The remaining two job descriptions stated that the physicians holding these positions would assist the department chairman in patient care, education, and research.

Voluntary physicians

We were told by the hospital director that four medical schools in the Chicago area assigned physicians to the hospital for teaching purposes. These physicians, he said, cared for patients in the course of their teaching duties and, accordingly, were also members of the medical staff. The hospital director said, however, that these physicians were compensated by the medical schools only for teaching and that, with respect to their duties as members of the medical staff, they served without compensation.

In reviewing the 75 Medicare patient cases, we identified 43 voluntary attending physicians in whose names billings had been made by APCCH. We mailed questionnaires to 42 of the 43 physicians, to ascertain whether they were affiliated with medical schools and whether the schools, private practice, or any other source was compensating them for services at the hospital. We also asked them to state how long they had been volunteering their services to the hospital.

We received replies from 36 of the 42 physicians; 6 did not reply. Answers to our questions by the 36 physicians were as follows:

Medical school affiliation	35
No affiliation	1
Compensated for hospital services	3
Not compensated	33
Years of service volunteered to hospital:	
Under 5	7
5 to 10	3
10 to 15	9
15 and over	16
Not reported	1

One of the three physicians who reported that he was being compensated for his services had received his compensation between January 1967 and January 1969 from a medical school. The dean of faculty at that school told us that the physician had been paid for teaching and not for patient care. Another physician reported receiving compensation from a medical research unit that worked closely with the hospital. According to an official of that unit, the physician had been paid for his duties as director of surgical research, which did not directly involve patient care at the hospital. The third physician said he had not been compensated after 1964. Since his compensation predated Medicare, we did not follow through on his statement.

Hospital and Blue Shield comments

The hospital director stated that members of the permanent staff had been hired for administrative and supervisory

duties. This concept, he said, was predicated on the fact that over 50 percent of the salaried staff carried an extraordinary administrative and educational work load. He stated further that an estimated 50 to 70 percent of those salaried physicians were expected to supervise a large number of medical and nonmedical personnel in activities not directly related to the care of the individual patient.

The director advised us that the current salary paid to over 60 percent of the full-time salaried staff represented only 60 to 70 percent of their total professional income and that their hospital salaries were about two thirds of the amounts usually paid to physicians in comparable positions in the Chicago area.

The Director stated that, in his opinion, when the majority of the salaried physicians go to the individual patients' bedsides or to the operating rooms, they are providing professional services for which they are not compensated by their hospital salary. This was, he said, consistent with the civil service rating which they hold as attending physicians--caring for patients without compensation.

The director of laboratory sciences, on the other hand, reemphasized that the permanent staff had not been hired solely for administration. He said that this matter was only thought of when Medicare came into effect and that the permanent staff knew that, to qualify for Medicare payments, it would have to make such a claim.

The vice president of the Blue Shield Government Contracts Division pointed out that considerable time and effort had been exerted by Blue Cross and its subcontractor to investigate and verify the representations made by the administration of the hospital concerning the purpose for which salaries were paid to attending physicians. He said the administration of the hospital had insisted, in correspondence and in discussions with Blue Cross and with Blue Shield representatives, that salaries were paid exclusively for administrative duties.

The vice president said that these representations could not be brushed aside, in the absence of data which would clearly refute the contentions of the hospital administration. He also noted that Blue Shield had refused to make payments for the services of hospital-based specialists, such as radiologists and pathologists, including those in the division of laboratory sciences.

32-106 O - 69 - 23

BENEFICIARY INVOLVEMENT (Item 5)

Our review showed that Medicare beneficiaries had not been billed for deductible and coinsurance amounts by APCCH and had not signed the appropriate claim forms but had been sent appropriate notification of the payments made on their behalf.

Beneficiaries not billed for deductibles and coinsurance

As pointed out on page 6, the beneficiary, under part B of the Medicare program, is responsible for the first $50 for covered medical services in each year and also for 20 percent of the reasonable charges for covered services in excess of $50 in each year. These amounts, which are payable by the beneficiary, are generally referred to as the deductible and coinsurance amounts.

At the time of our field review, APCCH had not billed the Medicare beneficiaries for the deductible and coinsurance amounts. For the payments we reviewed, about $4,100, or about 28 percent, of the $14,900 in charges allowed by Blue Shield represented deductible and coinsurance amounts which had not been paid by Blue Shield and which would usually be the responsibility of the beneficiaries; however, none of the 75 beneficiaries included in our review had been billed by APCCH.

Because of the absence of billings for the deductible and coinsurance amounts, we raised the question as to whether the patients actually owed anything to APCCH and we requested the views of the APCCH administrator. We were advised, in June 1969, that it was the contention of APCCH that its member physicians were entitled to reimbursement for the uninsured portion of the Medicare claims from patients who were financially able to pay and that it was the intention of APCCH to proceed with billing for such amounts in the near future.

Our review of the APCCH financial statements indicated that the deductible and coinsurance amounts applicable to the $1.6 million in Medicare payments received from the carriers totaled more than $600,000 and that, as of

April 30, 1969, the beneficiaries had made unsolicited payments of about $850, apparently on the basis of the information shown on the Explanation of Benefits form which the carriers had provided to the beneficiaries.

Beneficiaries did not sign claims

With respect to the procedures to be followed for making payments under part B of the Medicare program, the SSA regulations dealing with Form SSA-1490, which is customarily used to bill for physicians' services, generally require that the patient sign the form requesting the payment of benefits to him or to others on his behalf. When a physician accepts an assignment from the beneficiary (i.e., for payment to be made directly to the physician), the patient's signature provides evidence that the patient has made the assignment and that he recognizes the right of the physician or organization to request payment. Although SSA relaxed its requirements in this regard early in 1967, to expedite claims processing, we noted that, in October 1967, SSA advised Blue Shield that, effective January 1, 1968:

"*** Patient's Signature (Assigned Claim)

> As a general rule the patient's (or his representative's) signature is needed on all assigned claims. The carrier may, however, continue to process assigned claims where a blanket SSA-1490 has been submitted for the same illness. We have found that patients have challenged assignment payments to physicians, especially hospital-based physicians, stating that they did not make any assignment. Since the patient must make the assignment to the physician, it is questionable whether the validity of such payments can be maintained when challenged."

In addition to requiring beneficiaries' signatures on assigned claims, SSA regulations require the carriers to furnish beneficiaries with an Explanation of Benefits form which identifies the individuals or organizations to which the payments were made, the place and date of the services

provided, and the charges that were allowed by the carrier. The Explanation of Benefits form not only advises the beneficiary of the amount of the $50 deductible that has been applied and the amount of coinsurance payable but also provides the beneficiary with an opportunity to question any payments made on his behalf for services that may not have been provided.

The payments made to APCCH by Blue Shield were handled as assignments. Our review showed that Blue Shield, although it had been furnishing the beneficiaries with the Explanation of Benefits form in connection with its payments to APCCH, had made payments on the basis of claims forms that had not been signed by the beneficiaries. None of the 75 beneficiaries included in our review had signed Form SSA-1490. In lieu of the patient's signature, the form usually was stamped with the notation "signature of patient on file."

Our inquiry into this matter revealed that, prior to March 1968, the beneficiaries' signatures had been recorded on Form SSA-1554. This billing form was to be used only where a hospital or extended-care facility had a billing arrangement to collect physicians' charges for individual patient care. These signed forms, which included information concerning medical services rendered to Medicare beneficiaries, were accumulated by officials of PSF under the assumption that PSF would be the organization which would administer the part B program at the hospital.

In February 1968, the signed Form SSA-1554's were turned over to APCCH for the purpose of transferring the information to Form SSA-1490's and of initiating the retroactive billings for medical services furnished to Medicare patients subsequent to July 1966. The APCCH administrator advised us that the foregoing procedure had been proposed by APCCH and agreed to by Blue Shield.

For services provided after March 1968, we noted that the patient's signature had been recorded on a Cook County Hospital admitting form which included a request that payments of authorized benefits under title XVIII of the Social Security Act be made on his behalf.

In other words, in none of the cases we reviewed did we find that a beneficiary had specifically signed a document making an assignment to APCCH or to the specific physician in whose name APCCH was billing.

Blue Shield and APCCH comments

Regarding the absence of beneficiaries' signatures on Form SSA-1490's, the vice president of the Government Contracts Division, Blue Shield, told us that there had been a temporary period when SSA had not required the signatures and that Blue Shield had simply overlooked this matter when SSA, in January 1968, again required the signatures. He noted that SSA had not questioned this practice even though it had had an opportunity to do so when it received the 5-percent sample of claim forms which Blue Shield submitted to SSA and during SSA's onsite inspection of Blue Shield's claim-processing procedures.

The APCCH administrator advised us that Blue Shield had not brought the above SSA requirement to the attention of APCCH and that it had no reason, therefore, to believe that the procedures it followed were not correct and acceptable in every respect. He advised us also that Blue Shield had never questioned the procedure of stamping claim forms to show that the beneficiaries' signatures were on file or that the beneficiaries were unable to sign.

DETERMINATION OF REASONABLE CHARGES AND AMOUNTS ALLOWED (Item 6)

As discussed on page 7, payments for physicians' services under part B of the Medicare program are to be made on the basis of reasonable charges and, in determining the reasonable charges, the carriers making such payments should take into consideration the customary charges made by the physicians for their services, as well as the prevailing charges in the locality for similar services. With respect to payments for the services of attending physicians who provide personal and identifiable direction to interns and residents who are participating in the care of their patients, the SSA regulations state that:

> "*** the amount payable under the program for such service may be determined in accordance with the same criteria for the determination of reasonable charges as are applicable to the services which the physician renders to his other patients ***."

As pointed out previously in this report, there are over 500 physicians at Cook County Hospital who are members of APCCH and who have authorized APCCH to bill on their behalf. For the 75 Medicare cases reviewed by us, billings had been rendered in the names of 57 different attending physicians, of whom 14 also had been salaried employees of the hospital at the time the services had been provided.

Negotiation of reasonable charges

Although there are a large number of individual physicians who have authorized APCCH to bill on their behalf, APCCH has billed, and Blue Shield has made payment, on the basis of a uniform schedule of fees. Our review indicated that this fee schedule had resulted from extensive negotiations in March, April, and May 1968 involving officials of APCCH; Blue Shield; and SSA Bureau of Health Insurance, Chicago Regional Office. In general, this schedule of charges was based on the 1964 Relative Value Studies (CRVS) adopted by the California Medical Association.

CRVS consists of five separate sections or studies (medicine, anesthesia, surgery, radiology, and laboratory), of which only two (medicine and surgery) have been used by APCCH for billing purposes. These studies have assigned unit values to the various procedures within each section. According to the CRVS, the relative values in one section must not be related to or compared with those in any other section. For example, under the section for medicine, the CRVS assigns a unit value of three for a routine initial hospital visit and a unit value of one to a routine follow-up hospital visit. In other words, the value of the initial hospital visit--which includes a patient history, a physical examination, the initiation of diagnostic and treatment programs, and the preparation of hospital records--is three times the value of a routine follow-up visit.

In the surgery section, the CRVS assigns a unit value of 40 to an appendectomy and a unit value of 80 to a transurethral resection of the prostate. This is another way of saying that the prostate procedure is worth twice as much as an appendectomy. Usually, the listed values for surgical procedures that include both the surgery and a maximum number of days for follow-up care that may be required. For example, there is a 45-day follow-up period included in the assigned unit value for an appendectomy and a 90-day period included in the assigned unit value for the prostate procedure.

For the purpose of developing charges, a fixed dollar conversion factor or rate is applied to the unit values in each section. The rates negotiated by APCCH and Blue Shield for the purposes of billing Medicare were $7 for medicine and $5.50 for surgery.

Our review of the record of the negotiation showed that APCCH had asked for a $7 rate for medical procedures and a $6 rate for surgical procedures. We were advised by Blue Shield officials that, when they found that the application of the $6 conversion factor resulted in charges for some surgical procedures that were higher than the upper limits of the prevailing charges in the Chicago area, the conversion factor was reduced by Blue Shield to $5.50. Blue Shield stated that the resulting charges were no

higher than the prevailing charges. Also, there is some evidence that Blue Shield considered the surgical fees to include, in addition to the days of follow-up care listed in the CRVS, routine preoperative care when a patient was admitted to the hospital for major surgery.

With respect to meeting the customary-charge criteria, we noted that Blue Shield had made a comparison of the proposed uniform schedule of fees (based on $7 for medicine and $6 for surgery) with the charges to Blue Shield subscribers (non-Medicare) by 95 member physicians (surgeons) of APCCH. Blue Shield found that (1) for 38 APCCH physicians, their usual or customary charges to Blue Shield subscribers were less than the fees in the proposed schedule and (2) for 57 APCCH physicians, their usual charges to Blue Shield subscribers were equal to or greater than the fees in the proposed schedule.

We noted also that the customary and prevailing charge data considered by Blue Shield was applicable to physician services performed by the physician in person. As discussed on pages 21 through 44 of this report, the services for which Medicare was billed at Cook County Hospital generally had been performed by residents and interns at the hospital with evidence of only limited personal involvement of the attending physicians. Further, there may be other differences between a physician's charges in a teaching setting and his charges in private practice.

For example, at Cook County Hospital, we found that an attending physician's involvement with a Medicare patient usually ended when the patient was discharged from the hospital. Therefore, in the case of charges for surgical procedures, the attending physician in whose name the service was billed would not be likely to have provided all the days of follow-up care included in the charge and, unless the patient was in a position to use the hospital's outpatient facilities, it would be possible that another physician would have provided such care and also would have charged the Medicare program.

To illustrate this point, we noted that a Medicare beneficiary had been admitted to the hospital on May 2,

1968, with a diagnosis of a malignant prostate gland. A charge of $21 was made for a routine initial visit, which was allowed by Blue Shield. For the period May 3 through May 9, 1968, APCCH charged for 7 days of routine medical care at $7 a day, which was also allowed by Blue Shield.

On May 13, 1968, this patient received an operation; the procedure was a partial transurethral resection of the prostate, and the related charge was $440 (a unit value of 80 x $5.50), which was allowed by Blue Shield. According to the CRVS, this charge included 90 days of follow-up care and, accordingly, no further daily charges for routine medical care were billed by APCCH. On May 23, 1968, a second transurethral resection of the prostate was performed; however, the second $440 charge was not allowed by Blue Shield.

On June 3, 1968, this beneficiary was discharged from the hospital and transferred to a nursing home. On that date, another physician, not connected with APCCH or the hospital, began providing and charging for professional services in connection with the beneficiary's prostate condition. In other words, although the May 13, 1968, surgical charge of $440 included a 90-day follow-up period, the Medicare program did not realize the full benefit of this payment because, within this period, the patient left the hospital and received care for his prostate condition from another physician who also was entitled to charge for this service.

Amounts allowed

As shown on the table on page 25, for the claims reviewed by us, Blue Shield allowed about $14,900, or about 94 percent, of the $15,800 billed by APCCH. About $600 of the $938 in disallowances related to surgical procedures performed in the hospital operating rooms. Blue Shield disallowed a claim for one prostate procedure, which had been billed at $440, because it represented the second such operation performed on the patient within a short time. Also, Blue Shield reduced the billed fee for a major vascular operation from $825 to $660. The APCCH billings for other surgical procedures were reduced

by Blue Shield by about $210. Those Blue Shield disallowances generally related to reductions of the charges for spinal taps from $22 to $16.50 and for cystoscopies from $82.50 to $44 when the description of the services on the bills indicated that the lower-valued procedures had been performed.

The balance of the Blue Shield disallowances covered various medical services and included a reduction in the classification of medical care from intensive to routine and the elimination of a charge for an initial visit because the diagnosis on the bill indicated that the patient had entered the hospital for an operation and because Blue Shield considered that preoperative services should have been included in the allowable surgical fee.

We reviewed the claims applicable to the 75 Medicare beneficiaries with Blue Shield's senior claims examiners and found that, in addition to $938 actually disallowed, about $410 should also have been disallowed. About $200 of the $410 represented charges for 23 occasions of service (initial visits and daily follow-up visits) which Blue Shield personnel stated should have been considered as preoperative care and included in the allowable surgical fees.

The balance of the unallowable charges represented (1) $28 in charges for four daily follow-up visits which, we concluded, could not have been provided because the patient was not in the hospital, (2) a $21 charge for an initial visit where, the PHS physicians concluded, the services had not been provided, (3) about $105 in charges applicable to consultation and minor surgical procedures where, the PHS physicians concluded, the hospital's medical records did not support the classification of services billed, and (4) $55 where the wrong CRVS unit value had been assigned to the service described on the bill. In general, Blue Shield claims examiners agreed with our findings in the above instances.

OTHER MEDICAL INSURANCE PROGRAMS AND INDIVIDUALS PAYING FOR PHYSICIANS' SERVICES (Item 7)

The hospital executive staff, since May 1959, has authorized, in addition to APCCH, only PSF, administered by the Hektoen Institute for Medical Research of the Cook County Hospital, to request and receive reimbursement for physicians' services furnished to patients at the hospital. For the fiscal year ended August 31, 1968, PSF reported having received payments totaling $353,976 from insurance companies and other sources.

The hospital director told us that, as a matter of policy, individual members of the medical staff were not permitted to bill patients or third parties for their services. This policy was reduced to writing on October 8, 1968, in the form of a resolution passed by the executive staff. On the same day, the executive staff, in effect, revoked the earlier authorization given PSF by giving the staff's authorization exclusively to APCCH. These actions were subject to the approval of the Cook County Board of Commissioners, which had not been obtained as of June 20, 1969.

APCCH has billed only Medicare for services of its members. The APCCH administrator informed us, however, that, in July 1968, negotiations had been initiated with Blue Shield and with the Illinois State Department of Public Aid to arrange for reimbursement for medical services rendered to Blue Shield-insured patients and to patients eligible for medical assistance from the State Medicaid plan. Billing by the APCCH for members' services to patients covered by other third-party insurance, now being collected by PSF, has been deferred. The administrator further informed us that it was the intention of APCCH eventually to bill for all professional medical services rendered by its members to all of their patients at Cook County Hospital, pursuant to the APCCH members' assignments to APCCH of the right to collect and disburse such funds.

PSF was established by the executive staff in May 1959 for the purpose of billing insured patients and those who

could afford to pay for physicians' services rendered at Cook County Hospital. PSF was started as a result of private negotiations between the present director of the division of laboratory sciences at the hospital and 25 insurance companies and unions. The director informed us that these private agreements covered services provided at the hospital but did not specify whether the services were to be performed by attending physicians or by residents. The director informed us also that PSF had been established with the oral approval of the president of the Cook County Board of Commissioners and the State's attorney.

PSF is administered by the Hektoen Institute. The director of the institute is also the director of the division of laboratory sciences at the hospital. The institute bills and collects for services performed and makes expenditures which, the director informed us, require the approval of a special committee of hospital physicians. We were also told by the director that expenditures had been made for purchasing equipment for laboratories at the Hektoen Institute, which provide services for hospital patients and for supplementing the salaries of certain hospital employees, including physicians. Since 1964, these latter expenditures have also required the approval of the Cook County Board of Commissioners.

The director stated that, at the outset, PSF intended to bill all patients who could afford to pay or, as appropriate, their insurers. In practice, however, it appears that only those patients having private medical insurance are identified for billing and, if the insurers do not pay the bills, the individuals are then requested to pay. PSF officials identified a total of 63 insurance companies, employers, and unions that honored PSF bills and a total of 12 insurance companies and unions that did not.

Billings submitted to third-party insurers are signed by the director of the Hektoen Institute who informed us that billings for medical and surgical care were based on information recorded in the patients' medical records. Information submitted with the billings show the names of attending physicians who, we were told, were the attending physician named on the medical records. The director

stated, however, that the billings were for the performance of professional services, regardless of whether they were provided by attending physicians, residents, or interns.

Regarding assignment of insurance benefits to a physician by the patient, the patient is required, upon admission, to sign a statement authorizing the payment of medical and/or surgical benefits directly to PSF. The authority of PSF to bill for physicians' services is apparently derived solely from the executive staff, because members of the medical staff have not individually assigned their rights to fees to PSF.

In addition to the 63 insurance companies, employers, or unions identified by the PSF officials as paying for physicians' services provided to patients at Cook County Hospital, an additional 30 similar sources that had paid for these services were identified by us. This identification was made by analyzing the PSF financial records for 1 month of the fiscal year ended August 31, 1968. Revenues for that entire fiscal year totaled $356,065, of which $326,396 was received from insurance companies; $22,905 from employers or unions; and $6,764 from other sources, including individuals. Refunds for the fiscal year totaled $2,089, and net revenues, therefore, amounted to $353,976.

Our analysis of revenues for 1 month in which $34,511 was received showed that payments, ranging from $7.50 to $4,665, had been received from 53 organizations, most of which were private insurance companies. A total of $357 was received from sundry sources, including individuals. More than $1,000 was received during the month from each of 10 insurance companies.

Both PSF and APCCH were billing for physicians' services provided to patients at Cook County Hospital, and the basic setting in which these services were provided was the same. To determine whether the fees charged by both PSF and APCCH were also the same, we selected and compared charges by PSF for services commonly billed by APCCH, which we identified in the 75 cases we selected for review. The comparison was based on charges, not amounts paid, because, without having the individual medical insurance policies

applicable to the PSF billings, we were unable to determine why PSF had received amounts different from those paid APCCH by Blue Shield for the same types of services.

The comparison showed that, for three types of medical services, PSF had charged more than APCCH and that, for seven types of surgical services, PSF had charged more for three types and less for four types. Details of the comparison follow.

Types of services	Fees charged PSF	Fees charged APCCH
Medical services:		
Daily hospital visit	$ 10	$ 7
Consultations:		
Limited	25	21
Complete	50	49
Surgical services:		
Spinal puncture	35	22
Cystoscopy	50	44
Cystoscopy with retrograde pyelogram	75	82.50
Proctoscopy	16	16.50
Transurethral resection of prostate	350	440
Suprapubic cystotomy	300	275
Amputation, lower extremity	250	330

The PSF officials identified 12 insurance companies that would not honor PSF billings. One of these companies was Blue Shield. Generally, the PSF officials stated, the companies would not honor the billings because of a provision in their insurance policies which excluded from coverage any services rendered in an institution owned or operated by governmental agencies or subdivisions thereof. A Blue Shield official advised us that Blue Shield policies contained this exclusion. A PSF official also stated that the insurance companies which had honored claims had usually incorporated the same exclusion in their policies but nevertheless, in some instances, had honored the billings. This official stated that, in other instances, agreements that the billings would be honored had been reached as a result of personal negotiation between himself and company representatives.

SUSPENSION OF MEDICARE PAYMENTS
FOR SERVICES OF SUPERVISORY PHYSICIANS
IN THE TEACHING SETTING

As a result of SSA's April 9, 1969, directive to Blue Shield and the SSA guidelines issued in April 1969 (see p. 9), which Blue Shield reported it had received in May 1969, Blue Shield suspended the processing of all bills for services furnished by supervising physicians in the teaching setting. The suspension was effective April 15, 1969, for Cook County Hospital, and May 8, 1969, for five other hospitals in Chicago serviced by Blue Shield.

In making the suspensions, Blue Shield stated to APCCH and the hospitals that it would be necessary to verify with each provider that the guidelines had been satisfied and that the required documentation was on file for each case before the processing of pending and future bills could be resumed. Blue Shield was sending out medical review teams to determine whether the services furnished by supervising physicians qualified for payment under the provisions of these guidelines and whether the necessary documentation was available and to reevaluate the bases for reasonable-charge determinations.

We were informed by a Blue Shield official that, as of June 16, 1969, Blue Shield was performing the review and evaluation work necessary to make the foregoing determinations and that the suspensions were still in effect.

MATTERS REQUIRING
FURTHER ATTENTION OF SSA

We believe that SSA should inquire further into the propriety of charges being allowed for the services of supervisory and teaching physicians when circumstances such as those noted in our review and cited below exist at hospitals.

--For 60 initial visits for which billings were made, the medical records supporting the specific

services billed disclosed no involvement or identification of any attending physicians, although the SSA regulations provided that the attending physicians should review the patients' histories and physical examinations and personally examine the patients within reasonable periods after admission. (See p. 29.)

--For 129 follow-up visits billed, no notations were made by any physicians, including residents or interns, to indicate that physicians had seen the patients. (See p. 31.)

--The medical records applicable to 38 consultations for which the Medicare program was billed disclosed no involvement of the attending physicians in whose names the services were billed. (See p. 34.)

--Hospital records in nine instances involving charges for operating room surgery did not indicate that attending physicians had been present. (See p. 37.)

--Hospital records in 31 instances involving charges for minor surgical procedures did not indicate that attending physicians had been specifically involved. (See p. 40.)

Agency comments

HEW noted that SSA, on April 9, 1969, had advised Blue Shield that documentation in support of payments to APCCH were inadequate to justify payments and that, as a result, Blue Shield had suspended further payments to APCCH. HEW also agreed to inquire further into the propriety of charges being allowed by carriers when circumstances such as those cited above existed at hospitals.

SCOPE OF REVIEW

Our review was directed primarily toward an examination into selected Medicare payments made to APCCH by Blue Shield. Our review included an examination of the Cook County Hospital records pertaining to the services for which APCCH had made charges to the Medicare program. We reviewed the SSA regulations, policies, and procedures relating to payments for the services of supervisory or teaching physicians and the procedures followed by Blue Shield in making payments for such services to APCCH. In addition, we obtained information concerning the practices of other insurers with respect to paying for similar services at Cook County Hospital.

During our review, we interviewed officials of a number of organizations involved in the matters discussed in this report, including officials of the Cook County Hospital; APCCH; Blue Shield; SSA Bureau of Health Insurance, Chicago Regional Office; the Cook County Board of Commissioners; and the Cook County Civil Service Commission.

In the selection of specific Medicare payments for review, we applied the following procedures.

1. SSA, as part of its oversight function, and for statistical purposes, requests from each carrier all part B bills applicable to all beneficiaries whose social security numbers end in 05, 20, 45, 70, and 95. This project has been designated by SSA as the 5-percent sample. We obtained from SSA a list of all payments made by Blue Shield to APCCH that had been processed by SSA through March 6, 1969, applicable to the beneficiaries included in the 5-percent sample. This list contained 439 payment records applicable to 307 beneficiaries and represented payments to APCCH that totaled about $58,600.

2. From this list, we made a random selection of 103 beneficiaries with 149 payment records representing payments of $19,800.

32-108 O - 69 - 24

3. From the foregoing subsample, we selected for detailed review 77 payment records representing payments of $10,800 applicable to 75 beneficiaries. In this selection, we placed emphasis on payments for services provided after April 1, 1968, after which date, the APCCH principles and procedures indicated, the hospital medical records should show the personal involvement of the attending physicians.

The PHS physicians who were assigned by SSA to provide us with professional assistance reviewed the hospital medical records applicable to 47 of the 75 beneficiaries. In selecting the cases to be reviewed by the PHS physicians, we placed emphasis also on payments for services provided after April 1, 1968.

APPENDIXES

APPENDIX I
Page 1

United States Senate

COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

April 28, 1969

The Honorable
Elmer B. Staats
Comptroller General
of the United States
Washington, D. C.

Dear Mr. Staats:

In connection with my letter of March 3, 1969, requesting the assistance of the General Accounting Office in the development of a Committee staff report relating to problem areas in the operation and administration of the Medicare and Medicaid programs, I am taking this opportunity to renew the request of the Committee on Finance that your Office make a specific review of the Medicare payments made to supervisory or teaching physicians at Cook County Hospital in Chicago, Illinois. The formal request was made by the Committee sitting in executive session on Friday, April 25, 1969, with Mr. Smith Blair, Legislative Attorney, in attendance.

It is my understanding that, during 1968, an Association, consisting of both salaried and nonsalaried physicians at the Hospital, has received over $1 million in payments from the supplementary medical insurance (Part B) portion of the Medicare program for various services furnished since July 1966 to Medicare inpatients at the Hospital.

It is not the intent of this Committee to request your staff to develop overall conclusions relating to the legal and policy questions which may arise during this review but, rather, to develop a report summarizing the information obtained during the review for the consideration of the Committee. It is anticipated, however, that the review will be based on an examination of payments made on behalf of selected Medicare beneficiaries and will deal with the following matters.

[pp. 21, 22, 26]

1. The circumstances surrounding the admission of the Medicare patients to the Hospital. For example, was the physician who charged for services the "attending" physician at the time of the patient's admission to the Hospital.

APPENDIX I
Page 2

The Honorable
Elmer B. Staats

April 28, 1969

[pp. 21 to 44]

2. The extent that the services paid for were actually furnished by the supervisory or teaching physician and the extent that the services were performed by residents and interns under the supervision of the physician who charged for the services.

[pp. 46 and 47] [p. 47] [pp. 50 and 51]

3. The extent that the services for which payment was made from Medicare (Part B) funds represented charges by (a) salaried physicians and (b) nonsalaried physicians. For the salaried physicians, the extent that their compensation was being reimbursed to the Hospital under the hospital insurance (Part A) portion of the Medicare program. For the nonsalaried physicians, information as to their affiliations and whether they were otherwise compensated for their services at the Hospital.

[pp. 16 to 18] [p. 18]

4. Information regarding the relationship between the Association and the physicians at the Hospital including data on (a) the Association's authority to charge on behalf of the physicians and (b) any physicians who do not belong to the Association but who may be charging Medicare independently.

[pp. 54 and 55] [pp. 55 to 57] [pp. 55 and 56]

5. Information as to whether (a) the Medicare patients were billed for and subsequently paid the deductible and coinsurance portions of the charges paid by Medicare, (b) the patients signed the appropriate claim forms requesting that Medicare payments be made on their behalf, and (c) the patients received "explanations of benefits" or other notification of the payments made on their behalf.

[pp. 58 to 62]

6. Information as to the basis for arriving at the amount "reasonable charges" for the services paid.

[pp. 63 to 66]

7. Information as to whether any other medical insurance programs or other patients have made payments for services performed by the salaried or nonsalaried physicians at Cook County Hospital in amounts comparable to those paid from Medicare funds under comparable circumstances.

8. Please obtain also any other pertinent information which you find is merited by the facts gained in your investigation of the items already listed.

The Honorable
Elmer B. Staats

April 28, 1969

I would appreciate your Office making a preliminary draft of the proposed report available to the Committee staff not later than June 15, 1969. In this regard, the Committee has no objection if you desire to make a copy of the preliminary report available to appropriate officials of the Social Security Administration for their consideration and for any comments they may care to make, after you have submitted it to the staff.

With every good wish, I am

Sincerely,

Russell Long

Chairman

COOK COUNTY HOSPITAL

CHICAGO, ILLINOIS

SCHEDULE SHOWING CHARGES FOR SERVICES AND MEDICAL RECORD OF SERVICES

FOR 75 MEDICARE PATIENT CASES REVIEWED BY GAO

	Total
OCCASIONS OF SERVICE BILLED, INCLUDED IN 75 CASES REVIEWED	923
CHARGES FOR CATEGORIES OF SERVICES:	
Total amount billed	$15,804
" " allowed	$14,866
Average amount billed, per occasion	$ 17.12
" " allowed, per occasion	$ 16.11
OVERALL CHARGES FOR SERVICES:	
Total number of days hospitalized	1,112
Average charges allowed for service a day of hospitalization	$ 13.37
MEDICAL RECORDS SHOW RECORD OF SERVICE:	
For initial visit, medical care, and surgical procedure:	
Number of days no entry made for medical care	-
" " " entry made for medical care	-
Medical personnel identified with record of service:	
Attending physician, same as identified on bill:	
Salaried by Cook County Hospital	4
Nonsalaried	11
Attending physician, other:	
Salaried by Cook County Hospital	22
Nonsalaried	22
Resident	437
Intern	395
Medical student	74
Record not signed or signature not identifiable	36
For surgical--operating rooms:	
Operation performed by:	
Attending physician, same as identified on bill:	
Salaried by Cook County Hospital	-
Nonsalaried	-
Attending physician, other:	
Salaried by Cook County Hospital	-
Nonsalaried	-
Resident	18
Intern	2
Not known	2
Attending or associate physician present:	
Same as identified on bill:	
Salaried by Cook County Hospital	1
Nonsalaried	1
Other:	
Salaried by Cook County Hospital	-
Nonsalaried	4

APPENDIX II

Nature of services					
Medical care				Surgical	
Initial visit	Daily	Consultation	Other	Procedure	Operating room
72	747	38	9	39	18
$1,835	$5,341	$1,008	$63	$1,408	$ 6,149
$1,793	$5,334	$ 938	$59	$1,198	$ 5,544
$25.49	$7.15	$26.53	$7.00	$36.10	$341.61
$24.90	$7.14	$24.71	$6.56	$30.72	$308.00
-	-	-	-	-	-
-	-	-	-	-	-
1	129	-	-	-	-
71	618	-	-	-	-
2	1	-	-	1	-
4	7	-	-	-	-
4	11	3	-	4	-
2	16	1	-	3	-
54	329	32	4	18	-
65	313	1	3	13	-
10	58	1	2	3	-
4	24	5	-	3	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	18
-	-	-	-	-	2
-	-	-	-	-	2
-	-	-	-	-	1
-	-	-	-	-	1
-	-	-	-	-	-
-	-	-	-	-	4

APPENDIX III
Page 1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

JUL 1 1969

Dear Mr. Charam:

This is in response to your letter of June 24, 1969, requesting comments on your draft report to the Senate Finance Committee entitled, "Review of Medicare Payments for Services of Supervisory and Teaching Physicians at Cook County Hospital, Chicago, Illinois."

The comprehensive information obtained by GAO substantiates the principal findings made by the Social Security Administration review teams which visited the Cook County Hospital and Illinois Medical Service earlier this year. As indicated in your report, the previous SSA review resulted in a letter to the Illinois Medical Service from the Bureau of Health Insurance on April 9, 1969, pointing out that documentation in support of payments to the Associated Physicians of the Cook County Hospital (APCCH) was inadequate to justify those payments. The carrier then suspended further payments to the APCCH and has not made payments since then. While a reference is made in the report to the April 9 letter we feel it would be appropriate to include a copy of it in the Appendix to complete the record.

We have been in constant touch with Illinois Medical Service regarding efforts to obtain adequate documentation from APCCH and we are awaiting further information from them. As recommended, we will inquire further into the carrier's practices in allowing charges under the specific circumstances mentioned on page 63a of your draft report. The comments which Illinois Medical Service, APCCH, and the Cook County Hospital submit in response to your report will also have an important bearing on our decisions regarding the direction further action should take. We would therefore appreciate your forwarding copies of these comments to us as soon as you receive them. We will keep you informed as further action is taken.

Sincerely yours,

James F. Kelly
Assistant Secretary, Comptroller

Mr. Philip Charam
Associate Director, Civil Division
U.S. General Accounting Office
Washington, D.C. 20548

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21241

REFER TO: HI:PS

APR 9 1969

Mr. Leonard J. Allegretti
Vice President
Government Contracts Division
Illinois Medical Service
222 North Dearborn Street
Chicago, Illinois 60601

Dear Mr. Allegretti:

Last week a review team from the Bureau of Health Insurance met with you and others for the purpose of gathering information concerning the reimbursement of Part B physicians' services rendered to Medicare patients in the Cook County Hospital in Chicago. The review team has since met with my staff and submitted a report outlining its findings. After reading the report and other information which has been provided me, I find that the documentation on the part of Illinois Medical Service in support of the Part B payments which have been made is inadequate to justify these payments.

As you know, our regulations permit Part B payment to a physician either when he renders services to the patient directly or when the attending physician provides personal and identifiable direction to interns and residents who are participating in the care of that physician's patient and a number of other conditions are met. In the absence of more specific documentation of the services than has been offered, I am unable to determine that physicians in the teaching setting are carrying out the kinds of duties and responsibilities called for in section 405.521 of the regulations.

Our regulations permit Part B reimbursement for physician services in a teaching setting only if "the attending physician's services to the patient are of the same character in terms of responsibilities to the patient that are assured and fulfilled as the services he renders to his own paying patients." It is unclear, in the case of a physician who has patients of his own, that the services rendered to Medicare patients in the hospital meet this requirement and that charges made to Medicare patients for the services in Cook County Hospital are reasonable in relation to what the physician charges private patients. Nor is it clear that charges by physicians who have no private patients are based on customary charges for medical services rendered in this particular setting or how the customary charges were developed. Furthermore, it is not clear that the charges being used as the basis

for reimbursement are those which patients generally have an obligation to pay. I am told that information regarding the identification as to the type of practice each physician has and the amount of time spent by each physician at the hospital and in his own practice is unavailable. Such information may be important in determining whether the reimbursement made is reasonable.

There is, in my opinion, a lack of documentation to allow a continuance of Part B reimbursement to those physicians who are rendering and billing attending physician services to Medicare patients in Cook County Hospital. Accordingly, I am asking that no payments be made for Part B physician services except for services for which we can be assured that the reimbursement is both legal and reasonable in amount. Of course, in making further reimbursements you will want to take account of any overpayments which need to be recovered.

It was requested during the meeting last week that we ask for certain supporting documents in writing. Therefore, in complying with that request, we would appreciate your sending us the following documents as soon as possible:

(1) A complete identification of all physicians who provide services to patients on a "no compensation by the hospital" basis. The identification should include: (a) the physician's name; (b) any university or medical school affiliation; (c) the type of affiliation, if any; (d) the extent of time spent by him in the hospital subdivided between hospital and patient care services and with patient care services further subdivided between Medicare and non-Medicare patients; (e) the extent of time spent by him in the university or medical school, if any, and in his own practice outside the teaching setting, if any; and (f) the amount of compensation received by the physicians from each of these sources.

(2) A copy of the Hektoen Institute's Annual Report for 1966 and any prior year plus data showing that that Institute is now billing for non-Medicare patient services, the amount of fees involved by nature of service and an analysis of any difference in services and fee levels billed in the two ways (Hektoen vs. Associated Physicians of Cook County Hospital) and justification of any differences in fees considered reasonable in the two mechanisms for billing.

(3) A copy of the fee schedule being used at the Michael Reese Hospital and which is being used as the basis for billing for services at Cook County Hospital and an analysis of any difference in patient services by physicians in the two institutions.

(4) A copy of the Illinois Statute containing paragraph 1144 relative to the matter of compensation by the hospital being for administrative duties only. It was reported that the statute involved was not intended to suggest that nonpatient services are the only ones compensated for. The basis for determining that only nonpatient services are paid for by salary should be spelled out, taking into account the legislative history on this point.

(5) The basis for determining what amount of cost is reimbursed under Part A for services of physicians, a list of physicians compensated by the hospital, amount of compensation, time for which compensated and duties would be helpful in substantiating these payments. The amount of uncompensated time and amount of billing for this time would be further infonsation that might be helpful. If the payment for nonpatient services is excessive, it should be understood that reimbursement under Medicare's Part A is limited to reasonable costs.

(6) A copy of the complete Civil Service Announcement which asks for attending physicians in the 17 specialties to become members of the attending staff at Cook County Hospital at no compensation.

(7) The basis for determining what services were rendered by an attending physician rather than in administrative duties and for fixing the amount reimbursable for services performed as acts of an attending physician.

(8) The reason for failure to reimburse for these services under Illinois Medical Service plans.

I am fully aware of the implications of my decision that payments for physicians' services should be held up until the necessary documentation is secured to serve as a basis for continuing physician reimbursement. Present circumstances demand that a complete review of the situation be made. I would like you to keep us informed as to any progress that you are making to answer the questions and the request for documents asked above and for substantiating which services are properly reimbursable under Part B and in what amounts.

Sincerely yours,

Thomas M. Tierney, Director
Bureau of Health Insurance

APPENDIX IV
Page 1

BLUE CROSS | PLAN FOR HOSPITAL CARE OF HOSPITAL SERVICE CORPORATION
BLUE SHIELD | MEDICAL-SURGICAL PLAN OF ILLINOIS MEDICAL SERVICE
MEDICARE | GOVERNMENT CONTRACTS DIVISION
222 NORTH DEARBORN STREET, CHICAGO, ILLINOIS 60601 • 661-6252

July 3, 1969

Regional Office
United States
General Accounting Office
610 South Canal Street
Chicago, Illinois 60607

Attn: Mr. David A. Hanna

Gentlemen:

We have reviewed your draft of a proposed report to the Committee on Finance, United States Senate, concerning certain Medicare payments for services of supervisory and teaching physicians at Cook County Hospital. You have requested our comments. We have specified below a number of instances in which the draft report, in our opinion, is inaccurate or conveys a misleading impression. The shortness of time since the draft was received on June 25, 1969 has not permitted a detailed examination of the specific Medicare claims which the draft report reviews on pages 27-38 and, accordingly, we make no comment concerning your observations with respect to particular claims.

Our comments are as follows:

1. On pages 6-8 the draft report quotes at length from the new SSA "guidelines" (Intermediary Letter 372) issued in April, 1969 concerning payments to physicians in a teaching setting. The report states that the guidelines were intended to "clarify and supplement" the previous criteria. The report does not note, however, that although the guidelines were issued in April, 1969, in fact they were not delivered to Blue Shield until May, 1969, after Blue Shield had already stopped Part B Medicare payments to the Associated Physicians. Nor does the report point out that these "clarifying guidelines" were not issued until the Medicare program had been in effect for almost three years. More importantly, a comparison of those "guidelines" with the regulations referred to on page 5 of the draft report discloses that the guidelines, while purporting to "clarify and supplement" the regulations in fact change them substantially and are far more stringent than the criteria in effect when the payments were made.

GAO
Regional Office
Chicago, Illinois -2- July 3, 1969

2. We suggest that the report should recognize early in the text, for example at the bottom of page 15 or at the top of page 16, the relationship between the Cook County Board of Commissioners and the Associated Physicians of Cook County Hospital. The County Board has been informed of the operations of APCCH. In fact, in response to a request from the President of the County Board the State's Attorney of Cook County has rendered an opinion that charges, including charges under Medicare, can be made for the services of attending physicians at Cook County Hospital. The Ad Hoc Committee appointed by the President of the County Board reported on June 20, 1969 that APCCH has neither been approved nor disapproved by the County Board. The Committee recommended that all monies collected by the APCCH be deposited in a bank or trust account until negotiations between APCCH and the County Board yield the County Board a voice in the expenditure of those funds previously collected and any which may be collected in the future.

[See GAO note]

[See GAO note]

5. On pages 27-38 the draft report summarizes the review of certain specific cases. As noted above, in view of the shortness of time, we have not been able to analyze the Hospital records (which are not, of course, in our possession) with respect to those cases. We direct your attention to paragraph 15 which discusses the special procedures established for adjudication of claims submitted by APCCH. The report fails to note that Blue Shield has not made payment for out-patient service at the Fantus Clinic at Cook County

Hospital and has not made payment for professional services of the so-called Hospital based physician, e.g., the pathologist, radiologist, anesthesiologist, and physiatrist.

[See GAO note.]

8. The last paragraph on page 40 refers to the fact that the Blue Cross Association (the Part A Intermediary) and Hospital Service Corporation accepted, subject to audit, the Hospital's claim for reimbursement of salaries paid to physicians assigned to the permanent staff. Neither that paragraph nor the remaining discussion directs attention to the fact that Hospital Service Corporation exerted considerable time and effort to investigate and verify the representations made by the administration of Cook County Hospital concerning the purpose for which salaries were paid to attending physicians. The report, for example, does not disclose that Mr. McCoy, the administrator of Cook County Hospital, in several letters repeatedly represented and contended that the salary payments were made for administrative duties only.

[See GAO note.]

9. The references at the bottom of page 42 and on page 43 to job descriptions which purportedly support the views of the Director of the Division of Laboratory Sciences that the physicians are paid to care for patients underscores the need for a statement in the report that the Administration of Cook County Hospital insisted in correspondence and in discussions with Illinois Blue Cross and Blue

Shield representatives that salaries were paid exclusively for administrative duties. Obviously, Blue Cross and Blue Shield could not brush aside the representations of the administration of the Hospital in the absence of data which would clearly refute the contentions of the Hospital administration. Blue Shield, however, did refuse to make payments in the case of the hospital based physicians, including those in the Division of Laboratory Sciences.

10. The section beginning at the bottom of page 47 pertains to the matter of whether signatures of beneficiaries should have been on the claim forms submitted by APCCH. In the section of the report captioned "Scope of Review" (pp. 64-65) you refer to the fact that Blue Shield submits a 5% sample of all claims forms to the Social Security Administration to assist in the latter's oversight function. In addition, the Social Security Administration has repeatedly made on-site inspections of Blue Shield's claims procedures. SSA has not questioned the absence of the beneficiary's signature on claim forms from APCCH.

11. The last sentence on page 50 erroneously implies that Blue Shield officials advised that Blue Shield had been making payments to APCCH in error. Patient signatures were lacking on various SSA form 1490's submitted by APCCH. As noted on page 48 of the draft report, SSA had relaxed the signature requirements for other claims in the past, and in view of that background the absence of the signatures on APCCH claims was overlooked.

[See GAO note.]

32-108 O - 69 - 25

GAO
Regional Office
Chicago, Illinois -6- July 3, 1969

[See GAO note.]

15. On page 57 the report cites instances in which claims submitted by APCCH should have been disallowed on the face of the claim form. The claims upon which the statements in the report are predicated were submitted in the period April, 1968 through January, 1969. At that time APCCH claims were processed by various claims examiners along with the many thousands of other claims received throughout the metropolitan Chicago area. Subsequently Blue Shield assigned all APCCH claims to one claims examiner, a registered nurse with special qualifications to screen and evaluate the claims submitted by that group. This procedure has been in effect since January, 1969. In a further effort to assure proper adjudication, APCCH subsequently was required to submit additional supporting data from the medical records to assist the claims examiner in evaluating the representations made in the SSA 1490 Request For Payment filed by APCCH. In the interest of accuracy, we believe that these procedures established by Blue Shield with respect to APCCH claims should be recognized in the report.

16. The statement is made on page 62 that Blue Shield does not honor billings of PSF "essentially" because of an exclusion in the Blue Shield certificates. The Blue Shield certificates do, in fact, contain such an exclusion but Blue Shield officials also pointed out to the Cook County Board Ad Hoc Committee, as the transcript discloses, that even in the absence of such an exclusion there were serious obstacles to payment for professional services at Cook County Hospital because of language in the certificates and provisions of the Blue Shield Enabling Act. Many of the services covered by Medicare would not be covered by Blue Shield certificates whether rendered at Cook County Hospital or at any other institution.

GAO
Regional Office
Chicago, Illinois -7- July 3, 1969

[See GAO note below.]

In view of the many conferences we have had with you and other representatives of the GAO during your investigation, we appreciate having the additional opportunity to comment on the draft report. Our comments are made in the same spirit of cooperation which we extended to the GAO representatives during their visits to our office and we hope that they will contribute to the completeness and accuracy of the report. We are willing to discuss these comments with you, if you desire, and would appreciate receiving a copy of the report when completed.

Very truly yours,

Leonard J. Allegretti

Leonard J. Allegretti
Vice President
Government Contracts Division

LJA:rm

GAO note: The material deleted relates to suggestions for language changes which have been incorporated into the body of the final report.

APPENDIX V
Page 1

COOK COUNTY HOSPITAL

GEORGE W DUNNE, PRESIDENT
BOARD OF COUNTY COMMISSIONERS

WILLIAM H HARVEY, COMMISSIONER
HOSPITAL CHAIRMAN

1825 WEST HARRISON STREET
CHICAGO, ILLINOIS 60612
PHONE AREA CODE 312 633 6000

ROBERT J FREEARK, M D
HOSPITAL SUPERINTENDENT

FRED A HERTWIG
ASSISTANT SUPERINTENDENT

July 3, 1969

Mr. David Hanna
United States General Accounting Office
610 South Canal Street
Chicago, Illinois

Dear Mr. Hanna:

This will acknowledge my recent meeting with you and the opportunity it provided to review the rough draft of a proposed report by the General Accounting Offices. Other than the minor corrections which you have agreed to make, I would also ask that you make two major additions.

One of the issues which the study raises is the extent to which attending physicians are providing supervision and direction to internes and residents. While I would agree that in many instances this supervision and direction is poorly documented in the medical record, this does not mean that it was not given. In many private hospitals, the only notation in a hospital chart to indicate that a physician visited a patient or performed a procedure, is that which appears in the nurses notes. We simply do not have enough nurses to provide this documentation and it is not realistic to expect this to be done by the physicians. I believe the vast majority of "undocumented services" were so categorized because neither a doctor's or a nurse's note records a visit.

I believe Recommendations #31 and #36 of the report of the Joint Commission on Accreditation of Hospitals (February 1968) should be included in your report. These statements and the fact that our internship and residency training programs are fully approved by the Council on Medical Education of the American Medical Association, is ample evidence that attending physicians are providing supervision and direction to our house staff. There is no doubt in my mind that patient care in a "Teaching Hospital" (one that conducts approved residency and interne training programs) is under greater scrutiny and better supervised than in hospitals without these programs.

APPENDIX V
Page 2

These statements by the Joint Commission are pertinent to a thorough understanding of conditions at the hospital. In part, they constitute an explanation of why documentation of services rendered is so difficult.

My second request would be to ask that you include in your report my opinion as to the basis for compensation for salaried physicians at Cook County Hospital. This is in part a matter of semantics and has led to considerable misunderstanding. The concept that salaried physicians are not paid for patient care, but for their administrative and supervisory duties is predicated on the fact that over 50 percent of our salaried staff carry an extraordinary administrative and educational work load. An estimated 50%-70% of these salaried physicians are expected to supervise a large number of medical and non-medical personnel in activities not directly related to the care of the individual patient. (e.g., there are only two salaried positions for general surgery. These two men are administratively responsible for the assignment and education of 72 attending physicians, 62 general surgical residents, and an average of 30 internes and 42 medical students. This personnel changes regularly on the five general surgical wards that have a total bed capacity of over 300 patients. In addition, one of the two full time surgeons is also the Director of the Blood Bank, which has 23 technical persons in its employ.)

Furthermore, at the present time, the salary paid to over 60 percent of our full time staff represents only a portion (estimate 60%-70%) of their total professional income. In addition, this salary is approximately two-thirds that paid to physicians in comparable positions in hospitals in this geographic area. Based on the extraordinary administrative and formal educational responsibilities and the concept of a partial salary for a portion of their time, I am of the opinion that when

the majority of our salaried physicians go to the individual patient's bedside or to the operating room, they are providing professional services for which they are not compensated by the salary they receive from Cook County Hospital. This is consistent with the Civil Service rating which they hold as attending physicians, caring for patients without compensation.

I hope that you will see that this information is included in your report and I wish to thank you for the considerate manner in which you have carried out your activities.

Sincerely yours,

Robert J. Freeark, M.D.

RJF/ubd

cc: George W. Dunne

APPENDIX VI
Page 1

THE ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL
INCORPORATED NOT FOR PROFIT

810 SOUTH WOLCOTT STREET—CHICAGO ILLINOIS 60612

ROBERT J. BAKER, M.D.
PRESIDENT
FRED SHAPIRO, M.D.
VICE PRESIDENT
VINCENT J. COLLINS, M.D.
TREASURER
ROWINE H. BROWN, M.D.
SECRETARY
WILLIAM B. SALE
ADMINISTRATOR

TELEPHONE
AREA CODE 312
738-3744

July 18, 1969

Mr. Joseph P. Rother, Assistant Director
Civil Division, United States General Accounting Office
Social Security Administration
6401 Security Boulevard
Room 4-L-29B
Baltimore, Maryland 21235

Attention: Mr. David Hanna

Dear Mr. Hanna:

As agreed with Mr. Kintner during our extended review of our comments on the Draft Report of GAO on July 16, I am sending herewith a revision of my letter of July 16 to Mr. Hitzeman, and request that this revised text be accepted in place of the letter brought to Baltimore by Mr. Kintner. In addition to a number of deletions agreed upon during our meeting, I have made a few additional substantive changes, in particular, deletion of discussion of BHI Intermediary Letter No. 372 contained on page 2 of the original text. In addition to sending this original copy of my revised letter addressed to Mr. Hitzeman to you at Baltimore, in care of Mr. Joseph Rother, I am sending a copy to Mr. Hitzeman in Chicago.

If you have any questions concerning the matters discussed in this letter, I trust you will 'phone me for clarification.

Again I wish to thank you and your associates for your consideration and your patience in working with us to produce a report which will take into account matters of particular concern to us.

Best regards.

Sincerely,

William B. Sale
Administrator

Enclosures
cc: Mr. Kenneth W. Hitzeman

"TO PROMOTE MEDICAL AND SCIENTIFIC EDUCATION AND RESEARCH"

THE ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL
INCORPORATED NOT FOR PROFIT
518 SOUTH WOLCOTT STREET—CHICAGO ILLINOIS 60612

ROBERT J. BAKER, M.D.
PRESIDENT
FRED SHAPIRO, M.D.
VICE PRESIDENT
VINCENT J. COLLINS, M.D.
TREASURER
ROWINE H. BROWN, M.D.
SECRETARY
WILLIAM B. SALE
ADMINISTRATOR

TELEPHONE:
AREA CODE 312
738-3744

July 16, 1969

Mr. Kenneth W. Hitzeman
Assistant Regional Manager
United States General Accounting Office
610 South Canal Street
Chicago, Illinois 60607

Dear Mr. Hitzeman:

In accordance with the request made of us by field personnel of your office, to whom we previously have given oral comment, we provide you in this letter with our comments with respect to Draft Report dated June 1969 to the Committee on Finance, United States Senate, regarding Review of Medicare Payments for Services of Supervisory and Teaching Physicians at Cook County Hospital, Chicago, Illinois (Code 10550), Department of Health, Education, and Welfare. The aforementioned Draft Report is sometimes referred to herein as the "Draft Report" and the abbreviations used herein correspond with those used in the Draft Report.

This letter is not intended as an exhaustive survey but solely as a means of setting forth certain matters which we hope will provide a constructive basis for corrections and revision. In addition to incorporation of acceptable recommendations for correction or amendment of the Draft Report, we respectfully request that a copy of this letter be appended to the definitive report when issued by your office. Page references herein refer to pages of the Draft Report unless otherwise set forth or unless clearly indicated by the context.

Annexed hereto as Exhibit A is a copy of the press release issued February 8, 1967 by HEW commenting on and explaining proposed regulations published in the Federal Register February 8, 1967, a copy of these proposed regulations being annexed hereto as Exhibit B. Annexed hereto as Exhibit C is Bureau of Health Insurance (BHI) Intermediary Letter No. 221, dated April 21, 1967. Final regulations substantially similar to the proposed regulations were published in the Federal Register on August 31, 1967, and a copy is annexed hereto as Exhibit D. Since these documents constitute the legal basis for the submission of Medicare claims by The Associated Physicians of The Cook County Hospital, and were not appended to the Draft Report, we respectfully request that they be included with documentation annexed to the Report.

BHI Intermediary Letter No. 372, dated April, 1969 (Appendix III to the Draft Report), departs materially from requirements for reimbursement for services in the teaching setting as established in Exhibits A, B, C and D. It deals only with reimbursement for services rendered after the month of May 1969; it does not purport to have retroactive effect. We believe the Committee should have the perspective of Exhibits A, B, C and D, which control all billings for services rendered prior to June 1, 1969, including, of course, all claims examined by GAO in connection with this Report.

Our comments with respect to specific items in the Draft Report are made in the light of the practices of APCCH which conform to the criteria established by the Exhibits A, B, C and D, and specific agreements negotiated pursuant thereto with Blue Shield, the Part B carrier. We also submit a number of recommendations for factual correction in the interest of accuracy.

* * *

[See GAO note.]

[See GAO note.]

8. Page 23. Add the following text to the second paragraph from the top: "It should be pointed out that during this same period Blue Shield processed 11,966 claims submitted by APCCH, and that the 75 cases reviewed represent only six-tenths of one percent of claims processed. The Administrator of APCCH has questioned whether such a small sampling of claims processed can produce statistics upon which to base a valid judgment of the billing procedures of APCCH."

EXPLANATION: In Dr. Freeark's letter to you dated June 11, 1969, with particular reference to surgical services, he pointed out that a large proportion of the surgical cases reviewed were from one of the smaller surgical specialty departments, and that most of the "surgery" consisted of endoscopies, diagnostic procedures which do not ordinarily require the personal supervision of the attending physician responsible for the care of the patient. We cite this as evidence that the sampling technique produced a misleading and statistically unreliable result. However, we, ourselves, have undertaken a thorough review of the 75 cases and will make any appropriate comments at a later date.

[See GAO note.]

10. Page 25. The document referred to in the first sentence is furnished in full text as Exhibit F and should be considered as such. We respectfully request the deletion of the excerpt from the text and the substitution of the Exhibit as one appendix with appropriate reference thereto in the text.

The following additional text should be added to explain the pro-

cedures followed in billing Medicare claims: "The APCCH Administrator has stated that in accordance with these 'Principles and Procedures' claims have been filed on the basis of identifiable evidence of medical service rendered as recorded in the patient's medical record. As is indicated in written communications from various administrative officers of the hospital, due to circumstances which cannot rapidly be remedied there is a serious lack of recording in the patients' medical records of participation by specific attending physicians in the direction and supervision, and even their personal rendering of patient care. The absence of notes and orders in the patients' records written or countersigned by the attending physician is not considered by the Administrator to detract from the validity of the right of APCCH to receive reimbursement for identifiable services of the attending physician responsible for the care of the patient.

"The Administrator of APCCH has further stated that the provisions of the 'Principles and Procedures' contained in Paragraph II(B), providing guidelines as to how the hospital's medical records should be documented to support the charges were intended to encourage improved recording of services of attending physicians in medical records and provide written evidence of such services to further substantiate claims for reimbursement under the Medicare program. The specified provision of written evidence in the patient's chart go beyond the requirements of the Federal Regulations and Letter No. 221 (Exhibit C). Since the adoption of the 'Principles and Procedures', there has been marked improvement in the recording of attending physicians' participation in patient care, and it is anticipated that, with the cooperation of all members of the Medical Staff of the Hospital, the intent of the cited 'Principles and Procedures' will be fully implemented within the near future. The APCCH Administrator has pointed out, however, that while the implementation of these provisions is considered to be a highly desirable goal, it has not been considered a precondition for requesting reimbursement under the program.

"As one factor in support of this position, the APCCH Administrator refers to the fact that the revised 'Guidelines' of April 1969 in Paragraph A(3) state that 'Performance of the activities referred to above must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician.' He further points out that no such requirement is contained in the original guidelines of April 21, 1967, nor is there reference to such a requirement in Section 405.521(b) of the Federal Regulations establishing this program."

EXPLANATION: With respect to paragraph II(B)(1) of the "Principles and Procedures" adopted by the Executive Staff, quoted on pages 25 and 26, in order to fully understand the basis on which claims for reimbursement have been submitted by the Associated Physicians, the entire document should be read rather than the paragraph quoted out of context.

11. Page 31: Add the following sentence to the end of the paragraph at the top of the page: "The APCCH Administrator pointed out that in accordance with the agreement with the carrier, as provided in Paragraph I(B) of the

'Principles and Procedures', 'There shall be a charge for one visit of every day of hospitalization following the first day (covered by the 'initial visit')...'" He added that "There is no requirement in the Federal Regulations or BHI guidelines, or in the APCCH agreement with the carrier requiring a written record in the patient's chart to substantiate daily follow-up visits. It is an established routine at the hospital that every patient is seen at least daily by an attending physician or by a resident or intern assisting in the care of the patient under his direction. The failure to record the visit is not indicative that the service was not performed. Under this same provision of the agreement with the carrier, no additional charge is made in cases where a patient in critical condition is seen numerous times during one day."

12. Page 33. Insert the following new paragraph above the last paragraph: "The APCCH Administrator advised that minor medical procedures are generally under the supervision and direction of the same attending physician responsible for the medical care of the patient. The Administrator has indicated that billing has been done accordingly."

13. Page 37. Insert the following above "Other Surgical Services": "The APCCH Administrator advised that in connection with identification in the patients' medical records of the supervising attending physician who provided direction to the interns or residents either assisting him or personally performing surgical procedures, billing has been done pursuant to Paragraph II(1) of 'Billing Procedures' appended to the 'Principles and Procedures', which provides that 'Surgical procedures will be billed in the name of the attending physician who personally supervised the procedure in the operating room or gave his personal direction to the resident performing the procedure. This will be the attending indicated in the operation note in the hospital chart, or, in the absence of an indication in the chart, in the name of the attending indicated in the operating room record of the hospital.' APCCH stated that billing for surgical procedures has been in accordance with these cited procedures, in accordance with agreements with the carrier; that the official operating room record of the hospital indicates the name of the attending physician responsible for the supervision of each surgical procedure performed; that this information is usually also contained in related records of the Anesthesiology Department; and that in the absence of written indication in the patient's chart of the attending physician responsible for the supervision of the surgical procedure, billing has been done in the name of the attending indicated in these hospital records."

EXPLANATION: In view of our agreement with Blue Shield to bill on the above basis, it would appear that the emphasis in this section of the GAO report on the presence or absence of written evidence in the patient's medical record might incorrectly suggest that bills have been rendered by APCCH without the above mentioned supplemental substantiation.

14. Page 38. At the end of the paragraph at the top of the page, add: "The APCCH Administrator has stated that since such minor procedures are generally performed under the supervision and direction of the patient's attending physician on the ward, APCCH billing has been done accordingly."

15. Page 41. (a) Insert after second sentence in the second paragraph from the top, the following: "The APCCH Administrator has pointed out that the Executive Staff is established by the By-laws of the Medical and Dental Staff of the Hospital and has no By-laws of its own."

(b) After the second paragraph from the top, insert the following: "The APCCH Administrator has pointed out that the By-laws of the Medical and Dental Staff of the Hospital provides in Article IV, Section 4, Subsection 1, respecting the 'attending medical staff' that, 'The Attending Medical Staff will consist of voluntary physicians resident in the community and the permanent staff who have been appointed by the Governing Body to attend patients in the hospital...' As indicated above, not all members of the permanent staff are appointed to the attending staff, and only the attending staff is entitled to care for patients. As also is indicated above, appointments to the attending staff are in accordance with Civil Service regulations which, as is mentioned below, provide for 'no compensation' for such services."

16. Page 50. It is recommended that the following paragraph be added at the end of the discussion of the signature of beneficiaries on claims: "Respecting this matter, the APCCH Administrator has made the following observations: 'At the time of initiation of negotiations with the carrier, it was explained that we had on hand some eight to ten thousand SSA 1554 forms, prepared by the staff of the PSF, respecting cases involving the services rendered to Medicare eligible patients back to July 1966, and that all such forms were either signed by the beneficiary or, if the patient was unable to sign, signed by a case worker as provided in the pertinent regulations. The SSA 1554 assignment reads as follows: 'Assignment: I assign payment for unpaid charges of the physician(s) listed on this form. Authorization: I authorize release of any information required to act on this claim and permit a photographic reproduction of this authorization to be used in place of the original. The above information is correct. I request payment on my behalf for the medical insurance benefit, if any, payable for the reasonable charges for services described. I understand I am responsible for any medical insurance deductible and 20% of the remaining reasonable charges.' We proposed to transfer the service information from the 1554 form to a 1490, and stamp the form either 'signature on file' or 'patient unable to sign.' This arrangement was agreed to by Blue Shield and billing was submitted accordingly.

"Subsequent to about March 1968 the APCCH staff took over responsibility for abstracting necessary information from patients' charts for billing purposes, and 1554's were no longer executed by patients. However, the hospital Financial Controls Division obtains the signature of every patient presumed to be eligible for Medicare on an approved form containing the following assignment: 'Patient Certification: I certify that the information given by me in applying for payment under provision of Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.' It is to be noted that the assignment refers to 'provisions of Title XVIII of the Social Security Act', and is not limited to hospital benefits under Part A. It has been assumed that this assignment was sufficient

authorization for requesting reimbursement for Part B services during the hospital stay for which the assignment was executed. Consequently APCCH has stamped 1490's to the effect that signature of the patient was on file, or patient unable to sign on the basis of the assignment on file in the hospital. The procedure of thus stamping SSA 1490 Medicare claims has never been questioned by Blue Shield and payments have been regularly made in accordance with this procedure.

"The SSA directive to Blue Shield dated October 1967 referred to on page 48 of the Draft Report stating that 'As a general rule the patient's (or his representative's) signature is needed on all assigned claims,' was never brought to the attention of the APCCH by the carrier and we have had no reason to believe that procedures which we have been following were not correct and acceptable in every respect."

With respect to the last paragraph on Page 50, it is the understanding of the APCCH Administrator that Blue Shield officials have recommended revision of this section of the report; APCCH comments thereon, therefore, are omitted.

17. Page 53. With respect to the last sentence on the page, continuing on to page 54, concerning preoperative care, paragraph II(2) of the "Billing Procedures" of "Principles and Procedures" provides that "When the patient is admitted to the hospital for the sole purpose of performance of the operation, there will be no charge for up to three days of preoperation in-hospital care, or for postoperation care up to the number of days of 'covered' postoperation care indicated in the 'Schedule of Allowances'. The regular charge for in-hospital medical care will be made for preoperation and postoperation care beyond the above periods."

[See GAO note.]

[See GAO note below.]

19. Page 63. The fourth line of the second paragraph should read as follows: "...before the processing of bills for services prior to May 1969 could be resumed."

EXPLANATION: See April 1969 guidelines, paragraph C(1).

We sincerely appreciate this opportunity to provide comments and suggest revisions of the Draft Report prior to publication of the definitive report of the General Accounting Office. Should additional information be required, we shall be pleased to be of every possible assistance.

Sincerely,

William R. Sale
Administrator

Enclosures

GAO note: The material deleted relates to suggestions for language changes which have been incorporated into the body of the final report.

APPENDIX VI
Page 11

COPY

HEALTH, EDUCATION, AND WELFARE
Social Security Administration

Area Code 301 944-1925

For Release, Wednesday, February 8, 1967

Proposed regulations for determining the reasonable charges for physicians' services to medicare beneficiaries have been sent for publication in the Federal Register, Social Security Commissioner Robert M. Ball, said today.

The regulations set forth the same basic criteria for figuring reasonable charges as the guidelines issued at the start of the program to the insurance carriers who act as medicare reimbursement intermediaries.

The proposed regulations also contain the principles for determining reimbursement for the charges of attending physicians where the services of interns and residents are involved in rendering care in connection with medical education programs, Ball noted.

Commissioner Ball said the principles were developed after extensive discussion and consultation with the Health Insurance Benefits Advisory Council and representatives of organized medicine and medical education. Interested parties will have 30 days from the date of publication of the proposed regulations to submit their views, data, comments, or suggestions, before the regulations are issued in final form.

(M O R E)

EXHIBIT A

102

32-108 O - 69 - 26

According to the medicare law, two basic criteria for determining reasonable charges for physicians' services are: (1) the customary charges for similar services generally made by the physician, and (2) the prevailing charges in the locality for similar services. In addition, the law specifies the reasonable charge cannot be higher than the charge applicable for a comparable service under comparable circumstances to the carriers' own policyholders and subscribers.

The administering carriers exercise the necessary judgments to make these determinations of the program's liability, based on their own experiences with doctors' fees, Ball pointed out. They are also expected to give consideration to the facts in individual cases so that their determinations of reasonable charges will be realistic and equitable. But income or economic status of the beneficiary is not a factor to be considered by the carriers in determining reasonable charges.

A doctor's charge will be considered customary if it is the amount he charges patients generally for the particular service. The regulations point out that customary charges may vary from physician to physician. Thus, Ball said, medicare relies on the charge patterns worked out for all patients in the normal course of medical practice; carriers determining reasonable charges do not negotiate or set up special fee schedules for medicare.

(M O R E)

To be considered a "reasonable charge" for reimbursement under the medicare program, however, a physician's customary charge must also fall within the range of prevailing charges in a locality for the particular medical services or procedures. The range of prevailing charges may be different for physicians engaged in specialty practice than for others. The regulations provide criteria for determining prevailing charges by locality.

The program will base payment on actual charges when these are lower than the customary charge; but carriers will not include in a physician's "profile" of customary charges, token charges or those that are clearly below his customary charge in recognition of the low-income status of a patient.

Conversely, the charge recognized may be higher in an individual instance if there are special circumstances, such as medical complications or extensive travel, involving much more than the ordinary amount of a doctor's time; but such charges also do not become part of the physician's "profile."

With respect to teaching programs, a fee charged to a medicare beneficiary by a supervising physician, who functions as the responsible attending physician, will be reimbursed as a professional service on the basis of reasonable charges,

(M O R E)

regardless of the involvement of interns and residents. For such a charge to be reimbursable, the supervising physician must provide personal and identifiable direction to the interns and residents who are participating in the care of his patient. When major surgical procedures or other dangerous or complex procedures are performed by residents, the supervising physician must be in attendance in order to be reimbursed on a charge basis as the attending physician.

Ball noted that whether or not a physician's charge is recognized under the medicare program for services to teaching patients, the hospital can receive reimbursement on a cost basis for an appropriate share of the compensation it pays its residents and interns. If the teaching program is an approved educational activity of the hospital, reimbursement will also be available on a cost basis to the hospital for an appropriate share of the compensation it pays to physicians for teaching services that are not direct professional service to a given patient.

The Commissioner pointed out that determinations of reasonable charges are made by medicare carriers and are not reviewed on a case-by-case basis by the Social Security Administration, although the general procedures and performance of functions by carriers are evaluated. The "reasonable charge" guidelines, he said, are designed to assure overall consistency and equity in the application of the provision of the law.

APPENDIX VI
Page 15

COPY
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
P.O. BOX 1005, BALTIMORE, MARYLAND 21203

HI:PS:RSP

April 21, 1967

BUREAU OF HEALTH INSURANCE
INTERMEDIARY LETTER NO. 221

SUBJECT: Reimbursement for services of supervising physicians in the teaching setting

This supplements Intermediary Letter No. 196, which transmitted the proposed regulations governing the conditions under which Part B payments may be made on a reasonable charge basis for the services that physicians (other than interns and residents) perform in the teaching setting.

The proposed regulations explain, in section 405.521(b), that:

> "Payment on the basis of reasonable charges is applicable to the professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient. In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician. A charge should be recognized under Part B for the services of an attending physician who involves residents and interns in the care of his patient only if his services to the patient are of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients. The carrying out by the physician of these responsibilities would be demonstrated by such actions as: reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission; confirming or revising diagnosis; determining the course of treatment to be followed; assuring that any supervision needed by the interns and residents was furnished; and by making frequent reviews of the patient's progress."

EXHIBIT C

Determining the Reasonable Charge

Section 405.521(c) of the proposed regulations states that the amount payable under the program for such services may be determined in accordance with the same criteria for the determination of reasonable charges as are applicable to the services the physician renders to his other patients. Thus, the reasonable charges for the services in question may, subject to the limitations imposed by the prevailing charges, be related to the amounts the teaching physician customarily charges outside the teaching setting.

In some cases, teaching physicians of a hospital may wish to adopt a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting. Such schedule should be submitted to the area carrier for its approval prior to the submission of claims. Approval can be granted by the carrier on a service-by-service basis and should not be withheld pending approval of the schedule in its entirety. The uniform schedule of charges would be acceptable so long as the scheduled charges (1) are not in excess of prevailing charges, and (2) are not expected to result in charges which would, in the aggregate, exceed the amount that would have been charged if the physicians in the group had billed individually. If as a result of using such a uniform schedule of charges, or for any other reason, an attending physician charges different amounts for his services to teaching patients than for his services to other patients, such charges should not be taken into account in determining his reasonable charge for patients outside the teaching setting.

Where a physician has little or no practice outside the teaching setting, his customary charges should be measured in terms of the hospital's charge for his services or, where the hospital has no established charge for the services, the carrier and intermediary must make the necessary charge and cost determinations based on the physician's compensation pursuant to the regulations governing reimbursement for the services of hospital-based physicians. It should be recognized, however, that a new or revised pattern of charges may subsequently develop or be established. Where on the basis of adequate evidence the carrier finds that new or revised charges for the physician are being made generally, the new charges may be recognized as customary charges in making determinations of reasonable charges. If the new customary charge is not above the prevailing level, it may be held to be reasonable by the carrier.

Billing Procedure

Where a physician performs services in the teaching setting as a medicare patient's attending physician, Part B payments may be billed for (1) by the physician or a corporation, partnership, or other organization of physicians (including an association of teaching physicians organized for the purpose of billing for and distributing insurance monies and other payments received for professional services to patients), (2) by the hospital, or (3) if the services are performed by a physician who is a faculty member of a medical, osteopathic, or dental school, by the school.

(The individual physician's authorization is required to permit any of the above organizations to bill on his behalf. The organization must furnish to the carrier the names of the physicians who have authorized the organization to bill on his behalf, and must agree to keep the carrier informed of changes on a current basis.)

Where the hospital bills for the services, it should use the SSA-1554. (The 1554 procedure may be utilized even though the physician is not paid for his services by or through the hospital, i.e., even though he may not be "hospital-based.") If the individual physician or an entity other than the hospital bills, the SSA-1490 should be used. In any case where a party other than the attending physician bills for his services, the name of the attending physician must be entered on the billing form as part of the description of the services rendered and the name of the hospital must be shown in item 7C of Form SSA-1490. In addition, carriers should make arrangements to assure that bills for services rendered in the teaching setting can be identified as such. Whatever method of billing is used, the Part B payments can be disposed of in whatever manner is agreed upon by the physician and hospital.

The foregoing guidelines and instructions, although they are written in terms of services performed in the hospital setting, will, to the extent they are applicable, also govern reimbursement for services of attending physicians supervising interns and residents in extended care facilities.

/s/ Thomas M. Tierney

Thomas M. Tierney, Director
Bureau of Health Insurance

COPY

THE ASSOCIATED PHYSICIANS
OF THE COOK COUNTY HOSPITAL, INCORPORATED
627 SOUTH WOOD STREET-CHICAGO, ILLINOIS 60612

TELEPHONE:
AREA CODE 312
738-2500 EXT. 834

March 1, 1968

Mr. Arthur C. King
Assistant Vice President, Medicare
Illinois Medical Service
300 North State Street
Chicago, Illinois 60601

Dear Mr. King:

Mr. Leon Silin, Assistant Regional Representative of the Bureau of Health Insurance, has advised me of arrangements for us to meet with you at your office at two o'clock, Wednesday, March 6th to discuss establishment of a program for reimbursement to members of the Associated Physicians of Cook County Hospital for their services to Health Insurance Program beneficiaries at Cook County Hospital. I have provided Mr. Silin with a number of background documents which I think might be helpful in connection with our discussions; he has asked that I also send a set of these papers to you.

The following papers are enclosed:

1. By-Laws of the Associated Physicians of the Cook County Hospital.

2. Application for membership and assignment form to be executed by members of the Medical Staff of Cook County Hospital.

3. Draft Guidelines for Appropriation of Funds.

The above papers will inform you with respect to the organization and purposes of the Association.

4. Draft statement of Principles and Procedures proposed as the basis for requests for reimbursement under the program.

5. Draft statement of proposed billing procedures.

EXHIBIT F

"TO PROMOTE MEDICAL AND SCIENTIFIC EDUCATION AND RESEARCH"

APPENDIX VI
Page 19

Items 4 and 5 are revisions of guidelines for the program established for the Professional Service Fund of New York University School of Medicine by arrangement with the New York office of the Bureau of Health Insurance and the carrier, United Medical Service of New York.

6. Copies of correspondence with UMS establishing the fee schedules for the NYU program.

7. Copy of my letter of February 21, 1967, to Commissioner Ball setting forth the basis for reimbursement under the Medicare program in the teaching setting at Bellevue Hospital.

I fully realize that the primary responsibility for approval of our program here at Cook County rests with the Illinois Medical Service, as carrier. I am sending you copies of correspondence relative to the NYU-Bellevue program in the hope that the precedents established with the New York program might be helpful in connection with our negotiations here.

We look forward to seeing you and Mr. Silin next Wednesday. Dr. Robert J. Baker, who is Associate Director of Surgery at Cook County Hospital and a Director of the Associated Physicians, will also attend the meeting.

Sincerely yours,

William B. Sale
Administrator

Enclosures
cc: Mr. Leon Silin
Bureau of Health Insurance

COPY

As adopted by
Board of Directors
March 20, 1968

ASSOCIATED PHYSICIANS OF COOK COUNTY HOSPITAL

Reimbursement for services of Attending Physicians
Federal Health Insurance for the Aged (Medicare)

PRINCIPLES AND PROCEDURES

I. Principles

A. Physician-Patient Relationship: Basis for Request for Reimbursement.

1. The professional care of patients of the Cook County Hospital is the responsibility of the attending physicians, appointed to the Medical Staff of Cook County Hospital by the Civil Service Commission of Cook County and the State of Illinois upon the recommendation of the Executive Staff of the Hospital.

2. The medical care rendered to each patient admitted to Cook County Hospital is the personal responsibility of the attending physician whose care he has accepted. In his relation to his patient, the attending physician demonstrates fulfillment of his responsibilities by such actions as:

a. Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission;

b. Confirming or revising diagnosis;

c. Determining the course of treatment to be followed;

d. Assuring that any supervision needed by the interns and residents was furnished, including supervision in person of major surgical procedures and other complex and dangerous procedures or situations;

e. Reviewing patient progress frequently; and

f. Authorizing discharge of patient.

3. In the actual rendering of care to his patient, the attending physician is assisted by other members of the attending staff who are available, at his request, as specialists for consultations and for rendering or supervising surgical or other procedures within their special areas of competence. Under his personal direction and supervision the attending physician is also assisted in the care of his patient by the interns and residents appointed to his Service.

Thus, the attending physician responsible for the care of his patient acts as the captain of a team of highly qualified associates

PRINCIPLES AND PROCEDURES (cont.)

and assistants, ensuring that his patient will have the full advantage of the highest professional knowledge and skills in every area of medical science, as well as the attending physician's own personal responsibility for the patient's care and welfare.

B. Assignment of Professional Service fees to the Associated Physicians of Cook County Hospital.

1. The professional care rendered to the patients by the attending physicians at Cook County Hospital is a primary and essential element of the physician's teaching responsibilities as a member of the Medical Staff of the Hospital. Whereas the attending physicians may be duly compensated by a school of medicine for their services as faculty members, and by the Cook County Board of Commissioners for medical administrative services at the Hospital, such reimbursement as may be available for their professional service to their patients, and for their directions to the interns and residents assisting in the care of their patients, shall accrue to the Professional Service Fund of the Associated Physicians of Cook County Hospital. Funds received shall be used solely for the furtherance of the purposes of the Associated Physicians of Cook County Hospital, in accordance with the authorization of the Board of Directors of The Associated Physicians of Cook County Hospital.

2. Pursuant to the above principles and considerations, the members have agreed to assign to the Associated Physicians of Cook County Hospital Professional Service Fund such payments as may be due for their professional services to patients at Cook County Hospital.

II. Procedures

A. Eligibility for Reimbursement

1. In order to qualify for reimbursement, the attending physician must have established his responsibility for the care of the patient in accordance with paragraph I, (A), (2) above, except as provided in paragraph II (B) (2) below.

2. All requests for reimbursement will be submitted in the name of the attending physician responsible for the care of the patient at the time of admission, unless the patient is permanently transferred to another Service. In the case of such transfers, reimbursement will be requested after the date of transfer in the name of the attending physician receiving the transferred patient.

3. When a patient is transferred temporarily to a second Service (such as to Ophthalmology, for special surgery, or for a consultation, such as to Medicine for a pre-operation examination) services rendered by the second Service will be billed in the name of the attending physician responsible for the special procedure or the consultation.

B. Billing Procedures

1. As of the effective date of the approval of these Principles

PRINCIPLES AND PROCEDURES

and Procedures by the Executive Staff of Cook County Hospital all patients' charts will include the following information essential for billing requests for reimbursement for services rendered to Medicare and Medicaid qualified patients:

a. A note signed by the attending physician or his designate within a reasonable period after admission indicating that the attending physician reviewed the patient's history and physical examination, his personal examination of the patient, confirmation or revision of the diagnosis, and determination of the course of treatment.

b. The operative note must include the name of the attending physician personally supervising in the case of a major procedure, or personally authorizing or directing other procedures.

c. In cases involving extended treatment in the Hospital, frequent progress notes, by the attending personally, or for him by interns and residents assisting in the care of his patient, should indicate when the patient's progress has been reviewed personally by the attending, and when he has given directions changing the course of treatment.

d. Request for consultations should indicate that they are at the direction or with the authorization of the attending physician responsible for the care of the patient.

e. Consultation notes should indicate the name of the attending physician responsible for the consultation.

f. Discharge note should be initialed by the attending physician.

2. With respect to the back-log of Medicare cases which may lack written confirmation of the explicit participation of the attending physician in accordance with the above procedure, and, subject to the concurrence of the Director of the Division concerned, it will be assumed that the care of the patient has been under the personal direction of the attending physician (a) indicated in the patient's chart, or (b) the attending physician assigned responsibility for patient care in the area in which services were rendered. With respect to surgical procedures, it will be assumed, with the concurrence of the Director of the Division concerned, that the attending physician indicated on the Operating Room Log Book provided personal supervision in the case of major procedures, and gave his personal direction in other cases.

APPENDIX VI
Page 23

BILLING PROCEDURES

I. Billing for Hospital Visits and Consultations

A. Initial visits. Every patient admitted to the hospital is given a complete examination and seen by the attending physician responsible for his care within the first twenty-four hours of his hospital stay. Every patient will be billed for the initial visit, as a separate item, either "Initial visit, Routine," or "Initial visit, Intensive."

1. Initial visit, Routine: When the patient is not suffering from a major illness (as defined on page 19 of UMS Handbook), and when the patient is not admitted directly to the Intensive Care Unit. The charge for Initial visit, Routine is $21.00.

2. Initial visit, Intensive: When the patient is admitted directly to the Intensive Care Unit or is suffering from a major illness. The charge for Initial visit, Intensive is $42.00

B. Follow-up visits. There shall be a charge for one visit for every day of hospitalization following the first day (covered by the "initial visit"), excepting that there shall be no charge for medical care while patient is awaiting disposition after treatment has been completed. Visits shall be charged either as "routine" or "intensive" care.

1. Unless "intensive care" is involved, all visits shall be billed as "routine," for which the charge shall be $7.00 per day.

2. If the patient is suffering from a major illness, daily visits shall be billed at the "intensive care" rate during the period, or periods, when intensive care is given. Ordinarily, periods of intensive care will coincide with periods of the patient's stay in the Intensive Care Unit. Daily visits during periods of intensive care shall be charged at the rate of $14.00

C. Consultations. Consultations are indicated as such in the Progress Reports of the patient's chart. Consultations may be requested of another Service or of a "sub-specialty" of the Service in which the patient is being cared for (e.g., a patient in Medicine could have a consultation by "Cardiology" even though Cardiology is a part of the Medical Service). Consultations are either Limited, Complete, or Follow-up.

1. A consultation is limited when the examination or evaluation is of a given system only (e.g., an Ophthalmology consultation, or a Surgical consultation having to do with a specific problem, would be limited consultations). The charge for a limited consultation is $21.00.

BILLING PROCEDURES (cont.)

2. A Complete consultation is one requiring a complete diagnostic history and examination and/or evaluation. (e.g., A Medical or Neurology consultation would usually be complete; a sub-specialty consultation would not.) The charge for a complete consultation is $49.00.

3. A Follow-up consultation is one which follows either a partial or complete consultation of the same kind not requiring a re-examination or re-evaluation of the patient. Such consultations are considered concurrent care and will be billed at the same rate as a daily visit: $7.00.

III. Billing for Surgical Procedures.

1. Surgical procedures will be billed in the name of the attending physician who personally supervised the procedure in the operating room or gave his personal direction to the resident performing the procedure. This will be the attending indicated in the operation note in the hospital chart, or, in the absence of an indication in the chart, in the name of the attending indicated in the operating room record of the hospital.

2. When the patient is admitted to the hospital for the sole purpose of performance of the operation, there will be no charge for up to three days of preoperation in-hospital care, or for postoperation care up to the number of days of "covered" postoperation care indicated in the "Schedule of Allowances." The regular charge for in-hospital medical care will be made for preoperation and postoperation care beyond the above periods.

3. When an operational procedure is incidental to other care, there will be a regular charge for all preoperation care, for care beyond the above-mentioned "covered" period, as well as for non-operation related concurrent care and services during the covered period.

4. Diagnostic surgical procedures (i.e., endoscopies and biopsies) will be billed in the name of the attending physician responsible for consultations or consultation supervision during the period concerned.

Note: Fees for surgical procedures shall be established through negotiation with the carrier (Blue Shield) in accordance with Social Security Administration Regulations.

APPENDIX VII
Page 1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

HI:PS:H

April 1969

BUREAU OF HEALTH INSURANCE
INTERMEDIARY LETTER NO. 372

SUBJECT: Part B payments for services of supervising physicians in a teaching setting

From questions which have been raised and from our onsite reviews, there appears to be a serious need to obtain a better and more uniform understanding among carriers, providers, and physicians of the conditions under which payment may be made under Part B for services rendered to patients by supervising physicians in the teaching setting and the method for determining the reasonable charge which may be recognized for such services. The enclosed guidelines are intended to clarify and supplement the criteria that govern reimbursement in this area as reflected in §§6102.7, 6335, and 6720 ff. of the Part B Intermediary Manual.

Carriers are urged to review their present reimbursement practices in light of these guidelines and to take appropriate action as soon as possible to bring practices into conformity with the guidelines. The Part B Intermediary Manual will be revised to incorporate these clarifications and additions.

Thomas M. Tierney, Director
Bureau of Health Insurance

Enclosure

Part B Payments for Services of Supervising Physicians in a Teaching Setting

A. Conditions Which Must be Met for a Teaching Physician to be Eligible for Part B Reimbursement as an Attending Physician

The physician* must be the patient's "attending physician." This means he must, as demonstrated by performance of the activities listed below, render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized; his services to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients.

1. To be the "attending physician" for an entire period of hospital care, the teaching physician must as a minimum:

   a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

   b. personally examine the patient; and

   c. confirm or revise the diagnosis and determine the course of treatment to be followed; and

   d. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and

   e. be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and

*The term "physician" does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff. For example, a senior resident who is referred to as an "assistant attending surgeon" or an "associate physician" would still be considered a resident since the senior year of the residency is essential to completion of the program.

f. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

EXAMPLE: A supervising physician carried out all of the activities listed above for a surgical patient but (e). He was not present in the OR when the major surgery was performed because supervision of the 5th-year resident performing the operation was not required. A physician's charge would not be recognized for the surgical procedure because criterion (e) was not met. Therefore, the physician would not be an attending physician for the period of hospital care although he might meet the criteria listed in A.2. below and be held as the attending physician for a portion of the care provided.

Even if the supervising physician chose to be present in the OR, payment could not be made to him for the surgical procedure since his presence was not medically necessary and he could not, therefore, function as the attending physician in connection with the surgery. However, if he was scrubbed and acted as an assistant, payment could be made to him as a surgical assistant if such an assistant was needed and another resident or physician did not fill the role (see item A.2. below).

If the supervising physician was present at surgery, and the surgery was performed by a resident acting under his close supervision and instruction, he would not be the attending surgeon unless it were customary in the community for such services to be performed in a similar fashion to private patients who pay for services rendered by a private physician.

EXAMPLE: A group of physicians share the teaching and supervision of the house staff on a rotating basis. Each physician sees patients every third day as he makes rounds. No physician can be held to be one of these patient's attending physician for any portion of the hospital care although consultations and other services they personally perform for the patient might be covered.

2. A teaching physician may be held to be the attending physician for a portion of a patient's hospital stay: if the portion is a distinct segment of the patient's course of treatment (e.g., the pre-operative or post-operative period) and of sufficient

32-108 O - 69 - 27

duration to impose on the physician a substantial responsibility for the continuity of the patient's care; if the physician, as a minimum, performs all of the activities described above with respect to that portion of the stay; and if the physician is recognized as the patient's physician fully responsible for that part of the stay. If a teaching physician is not found to be the attending physician with respect to a portion of a patient's stay, he may not be reimbursed for any service provided to the patient for that portion of the stay unless it is an identifiable service that he personally rendered to the patient.

EXAMPLE: A physician carried out all of the activities listed above for a surgical patient until midway in the post-operative period, when the physician's teaching tour of duty ended. Since he was not responsible for the continuing care of the patient throughout the post-operative period, he cannot be reimbursed as the attending physician for that period.

3. Performance of the activities referred to above must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician.

4. The services of a teaching physician while visiting patients during grand rounds is basically teaching and does not contribute to an "attending" relationship with any of the patients visited.

5. An emergency-room supervising physician may not customarily be considered to be the attending physician of patients cared for by the house staff. It is only through his direct personal involvement with a patient that a charge may be recognized under Part B. Such an involvement would necessarily include personal examination of the patient as well as direction of and responsibility for the treatment provided.

B. Determining the Amount Payable Under Part B

1. The amount paid for direct medical services rendered by the teaching physician should be related to only that discrete portion of the patient's care for which the physician exercised the pertinent responsibilities of an attending physician outlined in A.1. For example, if the patient's personal physician furnishes services before the hospital admission and after the discharge and the teaching physician becomes the attending physician only with respect to the inpatient care, the lesser extent of the teaching physician's service should be taken into account in recognizing a charge; otherwise the out-of-hospital service would be billed for and paid twice. Sinilarly, if surgery was performed and the teaching physician rendered identifiable personal service to the patient in the operating

room, it is necessary to determine whether that physician performed services more nearly analogous to a consultant, an assistant at surgery (see first "Example" in part A), or as the "attending" surgeon in order to identify the appropriate reasonable charge. If the physician acted as the attending surgeon but did not render the pre- or post-surgical services generally performed by a private surgeon to a private patient, the difference in service should be reflected in the amount of reimbursement.

2. The following conditions should be taken into account in determining the "customary" charges of teaching physicians for services which they provide as attending physicians to Medicare beneficiaries.

   a. If the teaching physician has a substantial practice outside the teaching setting (i.e., more than half of the time spent in the practice of medicine is spent caring for people who were his patients before they were hospitalized or who were referred to him by physicians responsible for their care outside the hospital setting), his "customary" charges for services in the teaching setting will be related to the amounts he charges for similar services in his outside practice. Where the services performed in the teaching setting differ from those in the outside practice, reductions should be made for the lesser scope of services provided, time spent, visits or responsibility as an attending physician (not counting supervisory acts as time or visits).

   b. If the teaching physician does not have a substantial practice outside the teaching setting and the provider has established one or more schedules of charges which are collected for medical and surgical services furnished to a majority of non-Medicare teaching patients, his charges should be related to the provider's schedule of charges which are most frequently collected.

   EXAMPLE: A hospital with an approved teaching program receives payment for physicians' services rendered to 80 percent of its non-Medicare patients. Fifty percent are paid for by public assistance under a relatively low payment schedule; 20 percent are covered under a Blue Shield Plan with a somewhat higher fee schedule and the balances are covered under commercial plans. Since collections are made for a majority of patients and the most frequently used schedule of payment is the welfare schedule, the welfare schedule of charges should serve as the basis for determining the teaching physicians' customary charges for Medicare.

c. Where neither the physician nor the provider has established charges for the physician's services which are in effect for non-Medicare patients, the carrier and intermediary must make the necessary charge and cost determination based on that portion of the physician's compensation which is for services to patients, determined pursuant to the regulations governing reimbursement for the services of provider-based physicians.

3. Where teaching physicians of a hospital, billing through a hospital or other organization, adopt a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting, carrier acceptance of the schedule for reimbursement purposes should be based on a finding that the schedule does not exceed the average of reasonable charges which would be determined if each physician were individually reimbursed his reasonable charge for the services involved.

4. In determining the number of visits which may be considered reasonable, e.g., in a course of treatment for which a global fee is not ordinarily charged, the total number of visits which would have been made to the patient in a nonteaching setting should be used as a guide; visits in excess of this number are presumed to be primarily for teaching purposes. Similarly, total reasonable charges for a course of treatment in the teaching setting should be compared with and should not exceed the charges that would be expected in nonteaching settings for similar services. Also, the charges billed for an hour of a teaching physician's services should not exceed the amount of fees the physician generally receives for an hour's work in caring for nonteaching patients.

5. Where payment is made under Part B on a reasonable charge basis, payment may not also be made on a cost basis to the hospital for the same service as a teaching service. Part A payments to the hospital should therefore not be based on the total compensation of the physician if that compensation is in part for patient care. The total compensation should be reduced by the portion paid for patient care in accordance with the applicable provisions of the principles of reimbursement for services of hospital-based physicians to arrive at the hospital cost portion. Allocation of compensation received between both parts of the program should be in accordance with how the physician's time is actually spent. If a physician's only compensation for services in a teaching setting are paid by the hospital and the agreement states that only the supervisory, and not patient care, services are compensated, it is necessary to look behind the words of the agreement by reviewing the physician's actual obligations and activities and determining whether the compensation level is

reasonable for the supervisory and teaching services alone and insufficient to cover patient care services as well. The carrier and intermediary should make this finding jointly.

EXAMPLE: An employment agreement between a physician and the hospital states that he will be paid $50,000 a year for administration, supervision and teaching. However, he spends one-half of his time in providing patient care. The carrier and intermediary determined that if his compensation were allocated solely to the time the physician spent in the performance of his hospital duties, it would yield an hourly rate of compensation about double the rate paid for similar work elsewhere in the area. Therefore, the carrier and intermediary concluded that only a portion of the compensation was for hospital activities and reimbursable under Part A. Since charges were not customarily billed for the medical services the physician provided, the remainder would serve as a basis for computing the physician's reasonable charges for patient care in accordance with B.2.b. above.

C. Carrier Responsibilities for Claims Review and Verification

1. The carrier is responsible for assuring that the bills being submitted were prepared with an understanding of the conditions governing payment for physicians' services in the teaching setting.

   To help carry out this responsibility, carriers will not pay bills (SSA-1490 or SSA-1554) for services rendered in the teaching setting in any month after May 1969, unless:

   a. the chief of the department or service involved certifies on a form furnished by the carrier that each of the billed services for that month meets the pertinent requirements of A.1.; or

   b. the bill has been signed by the attending physician and he understands that he is certifying that he met the requirements for those services for which the claim is made.

2. The provision of personal and identifiable services must be substantiated by appropriate and adequate recordings entered personally by the physician in the hospital or, in the case of outpatient services, outpatient clinic chart. The carrier is expected as part of its responsibilities to make appropriate checks of patient records, examining admission, progress, and discharge notes to verify that services for which charges are billed met the appropriate coverage criteria. If the carrier

review shows that a significant portion of the services in the sample do not meet the criteria, appropriate steps should be taken to adjust the reimbursement.

3. Bills must indicate when services are furnished in the teaching setting, the name of the provider and attending physician involved, and the extent of the services provided as an attending physician. The services must be defined and quantified to avoid errors in applying the reasonable charge limitation--e.g., to avoid applying the reasonable charge for a global service where only the surgical procedure or another component service was provided as an attending physician.

4. The carrier will need to carry out the steps necessary to assure itself that these conditions set out in B.1. are met--for example, to assure itself that any schedule of charges proposed for the teaching setting is actually applied and collected.

D. Who May Bill

Where the supervising physician is a member of a group which provides teaching services in a hospital, the Part B payment for services rendered as attending physicians by the group may be billed for:

1. by the physician or a corporation, partnership, or other organization of physicians (including an association of teaching physicians organized for the purpose of billing for and distributing insurance monies and other payments received for professional services to patients) on form 1490;

2. by the hospital on form 1554 provided that the carrier has determined that the certification described in C.1.a. has been executed and complied with; and

3. if the services are performed by a physician who is a faculty member of a medical, osteopathic, or dental school, by the school on form 1490.

The individual physician's authorization is required to be on file in writing with the hospital or other organization to permit any of the above organizations to bill on his behalf. The organization must furnish to the Part B carrier the names of the physicians who have authorized the organization to bill on their behalf, and must agree to keep the carrier informed on a current basis of changes in membership in the group.

APPENDIX B

Social and Rehabilitation Service and Social Security Administration Comments on Committee on Finance committee print entitled "Staff Data Relating to Medicaid-Medicare Study"

(Separate Comments of Robert J. Meyers, Chief Actuary, Social Security Administration, Appear at Page 445)

Social and Rehabilitation Service and Social Security Administration Comments on Committee on Finance committee print entitled "Staff Data Relating to Medicaid-Medicare Study"

The Social Security Administration and the Social & Rehabilitation Service hope that the following comments on the preliminary findings of the Committee staff as presented at the hearing in a series of charts will be helpful in amplifying and clarifying the record being compiled by the Committee. The comments are presented under an underlined reference to a legend on a chart or to the portion of the text accompanying the chart presentation.

Many of these comments—particularly those on the early charts—are clarifications with respect to the financial and actuarial information presented by the Committee staff. The comments with respect to the later charts—those focused on administration—present additional information to place in perspective the preliminary findings of the Committee staff which in many instances are based on a relatively small number of cases of abuse, generally identified by the Social Security Administration and reported to the Senate Finance Committee for its information.

As indicated by these comments, an understanding of the cost of administration for an insurance system does not require consideration of raw dollar amounts, but rather of the relationship of expenses to the size of the operation and of a comparison of this cost ratio with those of other programs. For this reason, information is offered on the cost of administering Medicare as a percentage of benefit outgo and the favorable relationship of this ratio to similar ratios for private insurance operations. Similarly, an appraisal of the actuarial estimates for a system requires consideration of the relationship of income to outgo rather than merely dollar outgo, and the date required for such consideration has been supplied.

As further indicated by our comments, administrative vigor should not be judged wanting solely because several instances of abuse or areas for improvement of administration are uncovered by the administering organization. Indeed, the existence of systems and procedures for uncovering such instances and ongoing corrective action seem to be the very hallmark of vigorous administration. As far as is known, no health insurance system has been able to avoid all possibilities of abuse, nor has any program reached perfection in its administration. In these comments information is offered on the corrective actions taken with respect to the instances of program abuse and carrier and intermediary deficiencies (most of which were uncovered by program monitoring systems).

In some cases the preliminary findings indicate a difference of opinion with the Social Security Administration as to the intent of the Medicare law. For example, an opinion expressed in the Committee's report is that the intent of the law was to limit payment under the program to the amounts paid by private regional carriers for their own subscribers. The report does not exclude from the limitation carrier programs that were designed to pay only a small part of the physician's actual charge to the beneficiary. The Social Security Administration quotes the appropriate committee report language and other evidence to show why the Social Security Administration is of the opinion that the July 1 Committee presentation is only partially correct. In other cases the preliminary findings indicate a difference of opinion with the Social Security Administration as to the advisability of an administrative action taken at the outset of the program. For example, the report states that Social Security account numbers should have been used to identify physicians from the start of the program. The Administration has presented the reasons for its original action not to use the Social Security number as well as the fact that a change is now supported by the Social Security Administration.

CHART 1.—Medical assistance: Vendor payments for medical care

Current estimates of medical vendor payments (Federal, State and local) total $4,980,188 not $5.5 billion. The total for fiscal year 1970 should be $5.0 rather than $5.5; this is the total of the Federal share which compares to the $2,680,305 in the revised President's budget for medical assistance. This excludes amounts paid for intermediate care which is funded under the other public assistance titles.

CHART 2.—Revision in estimates of fiscal year 1969 medicaid costs

The $1.58 billion was the estimate that had been used by the congressional committees earlier in 1967 when the Congress was considering amendments to the Social Security Act. It is, therefore, true that the quoted figure is the figure the Congress has and used in December 1967. Final figures for the President's budget had not been developed at the time the conferees met.

In January 1968, President Johnson's budget indicated an estimated expenditure of $2.118 billion in Federal funds for medical assistance for fiscal year 1969.

CHART 3.—Increased medicaid costs outstrip increases in numbers of people served

The total should be $5.0 billion not $5.5 billion for 1970. The percentage increase in expenditures is therefore 43% and 57%.

CHART 4.—These are the trends that occurred

CHART 5.—Actuarial estimates of 1970 and 1990 hospital insurance benefits

The chart correctly reflects the changes in the estimates of cash disbursements that have been made since 1965. However, concentrating solely on the dollar figures obscures the fact that to a considerable extent the same inflationary situation that is responsible for a significant part of the increase in the estimate of dollar disbursements also creates a significant increase in the income to the program since, as earnings go up, program income—which is based on a percentage of payroll—also goes up. The financial soundness of the program, therefore, does not depend so much on dollar disbursement as it does on the relationship between disbursements and contribution income.

A more accurate perspective on previous versus current cost estimates—both as to the financial soundness of the program and the impact on taxpayers—is provided by a comparison of the 1965 and 1969 estimates expressed as a percent of taxable payroll. The contribution rates established in 1965 were based on an estimated level cost of 1.23 percent of payroll; the 1969 estimate is 1.79 percent. The increase in estimated cost, therefore, has been about 45 percent, not double. The 1969 rate is figured on a higher earnings base, $7800, and on more recent earnings levels than the 1965 estimate, which is figured on a $6600 base and on earlier, lower earnings levels. Thus the total taxable payroll on which the present estimate is figured reflects increases in general wage levels, which increases produce additional income offsetting the effect of inflation on benefit costs. (Average earnings have increased approximately 27 percent during the period 1965–1969, rather than by 13 percent as estimated in 1965. Thus, the increase which has occurred in taxable payroll very nearly corresponds to the inflationary effect that appears when the 1965 and 1969 estimates of the cost of the program are compared in dollar terms.)

The 45 percent underestimate is primarily due to (a) an underestimate of hospital utilization by the aged, (b) an underestimate of the differential between the increase in hospital costs and the increase in average earnings, and (c) underestimate of utilization of extended care facilities.

The 1965 assumptions on utilization were based primarily on data obtained on a sample basis in a 1957 survey of beneficiaries conducted by the Social Security Administration. The use of such data was validated by a comparison with data obtained in a 1963 survey of the aged carried out by the Bureau of the Census for the Social Security Administration. As it developed, the data

used in 1965 resulted in a considerable understatement of hospital utilization under the program. Data based on experience under the program did not become available until 1968 in a form that could be used for estimating purposes.

The estimates made in 1967 reflected the sharp increase in hospital per diem rates that was taking place—not, of course, just under Medicare but generally. In the absence of anything more current in the way of utilization data than those which were used in the original cost estimates, utilization was assumed to be as originally estimated. Utilization estimates were modified for the first time in 1968, when actual data on an accrual basis for the first year became available. Evidence to date indicates that there has not been an upward trend in utilization since the program went into effect.

CHART 6.—Hospital insurance trust fund due to be exhausted in 1976

We believe that the income to the hospital insurance trust fund should be increased, and we are developing recommendations for this purpose. However, the Committee will want to keep in mind that the prediction that the hospital insurance trust fund will be exhausted in 1976 results from a cost estimate which assumes, on the one hand, that taxable earnings under the program will increase from year to year and that nevertheless the maximum earnings base will remain at $7800 during the entire 25 year period over which the estimates are made.

Congress has increased the earnings base from time to time in the past as the general earnings level rose, because such increases are necessary if the cash benefits program is to be kept reasonably up to date. In all probability it will do so in the future.

To the extent that the maximum earnings base is increased during the next 25 years, costs measured as a percentage of payroll will drop. Since it seems most unlikely that, if earnings levels rise in the future, the earnings base will be kept at the same level, it can be seen that these cost estimates are based upon very conservative assumptions and that it is unlikely that, given the presently scheduled contribution rates, the fund would actually be exhausted in 1976.

CHART 7.—Restoring actuarial soundness of hospital insurance program

On the basis of cost estimates which assume a continuation of the $7,800 maximum earnings base and, nevertheless, rising earnings, the long-range balance of the program is a —0.29 percent of payroll.

The chart suggests that one way to restore the actuarial soundness of the program would be to "control costs." We believe there are some cost savings possible by continually improved hospital administration and by continually improved administration of the Medicare law. However, we do not believe that a deficit in long-range financing of the size indicated by this estimate could be offset by the imposition of additional cost controls unless one were willing to abandon the principle of paying for the full reasonable cost of institutional care for Medicare beneficiaries. In other words, we know of no way in which cost savings under the program could be made that would be anywhere near sufficient to meet this imbalance unless some of the cost of Medicare patients were to be shifted to non-Medicare hospital patients.

The alternative of increasing the inpatient hospital deductible from $44 to $175, also mentioned in the chart, is an opinion. Those who would be affected however, are, for the most part, a low-income group, and a deductible of this size would be a barrier to their getting needed hospital care.

One way to restore approximate actuarial balance to the hospital insurance program under these assumptions would be to make the ultimate contribution rate of 0.9 percent, now scheduled to take effect in 1987, effective in 1975.

CHART 10.—Extended care benefits in 1967

The text accompanying this chart indicates that "actual experience in 1967 showed that the cost per beneficiary per year was $18—10 times the earlier estimate." This is factually correct for 1967 but misleading in its implication of runaway costs.

The actuarial estimates prepared in 1965 for the final bill were for total hospital and extended care facility utilization together. This was assumed to be appropriate because extended care facilities services were planned as a substitute for and a lower-cost alternative to hospital services. Thus, to a considerable extent, an increase in extended care facilities utilization was expected to mean a decrease in hospital utilization.

The estimate referred to in chart 10, then, was of the *proportion* of total utilization that would be in extended care facilities in the early years of the program. This estimate assumed that utilization would be restricted during the early years of the program by a severe shortage of extended care facilities participating in the program. However, the actual number of beds that qualified under the program was close to what had been anticipated in the long run. The underestimate of the proportion of utilization that would be in extended care facilities in 1967 has had very little effect on the long-range cost estimates, the cost of extended care facility benefits as estimated originally as well as currently is about 15% of the hospital insurance program costs. In the short run, the greater utilization of extended care facilities may have been offsetting in terms of what otherwise might have been a greater utilization of hospitals.

CHART 11.—Supplementary medical insurance deficit on an accrual basis

The text accompanying the chart indicates that "the $4 monthly premium for fiscal year 1970 is expected to be about 10 percent too low." It is very difficult to say at this point what the experience will be during fiscal year 1970. It is true that the actuaries have estimated that accrued disbursements for fiscal 1970 will be about 10 percent higher than the funds provided by the $4 premium that is in effect. Those estimates were based on the assumption that the SMI program will recognize a 5 percent increase in physician fees during fiscal 1970. Although it now appears likely that fees will go up by even more than this percentage, it is quite possible—because of the directives that we have given the carriers to hold the line on the recognition of fee increases—that the cost of the program may not increase as much as was estimated.

CHART 12.—Restoring actual soundness of supplementary medical insurance program

As indicated in the comments on Chart 11, it is not clear whether it would be necessary to raise the premium rate to $4.40 to meet the cost of the present program during this fiscal year. In any event, raising the deductible to $80 would reduce the amount of insurance coverage provided by part B of the program. The carriers are already under instructions to recognize increases in fees in only very exceptional circumstances, and there do not seem to be major cost control actions beyond those in effect that would be consistent with program objectives and also have major cost effects. To reduce reimbursement for physicians below the current level could well result in shifting cost to the beneficiaries. At present, the administration's approach is to continue present efforts to control costs and to closely watch the experience under the program. A new rate for the next fiscal year must, of course, be promulgated in December 1969.

CHART 13.—Increases in physician fees

While the text correctly states that the increase in physician fees was more than twice as rapid between June 1965 and June 1967 than had been estimated, the way in which the increases are charted might suggest that actual fees (and therefore the cost of the supplementary medical insurance program) more than doubled during the period. An example will help to put the effect of the underestimate in perspective: If a premium of $3 was required, assuming a given level of physician fees, an increase of 6.5 percent in fees instead of an increase of 3 percent (as was estimated in 1965) would mean an increase in the premium of 19½ cents, rather than of 9 cents.

Moreover, the gross increase in physicians' fees does not automatically determine how much the cost of the supplementary medical insurance program will rise. The increase in program cost results from recognition by the program of fee increases in the "reasonable charges" on which benefit payments are based.

Current estimates of program cost are expected to be subject to less than the 8% error occurring for the July 1966–June 1969 period and to be within 5% of the actual experience.

Incidentally, it is misleading to carry the 1965 estimates to 1970, because under the law estimates of physicians' fees and other components of the cost of the supplementary medical insurance program have never been made on a 5-year basis. The 1965 estimates covered only a period of about 2½ years.

Memoranda from Social Security Administration actuaries follow:

MEMORANDUM

SOCIAL SECURITY ADMINISTRATION,
July 13, 1969.

To: Mr. Robert M. Ball, Commissioner of Social Security.
From: Gordon R. Trapnell, Actuary.
Subject: Comparison of original and current estimates of Supplementary medical insurance accrued cost.

Original estimates

The "original" estimate of accrued supplementary medical insurance benefits and administrative costs for any period is taken to be the estimate on the basis of which the premium rate was set for that period.

Current estimates

The current estimates of supplementary medical insurance accrued disbursements are based on incomplete data for 1966 and 1967, and only fragmentary data concerning 1968. However, the estimates are believed to be within 5% of the actual experience.

Enrollment

Since the supplementary medical insurance program is financed by premiums and matching Government contributions, a change in enrollment results in proportional changes in income and disbursements. Consequently, any comparison of estimated and actual disbursements should be based on the same number of enrollees. The original estimates have been restated using the actual supplementary medical insurance enrollment in each year.

	Period			
	July 1966 to December 1967	January 1968 to March 1968	April 1968 to July 1969	July 1966 to June 1969
1. Original estimates of accrued disbursements per capita per month:				
Benefits	[1] $5.23	[2] $6.56	[3] $7.23	
Administration	.60	.63	.65	
Total	5.83	7.19	7.88	
2. Average enrollment (millions)	17.8	18.1	18.7	
3. Original estimates of total accrued disbursements (millions):				
Benefits	$1,676	$356	$2,028	$4,060
Administration	192	34	182	420
Total	1,868	390	2,210	4,480
4. Current estimates of total accrued disbursements (millions):				
Benefits	$1,824	$360	$2,184	$4,368
Administration	242	42	231	515
Total	2,066	402	2,415	4,883
5. Ratio of original projection to current estimate (percent):				
Benefits	92	99	93	93
Administration	79	81	79	79
Total	90	97	92	92

[1] Memorandum to R. J. Myers of July 29, 1965, "Income and Disbursements from SMI Trust Fund in 1966–67."
[2] 1967 Trustees report (Mar. 27, 1968); app. IV, table A.
[3] 1967 Trustees report (Mar. 27, 1968).

The total error was $415 million over the 3-year period, or approximately $140 million a year.

GORDON R. TRAPNELL.

JULY 20, 1965.

ROBERT J. MYERS, *Chief Actuary.*
GORDON R. TRAPNELL, *Actuary.*

Income and Disbursements from SMI Trust Fund in 1966–67, *Cash* Basis, Under 1965 Amendments to the Social Security Act:

1. Number eligible to participate:
   (i) On July 1, 1966: 19.08 million (after omitting 20,000 aliens and subversives).
   (ii) Average eligible, July-December, 1966: 19.18 million.
   (iii) Average eligible, 1967: 19.35 million.
2. Original contingency fund (appropriation requested): 19.08 x $18=$343.44 million.
3. Contributions ($3 per month from each of insured and Government).

CONTRIBUTIONS FROM INSURED

Year	Population (millions)	Participation (percent) 100	95	80
1966	19.18	$345	$328	$276
1967	19.35	697	662	558

4. Benefit payments:
   A. *Low-cost estimate:*
      Cost of benefits in 1967, as passed by House $4.60
      Additional cost of conference version ..... .21
      Cost of conference version, 1967 ..... 4.81 } 4.70
      Cost in 1966 (2 percent less) ..... 4.72 }

	Population (in millions)	Number of months	Benefit cost (per month)	Participation (in millions) 100 percent	95 percent	80 percent
Cost in 1966	19.18	3	$4.72	$272	$258	$218
Cost in 1967	19.35	12	4.81	1,117	1,061	894

Assumes that claims incurred but unreported are 25 percent of one year's incurred claims (an average lag in payment of 3 months).

   B. High-cost estimate:
      Cost of benefits in 1967, as passed by House 5.50
      Cost of conference version, 1967 ..... 5.71 } 5.67
      Cost of conference version, 1966 (2 percent less) ..... 5.60 }

	Population (in millions)	Number of months	Benefit cost (per month)	Participation (in millions) 100 percent	95 percent	80 percent
Cost in 1966	19.18	4	$5.60	$430	$409	$344
Cost in 1967	19.35	12	5.71	1,326	1,260	1,061

Assumes that claims incurred but unreported are 16.7% of one year's incurred claims (an average lag in benefit payment of 2 months).

5. Administrative costs:

Year	Population (in millions)	Number of months	Benefit cost (per month)	Participation (in millions)		
				100 percent	95 percent	80 percent
A. Low cost ($.40 per month per capita):						
1966	19.18	12	$0.40	$92	$87	$74
1967	19.35	12	.40	93	88	74
B. High cost ($.50 per month per capita):						
1966	19.18	12	.50	115	109	92
1967	19.35	12	.50	116	110	93

(A full year's administrative expenses were assumed for 1966.)

GORDON R. TRAPNELL.

SMI TRUST FUND—SUMMARY OF INCOME AND DISBURSEMENTS, 1966-67

[Conference bill]

Type program and calendar year	Contributions		Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
	Participants	Treasury				
Low-cost, 80 percent participation:						
1966	$275	$275	$220	$65	$5	$270
1967	560	560	895	75	15	435
Low-cost, 95 percent participation:						
1966	325	325	260	80	5	315
1967	665	665	1,060	90	15	510
High-cost, 80 percent participation:						
1966	275	275	345	85	5	125
1967	560	560	1,065	95	5	90
High-cost, 95 percent participation:						
1966	325	325	410	100	5	145
1967	665	665	1,260	110	5	110

Note: Figures for contributions and administrative expenses are the same as those in the report of the House Ways and Means Committee on H.R. 6675 as passed by the House.

CHART 14.—Intermediary and carrier costs

When measured in dollars, as is done on this chart, the data obscure the fact that a considerable portion of the increase in intermediary and carrier costs is attributable to larger workloads than were originally anticipated and to the general inflationary situation in which wages and other costs of doing business have risen more than was anticipated. Administrative costs measured as a percentage of benefits paid are not excessive. The entire cost of administering the hospital insurance program in the fiscal year just completed, including not only intermediary and carrier costs, but Social Security and Internal Revenue costs, was 2.4 percent of the benefit payments made. Intermediary costs alone were 1.7 percent of total benefit payments.

In part B it has always been anticipated that administrative expenses in relation to payments would be much larger than for part A because of the great volume of small bills (33 million bills were paid under part B during the last fiscal year). The entire cost of administering part B as a percent of part B benefits paid for the last fiscal year was 11.4 percent. The percentage for carrier costs alone was 7.7 percent.

In both parts A and B, the administrative costs of the Government program when measured as a percentage of benefits paid are generally in line with what it costs private organizations to perform similar functions. It should also be kept in mind that a careful job of overall cost control requires greater expenditures of administrative money; in other words, a dollar spent for administration may save several dollars of expenditures for benefits.

CHART 15.—Preliminary findings: Medicaid

Section 237 of the 1967 amendments to the Social Security Act requires States to establish methods and procedures designed to safeguard against unnecessary utilization of health care and services, as well as to assure that payments (including payments for drugs) do not exceed reasonable charges and that they are made on a basis consistent with efficiency, economy, and quality of care.

Departmental policy to implement the regulatory authority provided by section 1902(a)(30) was published in the Federal Register on January 25, 1969, and March 4, 1969. Copies of these regulations are enclosed.[1]

Capability of utilization review varies with each State. This was established this last winter when the States' responses to a Social and Rehabilitation Service telegram requesting a status report on utilization review in each title XIX State were evaluated. Last May this was followed up by a letter to the Director of each State Medicaid plan in all States where it appeared that utilization review was inadequate. The letter asked what each State was doing or intended to do to safeguard against unnecessary utilization. Responses at this date are still being received and reviewed by the Medical Services Administration which is responsible for the title XIX program. Further actions will be taken as necessary.

Within the Medical Services Administration, "Guidelines" on utilization review are being written with the advice and counsel of appropriate consultants and professional organizations. These guidelines, now in draft form, are being cleared for publication. They will offer to the States not only an explanation of the general concept of utilization review but specific suggestions a State may employ in its utilization review program, for example, the use of audit tolerance levels (all claims above a specified dollar amount for a specified time period are automatically selected for additional scrutiny). The first two services to be covered by these guidelines will be inpatient hospital care and skilled nursing home care which together account for approximately 70 percent of Medicaid expenditures.

In the area of controlling costs of practitioner services, the Department established an Ad Hoc Medicaid Task Force under the chairmanship of Mr. James G. Haughton, First Deputy Administrator of the New York City Health Services Administration, to help assess the methods the States are using to reimburse physicians and other Medicaid practitioners. The Task Force included representatives from health professions, providers of Medicaid services, third-party payers, and consumer groups. The recommendations generated by this group were incorporated in regulations published in the FEDERAL REGISTER on July 1, 1969, with an invitation to interested parties to respond in writing within 30 days. Enclosed is a copy of the July 1, 1969, policy regulation.

The Medical Services Administration has provided consultation to a number of States on the matter of utilization review. There follows a copy of an example of our consultative efforts:

STATE OF NEBRASKA,
Lincoln, May 2, 1969.

Mr. ROBERT H. FINCH,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: Cooperative effort between the Federal and State levels of government can result in lower costs and better utilization of the tax dollar. A dramatic illustration of this point is the recently completed Drug Utilization and Control Program undertaken by the Nebraska Department of Public Welfare with the assistance and advice of Dr. Bradley Neer of your staff.

Dr. Neer coordinated the development of methodology which has resulted in a considerable degree of control in our Nebraska Title XIX Medicaid Program. The savings because of this assistance is projected to be approximately $500,000 over the next biennium.

We express our appreciation to you, your staff, and particularly to Dr. Neer for this worthwhile effort.

Sincerely,

NORBERT T. TIEMANN, *Governor.*

[1] Regulations referred to were made a part of the official files of the committee.

The Committee might be interested in some comments on the statement that the impact of Medicare is one of the reasons for the high cost of Medicaid. It is true that following the Medicare formula for reimbursement to hospitals did significantly increase the costs of the assistance programs beyond what they would have been if the States had been allowed to continue the frequent practice of paying for the hospital care of welfare recipients and the medically indigent at rates that were significantly below cost. The 1965 amendments, however, required that reimbursement under title XIX for hospital services be on the basis of reasonable cost in order to prevent a possible adverse effect on hospitals or a shifting of such costs to other programs such as Blue Cross, private commercial companies, or to paying patients. A major departure from the Medicare reimbursement formula to pay less under Medicaid would have had the effect of having part of the reimbursement for Medicaid recipients actually paid for by others.

The provision of law requiring that reimbursement be on the basis of reasonable cost is the major reason for higher costs than would have been produced by the earlier State practice of negotiating bargain rates for assistance recipients.

By and large, reimbursement for care in skilled nursing homes under Medicaid is still on a negotiated rate basis, as it was under the public assistance legislation that preceded the 1965 amendments. There is no Federal requirement that such care be paid for on the basis of reasonable cost and most States have continued to pay negotiated rates rather than follow the Medicare reimbursement formula.

COMMENTS ON CHARTS 16, 17, AND 18

There are a few legends on these three charts with which we specifically disagree; more frequently, however, we have reservations about the specific wording which often implies that a situation is more widespread than we believe it to be. As indicated in the comments below, there are specific instances of abuse or inadequate performance which are related to most of the generalizations made on the chart, but we do not believe that the summary statements fairly characterize the operation of the program as a whole.

In working on this investigation with the staff of the Senate Finance Committee, we have transmitted many examples of various kinds of abuses that our staff has discovered, and other examples have come to light in the course of the investigation. On the whole and in general, however, we believe—given the unprecedented nature of this program, the newness of many of its requirements, the large number of organizations and people involved, and the inherent difficulty of its administration—that it can be fairly said that the great majority of physicians, hospitals, extended care facilities, carriers and intermediaries, State agencies and others involved in the administration of the program have performed as well as they have performed for programs in the private sector. Thus, as a matter of emphasis, we think that many of the statements on these three charts do not correctly reflect what has been happening in the Medicare program. More importantly, perhaps, the charts do not reflect the fact that the abuses and problems have, in large measure, been brought to light by the monitoring efforts of the Social Security Administration and that in instance after instance, strong action has been taken to remedy the defects.

CHART 16.—Preliminary findings: Physician reimbursement

The first preliminary finding on this chart is summarized as Congressional Intent Not Followed. The text accompanying the chart indicates that the "intent" referred to is that carriers should pay no more under Medicare than for their private subscribers. Actually, the law limits the application of this principle to the situation where the carrier makes a payment for its own subscribers "for a comparable service and under comparable circumstances." Otherwise, the carriers are required to determine whether the charge is reasonable, and the main guide-

lines in the law for making this determination are the customary charge made by the particular physician to his patients generally and the prevailing charge of all physicians in a given locality.

The congressional intent as indicated in the report of the Senate Finance Committee seems quite clear. On page 44 of the report accompanying the 1965 amendments, the Committee stated:

"Where payment by the program is on the basis of charges (for physicians' services and medical and other health services not furnished by providers of services), the carriers would take action to assure that the charge on which the reimbursement is based is reasonable and is not higher than the charge used for reimbursement on behalf of the carriers' own policyholders or subscribers for comparable services and under comparable circumstances. In addition, where payment is on the basis of an assignment, the reasonable charge would have to be accepted as the full payment. The Committee has inserted into the bill the House report language that, in determining reasonable charges, the carriers would consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.

"The committee believes that the use by carriers of certain existing mechanisms and procedures will help in the determination of whether a charge is reasonable. For example, procedures established by State or local medical societies for resolving fee disputes are regularly utilized by carriers. Such arrangements could be used not only to settle questions between carriers and physicians but also between patients and physicians when the patient believes that an incorrect charge has been made. Also, the use of relative value scales, where they have been agreed upon, is helpful in establishing a reasonable relationship between payments for various medical procedures. And, where service benefit plans, for payment for physicians' services, serve as carriers under the program, the use of the same agreed-upon fee schedules that are employed in their own programs may be helpful in avoiding the possibility of disputes regarding fees."

We believe it is clear from the law and from the legislative history that reasonable charges under Medicare were not to be limited to amounts paid by private insurers under their own plans when such payments were unrelated to the total liability of the patient and, on the contrary, were only in partial indemnity for what the patient would have to pay. Such plans are not comparable to the Medicare program, which was, generally speaking, designed, except for deductibles and coinsurance, to relieve patients of what they would otherwise have had to pay the physician.

If the most widely held Blue Shield schedule were interpreted as being comparable and as limiting payments wherever Blue Shield plans are carriers under part B, the result in a large number of States would be to shift a significant part of the liability for paying physician bills from Medicare to the patient. This is true because in many instances the Blue Shield fee schedule is not intended as full payment and it is expected that the patient pay the difference between the schedule and what the physician charges. To have interpreted the law that Medicare payments should be limited to the indemnity schedule provided in some Blue Shield plans and to the schedules which provide for full payment only for low-income people would have shifted the liability for a significant part of physician payments to the beneficiary and would have done so in a way that differed from State to State. Moreover, it would have made the specific statutory guides of customary and prevailing meaningless in the States affected.

There are 33 Blue Shield plans which act as Medicare carriers and the benefits of their most widely held plans in 1967 are as follows. Six of these Blue Shield plans pay benefits on an indemnity basis in their most widely held program. Under an indemnity Blue Shield program its benefits for all subscribers are based on a schedule of fees and there is no expectation that the physician accept the payment as his full charge. The physician is entirely free to charge as he wishes and significant extra charges are to be expected when the maximum paid under the schedule is significantly below customary charges. For example, in Alabama the indemnity fee schedule (now replaced by a usual and customary

program) under Blue Shield for a cataract operation was $75 as compared with a customary and prevailing charge of around $300 in many parts of the State. It is expected that the physician will collect the difference from the patient.

In other areas doctors participating in Blue Shield plans agree not to charge the patient more than the Blue Shield fee schedule only if the patient's income is below a specified level. In 13 Blue Shield plans that serve as carriers for Medicare, the individual income limit above which the physician is free to charge as he wishes is $5,000 or less in the most widely held plan. In these plans, too, many subscribers are expected to pay more to the physician than the fee schedule allows. There are eight carrier plans with individual income limits in the most widely held programs above $5,000.

In five Blue Shield plans that serve as carriers, the same general approach is taken as in the Medicare law of basing reimbursement on customary and prevailing charges and here the Blue Shield plan is certainly "comparable." Usually the Blue Shield allowed charges in these plans are the same or higher than have been allowed under Medicare.

Indemnity plans in which the patient is expected to pay part of the physician's bill are, of course, not the service benefit plans which the 1965 Committee report says may be helpful. And when a Blue Shield plan requires that the fee schedule be accepted by the physician as full payment for his services for only a minority of the subscribers of the plan, as is the case when income limits are set low, there would seem to be major doubt whether it is appropriate to consider the plan as a service benefit plan. In any event it is quite clear from the 1965 report that the absolute limitation was to be applied only where the private carrier's reimbursement in its own plan met the requirement of being applied "under comparable circumstances."

Since there has been some attention given to a comparison of reimbursement under Medicare with fee schedules under Blue Shield, the Committee might be interested in the information set out below. These data relate not only to Blue Shield plans that are carriers under Medicare but to all Blue Shield plans where the data are available as of 1967. Since, as already explained, in many cases Blue Shield benefits and Medicare benefits represent different types of insurance coverage, differences in benefits paid are not surprising, and do not necessarily reflect different determinations as to the reasonableness of charges. For example, in 14 Blue Shield plans (including the 6 plans that are carriers under Medicare) the most widely held plan is an indemnity plan as described above and the schedule would not be expected to bear a close relationship to current physician charges.

In 25 other most widely held Blue Shield plans, the Blue Shield rate is lower than the customary charge because it provides benefits on a full-payment basis only for people of incomes below $5,000 a year. Many who subscribe to these plans are above the $5,000 income ceiling and are expected to pay whatever is charged above the fee schedule. Such plans are not comparable to part B, of course, and in these States reasonable charges under part B, given the present statute, can be expected to exceed the Blue Shield fee schedules. There are nine plans (including 5 plans that are carriers under Medicare) which are comparable to part B. These plans base payment on customary and prevailing charges and reports by carriers on their policies for payments under their own programs indicate that the Blue Shield payments and part B payments are quite close together; in fact, the reports suggest that in quite a few cases the Blue Shield payments are higher. The plans which are also Medicare carriers use identical screening devices for Medicare claims and for claims submitted under their own programs. Thus, if a Medicare charge is determined to be reasonable, the charge would also be determined reasonable in the carrier's private program.

In 11 other States the most widely held plan is a service plan and has a schedule which is not based on income or is based on income of $5,000 or more. In those States Medicare payments are sometimes somewhat less than the schedule but frequently about the same as the schedule figure and sometimes more.

Below are tabular data for selected procedures comparing the payments by Medicare and Blue Shield with the Blue Shield plan differentiated by type.

RATIOS OF MEDICARE AVERAGE ALLOWED CHARGES [1] FOR SELECTED OPERATIONS TO MOST WIDELY HELD BLUE SHIELD SCHEDULED ALLOWANCES, GROUPED BY TYPE OF BLUE SHIELD MOST WIDELY HELD PROGRAM

	Cataract	Prostatectomy (TUR)	Hernia (inguinal)
AREAS WHERE PLANS NOT COMPARABLE TO MEDICARE (39 AREAS)			
A. Blue Shield indemnity areas (14 plans):			
Alabama	4.48	4.76	2.33
Kentucky	3.08	2.27	2.28
Illinois, Chicago area	2.53	2.25	2.23
Ohio, outside Cleveland	2.23	1.48	1.82
Illinois, Rockford area	2.05	1.84	2.04
Georgia, Atlanta area	1.92	1.57	1.67
New Hampshire-Vermont	1.72	1.86	1.70
Tennessee	1.58	1.59	1.68
Arkansas	1.47	1.67	1.91
Oklahoma	1.33	1.39	1.26
Texas	1.32	1.64	1.88
Delaware	1.25	1.68	1.09
Mississippi	[2]	[2]	[2]
Missouri, outside Kansas City	[2]	[2]	[2]
B. Blue Shield most widely held fee schedule programs offering service benefits to individuals with income limits of $2,500 to $5,000 where in all probability most people covered by the plans have higher incomes so that benefits for most are not on a service basis (25 areas):			
New York, Queens area	2.82	1.03	1.71
New York City area	2.65	1.33	1.55
North Carolina	2.14	2.37	2.45
Arizona	1.98	1.45	1.74
Iowa	1.98	1.79	1.76
Georgia, Columbus area	1.98	1.57	1.89
Maryland	1.92	1.32	1.37
Florida	1.89	1.82	2.02
Connecticut	1.77	1.45	1.41
Maine	1.69	1.68	1.74
Massachusetts	1.58	1.63	1.37
South Carolina	1.46	1.57	1.33
New Jersey	1.40	1.25	1.39
Rhode Island	1.37	1.55	1.45
Colorado	1.33	1.26	1.31
District of Columbia	1.33	1.25	1.30
West Virginia	1.32	1.44	1.27
New York, Buffalo area	1.31	1.15	1.34
Pennsylvania	1.17	1.18	1.29
Nebraska	1.08	1.09	1.13
Minnesota-Twin Cities area	.98	.94	1.12
Minnesota, outside Twin Cities area	[2]	[2]	[2]
Wyoming	[2]	[2]	[2]
South Dakota	[2]	[2]	[2]
Puerto Rico	[2]	[2]	[2]
AREAS WHERE PLAN SOMEWHAT COMPARABLE TO MEDICARE			
Blue Shield most widely held fee schedule programs offering service benefits to individuals with income limits of over $5,000 (11 areas):			
California, Los Angeles area	1.28	1.24	1.60
Missouri, Kansas City area	1.15	1.17	1.29
California, outside Los Angeles	1.14	1.24	1.37
New York, outside New York City, Buffalo, and Rochester	1.10	1.18	1.38
Ohio, Cleveland area	1.08	1.00	1.16
Utah	1.07	1.20	1.02
Washington	1.06	1.24	1.24
Montana	1.03	1.08	1.10
Michigan	.98	1.06	1.24
Idaho	.84	1.14	1.03
New York, Rochester area	.78	.89	1.05
AREAS WHERE PLAN COMPARABLE TO MEDICARE—USUAL AND CUSTOMARY (9 PLANS)			
Hawaii.			
Indiana.			
Kansas.			
New Mexico.			
North Dakota.			
Oregon.			
South Dakota.			
Virginia.			
Wisconsin.			
AREAS WHERE THERE IS NO PLAN (3 AREAS)			
Louisiana.			
Nevada.			

[1] Based on a 5% sample of bills processed to Social Security Administration files as of December 1967.
[2] Not available.

CHART 16.—Chart legend: Lax carrier performance

There are some instances of lax performance in the case of most carriers and in a few cases the entire performance of a carrier has left much to be desired. It needs to be kept in mind, however, that the Medicare program was unprecedented in many ways and also that the volume of claims work turned out to be much greater than was expected. We do not believe that the statement "lax carrier performance" is a fair characterization on the whole of the job performed by most carriers. Moreover, the characterization does not take into account the improvements that have been made since the program began.

Most carriers had about 4 months of preparation between the time of their selection and the beginning of actual operation. It was necessary that by and large they be allowed to handle the Medicare operation in much the same way they had been handling their own business with the minimum of modification necessary to meet the legal requirements of Medicare. For a considerable period of time the carriers were struggling with a very high volume of bills and had to put major effort into dealing with backlog situations and getting their payments current. Only gradually was it realistic to insist upon modifications of their traditional systems in the direction of higher levels of performance and more sophisticated claims processing. Many steps have been taken in the last year or so to improve carrier performance. These steps are listed in one of the items supplied by the Social Security Administration for the record.

Given the newness and complexity of the job, and the ways in which private insurers have customarily handled their operations, most carriers have performed in a satisfactory way. Carrier activities have not yet reached optimum levels of quality performance, but in overall performance has improved. Measures of performance include prompt and adequate service to the public, cost accuracy of claims determination, and care in auditing the costs.

The degree to which overuse and overcharging has been uncovered in Medicare, either by techniques administered by carriers and intermediaries or by the social security central office, is, according to our analysis, superior to that of virtually any other program in the United States. One indicator of past performance is that through May 1969 carriers denied a total of 4.5 million claims for part B benefits because they determined that the services were not covered or not medically necessary.

Those denials have accounted for 5.3 percent of all claims that carriers processed to final disposition during the same period. Since the beginning of the program, the denial rate has shown a gradual but fairly steady rise. During fiscal 1967, the 664,000 claims reported as denied accounted for 3.9 percent of all claims processed. In fiscal 1968, some 1.8 million claims, 5.5 percent of those processed, were denied. Denials through May of fiscal 1969 reached 1.7 million and accounted for 6 percent of all final dispositions.

The 4.5 million claims filed and denied through May 1969 would have generated benefit payments of about $183 million. As a result of carrier review of the medical necessity and legal coverage of claims an estimated $120 million will be saved this year.

Also, carriers are increasingly reducing physician fee billings before reimbursement. In May 1969, some reduction occurred in at least one item in 23.6 percent of all billings. Translated into dollars saved, this means that program costs are being reduced at a rate of about 5.2 percent, or an estimated reduction of another $90 million this year.

As a result of extensive Social Security Administration onsite visits during the last 2 years, negotiations with various carriers in connection with contract renewals, and explicit conditions of renewal—and as well in some instances limitations on the period or circumstances of renewal—carriers have been required to conform to prescribed specifications. All are required to have a system for detecting and handling cases of abuse and overutilization.

Carriers are, of course, in various stages of improving their performance. Having given the carriers the lead time necessary to get on top of the workloads and the administrative problems of the Medicare program, the Social Security Administration has developed a wide array of objective and subjective measures to evaluate carrier performance. In the next series of contract renewals, the occasion will present itself to reduce the number of carriers, if necessary, by transferring some of the business of the more ineffective carriers to those which are more effective.

CHART 16.—Chart legend: Costly and complex administration

As indicated earlier, the law requires that one of the main guides to determining reasonable charges should be the customary charges that the individual

physician makes to his patients generally. It has been necessary, therefore, to develop a screen of such charges for cost-control purposes. It is true that the development of such screens has resulted in somewhat more costly and complex administration than would have been the case if bills were reduced only when they went above an upper maximum represented by prevailing charges for the physicians in the locality. On the other hand, the development of physician profiles on customary charges has saved in benefit costs many time the extra cost of administration. Without the development of this type profile on individual physicians, it would have been impossible for the Medicare carriers to enforce the present directives concerning the nonrecognition of fee increases.

The Social Security Administration requires carriers to conduct an administrative review that is substantially more precise than was generally conducted by health insurers prior to Medicare. These stricter standards necessarily result in more complex procedures than most carriers performed in their private business. We believe, however, that these strict administrative standards are necessary to protect funds under conditions that are substantially different from those under which the private insurers were operating. The strict administrative standards seem to have been justified by the experience under the program, including the evidence accumulated by our staff and the Committee staff that some unscrupulous individuals have attempted to take advantage of the programs for their personal gain.

We have also required the collection of substantially more statistical information than generally collected and maintained by insurance carriers. These statistics are necessary to furnish Congress and the public adequate information on, and a basis for evaluation of, the conduct of the Medicare program. For example, most carriers are able to provide information concerning total payments to individual physicians only as a result of the statistical program. In spite of the more complex and detailed processing procedures and the detailed statistical information provided, administrative costs compare favorably to those of similar programs operated by private carriers.

The statement in the text accompanying the chart that collecting data on charges has led to payment delays and high costs is not based on any evidence of which the Social Security Administration is aware. The carriers that have applied the reasonable charge rules fastest generally have handled the claims workload well.

CHART 16.—Chart legend: Unprecedented payments to supervisory physicians

The Social Security Administration does not believe these payments are correctly characterized as "unprecedented." Fifteen major health insurance organizations handle about 80 percent of the part B claims workload under Medicare. Before Medicare became law, 10 of these 15 carriers had paid for services specifically described in SSA regulations as those of supervisory teaching physicians. Two did not make such payments before Medicare but now do and three did not make such payments before Medicare and still do not. The 10 that did so before Medicare are as follows:

1. Illinois Blue Shield.
2. Pennsylvania Blue Shield.
3. Texas Blue Shield.
4. Florida Blue Shield.
5. Aetna Insurance Company.
6. Occidental Life Insurance Company.
7. Prudential Insurance Company.
8. Travelers Insurance Company.
9. Continental Casualty Company.
10. Mutual of Omaha.

In the text accompanying this chart there is the statement "These services, in fact, are not provided by those physicians but by residents and interns."

Department regulations specifically preclude payments under part B to a supervisory physician in a teaching setting for services which are provided by residents and interns. Regulations also preclude duplication of payment for the same services. Instructions to carriers reinforce and amplify these provisions of the regulations. To the extent that duplication has occurred, as in Cook County Hospital, it was in direct violation of regulations.

During the past year we have conducted numerous onsite reviews of selected intermediaries and carriers for the primary purpose of assuring that reimburse-

ment being made for services of teaching physicians, residents, and interns was proper. Where erroneous payments were found to have been made, corrective action has been undertaken.

The text accompanying this chart says "There is a question whether Medicare beneficiaries have a legal obligation to pay for such services. (Medicare payments are expressly prohibited by law in the absence of a legal obligation to pay)."

The Act, in sections 1862(a)(2) and (3), establishes two separate exclusions from coverage. Section 1862(a)(2) bars payments for services for which the individual furnished services has no legal obligation to pay; section 1862(a)(3) precludes payment for services which are paid for directly or indirectly by a governmental agency, except in such cases as the Secretary may specify.

The distinction, in effect, between these two provisions was drawn most clearly in the report of the Senate Finance Committee accompanying the original bill, on page 48:

> "The proposed insurance programs would not pay for any item or service furnished an individual if neither the individual nor any other person (such as a prepayment plan) has a legal obligation to pay for or provide the services. (Under the provision, the third-party liability statute 42 U.S.C. 2651–2653 would not apply.) Free chest X-rays provided by health organizations, for example, would not be covered. Where health expenses are charged the patient by a member of the patient's household or by an immediate relative, no payment would be made. However, a person of little means would not be barred from payment under the insurance programs because he met the best of medical indigency and was otherwise eligible to receive medical assistance under a public assistance program."

The two provisions of the Act have been applied in accordance with the intention of Congress as expressed in the Committee's report. Under section 1862(a)(2) no payment is made for services otherwise covered if the services are furnished gratuitously in a nongovernmental setting without the expectation of payment from any source. Pursuant to section 1862(a)(3), payment is not made for services furnished (a) by a nonparticipating Federal provider, such as a VA hospital, except for emergency hospital services, (b) at public expense under the terms of United States law or a contract with the United States, or (c) by a State or local government-operated hospital which does not serve the community generally, e.g., a prison hospital. Services fall within this exclusion, also, if they are paid for by the VA, the Civilian Health and Medical Program of the Uniformed Services, or a State or local agency except for Social Security Act and government employee programs and services furnished because the person is medically indigent or to control infectious diseases.

To give effect to the directive of the Committee, as stated in its report, payment is made for services furnished in governmental hospitals serving communities to persons who are not considered eligible to receive treatment and care paid for by or provided at the expense of a governmental entity.

Nothing in either of these provisions which seems to bar payment to teaching physicians to the extent provided by regulation for identifiable personal services to patients for whom these physicians have accepted the doctor-patient responsibility.

CHART 16.—Chart legend: Abuses: "Gang visits"; visits not necessary; fragmentation in billing; conflict of interest situations; unnecessary services

The text accompanying the chart indicates that there is "substantial evidence" that many physicians are engaged in a practice characterized as gang visits (i.e., cursory visits to many patients in the same locality on the same day). We have furnished the Committee evidence of this practice and other types of situations in which physicians are billing for services in inappropriate ways; or are charging for visits that are not needed or have actually not been provided; or rendered services when there is a conflict of interest that would suggest the possibility that the services were provided to maximize Medicare billings. As indicated in the introductory comments on Charts 16, 17, and 18, however, these abuses are apparently confined to a small percentage of physicians. An active program designed to discover such situations and generally to prevent these types of activities is in operation. This involves a wide variety of carrier controls and reviews at the level of initial claims payment, as well as social security statistical and quality controls at the national records center level.

The Social Security Administration has established standards of performance for carriers on matters involving "program integrity" in general and specifically on matters involving practices which are undesirable, costly, or of questionable ethics. Social security instructions to carriers have called attention to practices such as fragmentation in billing and have instructed carriers to consult with professional committees and to have their own professional review staffs make known to physicians the unacceptable nature of such charges.

CHART 17.—Chart legend: Carrier and intermediary performance

The first legend on the chart under this heading is "Widespread Lax Administration." The situation as far as carrier performance is concerned was discussed in connection with Chart 16. Intermediary performance in the field of hospital insurance involves principally the processing of inpatient hospital claims and reimbursement for hospital costs, both of which are matters with which the intermediaries had previously had substantial experience. Better than 9 out of 10 Medicare hospital claims throughout the country are handled by Blue Cross intermediaries and these intermediaries are performing at least as well as they had in their private business.

On the other hand, that part of the Medicare hospital insurance program which involves determining the reasonable cost of and payment of claims for extended care services is a new and difficult area for the intermediaries. The requirement in the law that these medical care institutions be reimbursed on the basis of reasonable costs for services (which are essentially skilled nursing and related care) was largely unprecedented. There have been situations in this area where intermediary performance has been clearly inadequate in the past, but the problems are being overcome, and present performance is improving.

CHART 17.—Chart legend: "Conflict of interest situations" and "Intermediary solicitation of business"

We recognize the potential dangers in the statutory nomination procedure under which an intermediary might seek additional providers by implying more favorable treatment than competitors.

The Social Security Administration has taken strong steps to prevent attempts to switch intermediaries for any but valid program reasons. As of June 30, 1969, there were approximately 14,000 providers of service participating in the Medicare program. Switching of intermediaries has been almost negligible. For example, during the period January 1, 1969, through June 30, 1969, a total of 26 requests for change of intermediary were received by the Administration, of which 14 were denied.

In the case of the conflict of interest cited by the report, in which the Medicare administrator of an insurance company became a director of a nursing home chain, the Social Security Administration intervened promptly when the connection became known. The administrator resigned as director, a position which he had held only during a period when the chain did not participate in Medicare.

CHART 17.—Chart Legend: Poor claims control procedures

Medicare has been engaged for 3 years in the process of improvement of claims controls. Emphasis has been placed on the institution and appraisal of duplicate claims screening procedures and the use of systems-testing procedures. A model part B carrier system has also been developed which will, even if not used in total by carrier, identify the factors which must be included in an efficient claims processing system. It is true that the various carriers have not all reached the same stage in this process, but they have all attained a level of performance substantially higher than was the case before Medicare.

CHART 17.—Chart legend and comment: "Utilization review in hospitals is largely ineffective. Evidence of this may be seen in the tremendous jump in hospital utilization by Medicare beneficiaries

The Medicare requirement for utilization review involves a relatively new concept for most institutions. That the review in many places is not yet an optimally

functioning mechanism was to be expected because of the major adjustments in professional attitudes and professional practices which will need to be achieved to make it function most effectively. Furthermore, experimentation with different patterns has been needed to determine under which types of utilization review are likely to be most effective under various circumstances.

There are two aspects to the utilization review required under the law. The one which has had the most attention and the most success to date is the review of long-stay cases both to cut short unnecessary stays and to curtail the program's liability for payment for continuing inpatient hospital stays that may take place for reasons other than medical necessity. There is good evidence that this aspect of utilization review is fully operative. Although its effectiveness varies, it clearly has value. The problem is to continue efforts through public and private auspices to make these reviews still more effective.

The other aspect of utilization review is the review on a sample or other basis of admissions and services. Here, a great deal more can and needs to be done with the art of review. The Social Security Administration and the intermediaries are working with provider associations and individual providers to help in this matter by producing more effective statistical analyses as well as by expanding the stream of data back to provider institutions and their medical staffs that will shed light on institutional practices and provide an information base that can lead to more effective admissions practices and more effective and selective control over volume and amount of services.

Before Medicare, financial considerations kept some aged people from obtaining needed medical care, and an increase in hospital utilization by the aged was, therefore, anticipated. While the utilization under Medicare was larger than estimated, data were lacking—prior to the receipt of the first Medicare claims—to indicate the true extent to which the aged availed themselves of inpatient hospital services. It is very probable that the larger-than-anticipated increase in utilization under medicare was more largely attributable to underestimates of the number of aged people who had previously been receiving care than to an underestimate of the increase in hospital use. The level of present use does not provide supporting evidence for an argument that a great deal of utilization is improper or that utilization review in hospitals is largely ineffective.

Even with all of its present imperfections, utilization review—in which hospital staff members examine the work of their peers or medical society or other professional review bodies pass judgment on the use of services—has had a beneficial effect. A study completed at Yale University in May of this year included the following conclusions:

"There are some features of utilization review that do exhibit a high degree of similarity among Connecticut's hospitals. One such feature is the emphasis, during the review process, on the committee's responsibility to justify patients' necessity of admission and/or extended length of stay. This entails the determination, by the reviewing physician, that each patient is receiving active therapy which can only be offered in the hospital setting. When such a finding is made, approval is given for continued hospitalization. The preceding data have indicated that this responsibility is being adequately executed."[1]

As part of the effort to improve utilization review during the past year, detailed questionnaires on the functioning of utilization review committees were sent to approximately 1,500 hospitals.

The responses indicated that all but a small number are reviewing long stay cases (and administrative action has been taken to bring the few exceptions into line). Also, the responses disclosed that more than 80 percent of the hospitals are reviewing on a sample basis claims, including those involving short-stay cases, with respect to one or more of the following elements: necessity of admissions, durations of stay, and professional services furnished, including drugs and biologicals. Further administrative action has been taken in these cases and State agencies have been asked to step up their reviews of all provider utilization review processes.

[1] Berman, Dvorshock, and Smith, *Utilization Review in Connecticut Hospitals: Three Years After Medicare*, Hospital Administration Program, Yale University School of Medicine, May 29, 1969, p. 58.

CHART 17.—Chart legend: Hospitals, only 22 % of first period accounts (1966–67) settled

Even if one considers an account to be settled only after a hospital agrees to all changes made in audit—the very last possible point in the process after all appeals have been heard—44 percent, not 22 percent, have been settled. If the essentially final determination of cost by Medicare auditors is taken as the end point—even though the hospital may not have signed—then 75 percent are complete.

For the first year of operation 94 percent of all hospital cost reports due have been filed, and over 5,000 reports have been field-audited. Since outlays for the hospital insurance system have, from the start, been kept very closely current to accruing liabilities by use of an interim rate and interim-payment method, the lag in final accounting does not create such substantial difficulties in estimating and program accounting as is suggested.

Among the actions we have initiated to speed up cost reports are instructions to intermediaries to withhold funds until cost reports are filed.

CHART 17.—Chart Legend: Extended Care Facilities—Utilization Review Virtually Nonexistent

In the area of utilization review, as in other areas of intermediary-provider administration, the situation differs greatly between hospitals and extended care facilities. The problem of utilization review in extended care facilities is compounded by the nature of the coverage, the lack of any prior precedents, the fact that these institutions are, on the whole, generally much smaller and do not have organized medical staffs, and the predominance of proprietary motives. Special efforts responsive to the particular problems of utilization review in extended care facilities are being carried out by State agencies, intermediaries, and the Social Security Administration.

It is true that utilization review is less effective in extended care facilities than in hospitals, but the chart seems to overstate the case. All State agencies have recently begun surveying utilization in extended care facilities as a part of their continuing recertification of all extended care facilities in their States, and they are providing consultation and assistance when they discover deficiencies or detect areas requiring improvement. As surveys are completed, detailed reports are being submitted to the Social Security Administration. Thus far only 139 reports have been received. These indicate that of 3,820 long-stay cases reviewed, 720 (16 percent) were questioned by the extended care facility utilization review committee. Of the 720 cases questioned, 90 percent had benefits terminated—48 percent of those resulted in discharge and 42 percent resulted in termination of benefits without discharge. All 139 of the ECF's surveyed have UR committees which, in addition to reviewing extended duration cases, are reviewing admissions, durations of stay or professional services rendered.

CHART 17.—Preliminary Staff Comment: Extended Care Facilities, Chain Questions Growing

The fact that chain operation of nursing homes is increasing is not in itself necessarily to be regretted. Larger size of operation may be accompanied by greater efficiency and lower cost, as is often the case in other industries. On the other hand, if the growth results from a search for profits achieved by abuse of the program, the abuse has to and will be corrected wherever it does occur. Regulations provide that reimbursable cost to the provider is the cost to the supplier organization, not a fictitious price that may be set. As experience is gained through audits and policy definition, abuses will be uncovered and corrected. We have commented elsewhere on the program policy in relation to the new basis for depreciation in the acquisition of homes by sale.

CHART 17.—Chart legend: Extended care facilities—very few first period accounts (1967) settled

It is true that of the extended care facility cost reports due for the 1967 accounting period, relatively few have been finally settled. Three-fourths of the total have been filed, however, and half are either in field audit or it has been determined that, due to limited amount of declared reimbursable cost, audit is not required.

The audit program for extended care facilities has encountered unique problems which delayed settlements. Recordkeeping and accounting methods of extended care facilities are generally inferior to those of hospitals. Extended care facilities have been handicapped by a lack of trained accounting staff to maintain records and submit cost reports. Many are new in the health field; some are quite small (38 percent have fewer than 50 beds). Many have had little Medicare business; for these, relatively small amounts of money are involved.

CHART 17.—Chart legend: Extended care facilities—unnecessary services

As evidence that unnecessary services are widespread, the text accompanying the chart describes the findings in one of the cases the Social Security Administration submitted to the Committee. Abuses do exist and do call for strong action. In this connection, we have identified from our records cases where the possibility of overuse was suggested, and have initiated a broad investigative program to correct this situation and to aid intermediaries in improving their procedures to prevent other such occurrences.

CHART 17.—Chart legend: Extended care facilities, participation of unqualified facilities

The regulations (Conditions of Participation for Extended Care Facilities) permit the certification of an extended care facility for participation in the program if it meets fully the standards set in the law; or is found to have deficiencies only with respect to one or more subordinate conditions of participation as determined by regulation but is making efforts to correct such deficiencies and despite the deficiencies is rendering adequate care without hazard to the health and safety of patients. This approach is intended to encourage upgrading of facilities and services.

The certification of facilities that have some deficiencies which are not considered so serious as to bar participation is entirely consistent with the approach taken by the Joint Commission on Accreditation of Hospitals in accrediting hospitals and extended care facilities and by State licensure agencies in the discharge of their responsibility for hospital and other licensing. The approach permits program participation of a facility that renders an adequate quality of care and enables the certifying agency to continue to work with that facility to assist it to produce better-quality service.

As of March 31, 1969, there were approximately 1,300 extended care facilities certified as in compliance with all requirements of the statute and regulations, and 3,400 certified as in compliance with statutory requirements and substantially meeting requirements in the regulations but with some correctible deficiencies. Certification of fewer qualified extended care facilities would have led to a scarcity of these services, possibly resulting in more unnecessary hospitalization and higher program costs.

CHART 18.—Preliminary findings: reimbursement of institutions, Federal administration

Chart Legend: Formula Provides 2% Bonus

The 2 percent and 1½ percent allowances in addition to accounted-for costs were not provided as a bonus, but represented a finding that some costs were present that were not otherwise expected to be specifically provided for in the costs accounted for and apportioned to Medicare. At the beginning of the program it appeared that institutions' inexperience, the inexactness of available cost-finding methods, and uncertainties of apportionment as well as the lack of available data would, under reimbursement principles being proposed, result in failure to reimburse for the full reasonable costs that institutions incur in furnishing services to Medicare beneficiaries. It appeared, for example, that patients over 65 require more nursing service than younger patients, even though the established daily charges for routine nursing services, being uniform for all patients, did not reflect such a differential. The percentage factors were finally arrived at as a method of recognizing costs not otherwise specifically recognized by regulation or precisely measurable by cost-finding techniques applied to available data.

The decision to delete these allowances was made during the course of consideration of the budget for fiscal year 1970, and became effective on July 1,

1969. A complete review of the reimbursement formula is being undertaken to assure recognition of all valid costs.

"In most cases it (the Medicare reimbursement formula) pays a disproportionate share of unoccupied bed costs in a facility. . . ."

The Social Security Administration does not think the facts support the assertion that in most cases Medicare is paying a disproportionate share of unoccupied bed costs.

This is a problem which exists primarily in extended care facilities which are distinct parts of larger institutions or in new institutions during a start-up period. It does not exist to any significant degree in hospitals, and it does not exist in many extended care facilities. Where it does exist, the Social Security Administration has been working to resolve it.

"The Medicare reimbursement formula permits inflated depreciation allowances on inflated costs bases."

The regulations and instructions include several safeguards to protect the trust fund in this area.

The regulations provide that asset depreciation is to be based upon the historical cost of the assets as incurred by the provider in acquiring assets. Where an established facility is purchased after July 1, 1966, the regulations provide that the Medicare program will accept the price paid by the purchaser as the historical cost, provided that:

1. A bona fide sale can be demonstrated, and
2. the price did not exceed the actual fair market value of the facility at the time of sale.

Where the sale is not demonstrated to be bona fide, the purchaser's historical cost will be the same as the seller's. Similarly, where the purchase price exceeds the fair market value of the depreciable assets, the excess amount paid is not recognized for Medicare depreciation purposes.

For example, if the cost after allowable depreciation of an extended care facility that participated in the Medicare program from its inception is $700,000 ($900,000 cost less $200,000 depreciation), with a fair market value for its depreciable assets of $800,000, and the business is sold in a bona fide transaction for $1 million, the program would recognize $800,000 as the cost basis of depreciable assets for the new owner. The excess of the cost over the fair market value of the depreciable assets would not be recognized in the basis for depreciation even though it might legitimately be the fair value of the going business when based on past earnings, good will, increases in land values, etc.

CHART 18.—Chart legend: Supplier kickback arrangements

The principles of reimbursement provide that discounts, allowances, and rebates to providers by suppliers of goods and services are reductions from allowable costs. Kickbacks, being essentially rebates, would be covered by those principles.

There have been allegations that nursing home operators in some areas have arranged for rebates from suppliers while charging the full price to Medicare. We have had only a few situations to date documenting the existence of such arrangements. Nonetheless, the Social Security Administration has cautioned all intermediaries and auditors to be alert to this problem and spot investigations are being made in several areas of the country.

CHART 18.—Chart legend: Federal administration, inadequate and ineffective controls

From the beginning many carrier organizations attempted to assert extensive autonomy deriving from their responsibility under the statute and their contracts for the payment of claims. The Social Security Administration, nonetheless, insisted in all negotiations that primary responsibility for the proper administration of the program rests with it. The basic decision that was the key to the relationship the Social Security Administration has with carriers and intermediaries was that these fiscal agents would not have exclusive control over individual claim records and would not be given free rein regarding Medicare as they had in their previous private business and in the Federal programs for Armed Forces dependents and for civil service employees. Instead, the Medicare agents were required to follow a national policy set forth by the Social Security Administration and to seek to raise their quality of performance to levels established as national standards for Medicare. To implement this decision a system of central direction and oversight of their performance was required.

The overall administrative design of the Medicare program was established during the 11-month period between the enactment of the Social Security Amendments of 1965 and the start of Medicare operations on July 1, 1966. During that time, measures were taken to provide the systems that would be essential for the identification of areas where excesses of utilization of covered services or cost issues might be present.

Actions Taken at Onset of Program

1. Statistical System—A major step in achieving the capacity to detect instances of program abuse was the development of a nation-wide system for obtaining uniform and reliable program information from organizations and individuals—providers, physicians, suppliers, intermediaries and carriers.

a. The statistical system was designed to collect data on payments to physicians so that information concerning individual physicians, including their specialty, place where services was provided, type of services performed and the amount of total Medicare payments could be tabulated. It was intended that the tabulations would serve, among other purposes, to identify cases where possible abuse of the program occurred so that such cases could be investigated. It was this system which made it possible to provide the Senate Finance Committee with the list of physicians who received a specified amount of reimbursement from the program.

b. The statistical system also provided for the collection of similar data with respect to providers of services so that information on the type of services rendered and lengths of stay could be tabulated and institutions with unusual patterns of utilization identified and investigated.

2. Reporting of Cases of Possible Fraud—

All instances of possible fraud were required to be reported to the Social Security Administration and fraud investigations were controlled centrally.

3. Notification to Beneficiary of Claims Paid in His Behalf—

A system was developed so that beneficiaries would be informed of claims paid in his behalf no matter who received the payment. One of the results expected from this process was that beneficiaries would inform the program where they thought an improper payment had been made, thus providing a source of evidence of possible fraud and also consequently a deterrent to claims for services not rendered or for higher charges than were actually made.

4. Cost Determination Process—

The law requires that institutional providers of services be paid on a cost basis, and an administrative process was developed in which the cost system was defined and arrangements were made for audit of the cost reports submitted. These audits have the direct effect of reducing payments and the indirect effect of reducing the tendency to claim for payment costs which would be rejected by audit. Audited reports were required to be submitted to the central office for analysis to permit both quality checks on the audit process as well as the development of improvements in cost review matters.

5. Centralized Policy and Procedure Development.

While it was not possible to develop before the program became operational all the details of policy and procedure that would ultimately be desirable, the decision was made that central policy control was to be included in the method of operation and policy was made available in manual and letter form from the program's outset. These statements have been made more detailed and been improved as time has passed.

6. System of Surveillance and Improvement of Carriers and Intermediaries.

To help achieve the national goals of uniform application of policy and quality of performance, a system was established that would permit surveillance of fiscal agent activities based on statistical reporting by the agents and a program of visits by Social Security central office and regional office personnel as well as personnel of the DHEW Audit Agency. Actions taken at the outset of the program to implement this system were:

a. Establishment of a system of periodic contract performance review of all carriers and intermediaries by central office personnel.

b. Continuing regular visits to fiscal agents by regional office staff.

c. HEW annual audits of carriers and intermediaries.

d. Requirement for regular statistical reporting by fiscal agents on administrative processes—workload, processing time, administrative costs, etc.

e. Requirement that cost reports of provider of services be submitted for central office analysis thus permitting a number of types of quality checking.

7. Establishment of Framework of Utilization Review and Surveillance of Review process.

Each hospital and extended care facility was required initially to have a utilization review plan and subsequently the performance of the plan was checked through on-site inspections as well as by examining the results of claims review and analyzing the data to be tabulated on allowed claims.

8. Physician Certification of Medical Necessity.

As one of the safeguards against excessive use, physicians were periodically required to certify to the necessity of services provided.

9. Claims Review Process.

A systematic review of claims was required to be carried out by each intermediary and carrier and claims were required to be submitted to central office. The central office claims data were to become a source of identification of various patterns of care which might require special attention by the agents if they had not done so already because of their own assessment of utilization patterns.

Each carrier's performance during the contract year is thoroughly reviewed by SSA to determine what action should be taken on renewal of the contracts. At the conclusion of the most recent surveys, several carriers' performance was found to be less than satisfactory in certain areas, but their overall performance and prospects for early improvement seemed to warrant renewal of their contracts. Each of those carriers was notified in writing that, while SSA would agree to renew its contract, this renewal was on condition that specific areas of its performance be improved.

Some of the deficiencies noted for some carriers were inadequate productivity, high administrative costs, inadequate "reasonable charge" and utilization screens, a large percentage of old cases on hand, and failure to give timely replies to inquiries from beneficiaries. A few carriers were notified that SSA would agree to renew their contracts for only a 6-month period and that further renewals were contingent upon marked improvement in their Medicare operations.

Further details on recent actions to expand Medicare cost and utilization controls and a summary list of recent steps taken to improve intermediary performance were included in materials supplied for the record by the Social Security Administration.

"There is a lack of current program information with respect to costs and utilization which hampers both effective administration and estimating."

The Social Security Administration has requested and obtains a large amount of statistical information with respect to costs and utilization. However, there are, of course, practical limits to the amount of statistical information that can be gathered within a reasonable overall cost for such activities. In the first years of the program, there have been delays in getting desirable statistics due to the newness of the system and to bill-processing lags. Monthly statistics are available on amounts reimbursed under both the hospital insurance and the supplementary medical insurance programs. While there is an unavoidable time lag between the time of reimbursement and the time when detailed data are available, the data give quite currently the key information necessary for direction of the program.

For the hospital insurance program, data are provided on the numbers and types of claims approved, by month of approval, and the amounts of reimbursement by type of benefit. Along with these data are information on the average covered days of inhospital care and data on hospital charges in total, on charges per claim per day, and on the relationship of charges to amounts reimbursed on an interim basis.

There is information from audited cost reports on the relationship of interim to final reimbursement.

For the medical insurance program, monthly information is provided on total bills on which reimbursement is made, the total amount of reasonable charges, the amount reimbursed, and the average charges per bill. This information is broken down by surgical and medical bills for physicians' services.

Current information on utilization of services is obtained first through the Current Medicare Survey. This continuing sampling of a statistically selected group of beneficiaries produces through personal contact and interview, information on services these people have obtained under the program. Data are also being extracted from statistical samples of hospital claims to provide information on an individual provider such as length of stay for selected diagnoses. These data will become available later this year.

Illustrative of special reports are those received monthly on extended care facility admissions wholly or partially denied because beneficiaries did not require skilled nursing care.

CHART 18.—Chart Legend: Cost of Program Apparently of Secondary Concern

The text accompanying the chart indicates "secondary concern seems to have been given to the quality of the care and the control of costs." The Social Security Administration disagrees with this conclusion. The conditions of participation established to identify those health care institutions which could qualify as providers of service under the Medicare program were designed to assure that only institutions having the facilities to furnish quality care were certified. This was an attribute of Medicare. In designating health care institutions as providers of service, special recognition was given to those situations, however, where the participation of the institution was essential if insured individuals were to have the necessary health care under program coverage. While the providers participating in the program represent the bulk of the health care institutions in the United States, there has been a good deal of evidence that the requirements for participation have had an effect in improving quality in many health facilities.

Concern for the quality of care is implicit in the evaluations carried on through the State agencies in the process of recertification of providers. Instances of reported poor-quality care are investigated by the State agency or SSA. Furthermore, the efforts of Medicare to improve carrier and intermediary performance in identifying and denying claims where services are inappropriate or otherwise not covered demonstrates both a concern for cost and the view of the Social Security Administration that a large quantity of service is not always advantageous.

CHART 19.—Chart legend: lack of coordination with other government agencies—Medicare-Medicaid

Coordination between Medicare and Medicaid began with the inception of these programs in 1966. Initially, emphasis was placed on establishing an integrated part B buy-in systems for welfare recipients. This complex process has been completed in 44 States which have bought in for some or all of their eligibles. Of equal concern was effective coordination of claims activities under the two programs to the extent possible, in keeping with State welfare agency patterns of operation and State law requirements. The use of the same intermediaries and carriers for both programs has been emphasized with the result that of the 44 States with Medicaid programs 20 are using the Medicare part A intermediary for some functions while in 16 the same part B carrier services both programs. Greater efficiency and reduced administrative cost are realized through determining appropriate payment under both programs in the same claims process; steps are now underway to apply the same standards to the activities of these agents for both programs.

To meet those situations where the State public welfare agency receives and processes Medicaid claims special arrangements have been made to simplify referral of Medicare payment data including the use in some States of copies of completed Medicare claims forms or the use of a specially-designed common form.

Thus, while a substantial number of individuals receiving health care services are covered under both programs, effective procedures have been developed to first identify Medicare liability and then that of Medicaid—whether in integrated or separate processes—with adequate safeguards against duplication of payment.

Other examples of coordination activity are in the fiscal area. Interim provider rates under Medicare, title XVIII, are available to States administering Medicaid programs and developmental work has been going on for some time on a common audit process for both programs. There has also been close and continuing coordination between SSA, the Social and Rehabilitation Service and the Public Health Service in developing policies governing standards for nursing homes and intermediate care facilities, the appraisal of utilization review, and conduct of medical audits. Again, the same State agency responsible for working in these areas under Medicare is in many instances delegated the same responsibility under Medicaid.

There has been a sharing of information gained from validation visit reports to providers with inordinate billings or treatment patterns. Similarly, reports of fraud investigations completed by State agencies administering title XIX are reviewed by title XVIII investigators to determine if Medicare payments are involved and vice versa.

CHART 19: Chart legend.—Federal tax collector—$2 billion unreported; "Swiss bank account" numbers

The Social Security Administration has now taken steps to assure that appropriate systems modification promptly will be made by carriers to maintain Medicare records by social security account numbers of physicians. The Treasury Department has indicated that it intends to require reporting of all amounts paid by carriers to physicians although it may be necessary to seek some legislation in connection with such a requirement.

Social security account numbers were not required for identification of physician bills at the beginning of the program because there was no Treasury requirement for income tax reporting and only a short time in which to have the program fully functioning. Under these circumstances it seemed best in initiating the program to use carrier methods of identifying physicians that predated the beginning of the Medicare program and thus minimize disruption of existing billing arrangements.

Separate Comments of Robert J. Myers, Chief Actuary, Social Security Administration

AUGUST 4, 1969.

Memorandum
From: Robert J. Myers, Chief Actuary, Social Security Administration.
Subject: Comments on Actuarial and Related Aspects of "Staff Data Relating to Medicaid-Medicare Study."

This memorandum, which is prepared at the request of the Senate Committee on Finance, will give my views on the actuarial and related aspects of the Committee Print, "Staff Data Relating to Medicaid-Medicare Study," dated July 1.

MEDICAID

I should point out at the beginning that I have had only a limited responsibility in the Medicaid area, dating only from when the program was enacted in 1965. Specifically, in 1966 and later, I made certain overall estimates of the cost of this program and indicated the likelihood of sharply increasing costs unless "tightening up" legislation were enacted (which was done in part). Nonetheless, the actual experience has far outstripped the estimates that I made of rising costs. In part, this has been due to medical costs increasing more rapidly than I had assumed, and in part, it has been due to much more rapid expansion and utilization of these programs than I had thought possible. Also, the liberal eligibility requirements adopted by some States were beyond any reasonable expectations.

Still another problem with comparing various cost estimates for the Federal Government portion of the Medicaid program with the actual experience developing is that budgetary authorities and officials quite often reduce the cost estimates made by the professional staff involved in this field. The aim, of course, is to show a more favorable general budget position when the Budget is first presented to Congress, but then later, supplemental appropriations are required. As a specific example, for fiscal year 1967, the original estimate for all public assistance grants was $3,046 million (it is not possible to separate this out as between cash payments and Medicaid, although the latter was a significant element in the experience). The Bureau of the Budget reduced this by $200 million, and Congress took off another $46 million, so the original appropriation was $3,700 million. The actual expenditures, financed in part by a supplement appropriation, were $4,259 million.

The experience has generally been that such supplementals have been needed both to offset the reduction in the estimates made by the professional staff and also because the actual experience has been well above such estimates.

As a sidelight, I might mention that, when I was a member of the State-Federal Task Force on Costs of Medical Assistance and Public Assistance, established by the Department of Health, Education, and Welfare in 1968, I wished to make a minority statement to the effect that increasing the accuracy of the Medicaid cost estimates would be of no avail if the budgetary officials then arbitrarily reduced the estimates to produce an artificially low budget. Since the Chairman did not want this statement included in the final report, I withdrew from the task force rather than being associated with a report that did not include this statement.

MEDICARE

Principal responsibility for the cost estimates for the Medicare program (except for certain "economic" assumptions) has always been assigned to me. On the whole, I believe that the report presents the data accurately and draws valid conclusions therefrom. In certain instances, I disagree with the analysis. In addition, I would like to give more detailed explanations of the reasons for some of the differences between the actual experience and the estimates.

32-108 O—69——29

Chart 5

This chart compares estimates of Hospital Insurance benefit payments for 1970 and for 1990 according to estimates made (or first published) in three years, 1965, 1967, and 1969.

The figures presented for the estimates made in 1965 and 1967 are incorrect, because they relate only to benefits for insured persons, whereas the figures for the estimate made in 1969 relate to both insured and noninsured persons combined. This, of course, affects only the figures for benefits in 1970, since by 1990 the noninsured group is relatively negligible in size. The correct figures for the benefits in 1970 are $3.1 billion for the estimate made in 1965 (instead of $2.9 billion) and $4.4 billion for the estimate made in 1967 (instead of $4.0 billion). The result of using the correct figures is, of course, to show less of an increase from the earlier estimates to the estimate made in 1969. Specifically, for the estimates of benefits in 1970, the ratio of the estimate made in 1969 to that made in 1965 is 1.61 (instead of 1.72).

Even more important with regard to Chart 5, it is not proper to compare dollar disbursements alone, since the underlying financing is based on the relationship of benefit outgo to taxable payroll.

If higher earnings assumptions are used in one estimate than in another one, the former will automatically show higher benefit costs in terms of dollars, since over the long run, hospital costs are assumed to rise proportionately with total earnings. On the other hand, if the maximum taxable earnings base is changed between the two estimates, as was actually the case (and the benefit provisions remained essentially the same insofar as cost aspects are concerned, as again was actually the case), it would not be proper to measure changes in the cost estimates by considering the higher taxable payroll due to the increased earnings base; but there still should be considered any changes in the assumptions as to total earnings.

The earnings assumptions for 1970 which were made in the 1969 estimates were 8.1% higher than those for 1970 which were made in the 1965 estimates; accordingly, the proper ratio to compare the estimate of 1970 benefits which was made in 1969 with that which was made in 1965 is 1.49 (1.61 divided by 1.081), not 1.61. Similarly, the earnings assumptions for 1990 which were made in the 1969 estimates were 20.5% higher than those for 1990 which were made in the 1965 estimates; accordingly, the proper ratio to compare the estimate of 1990 benefits which was made in 1969 with that which was made in 1965 is 1.59 (1.91 divided by 1,205), not 1.91.

The text states that the 1969 estimates for both 1970 and 1990 were "almost twice the original estimates made in 1965". Based on the foregoing analysis, the ratios are 1.49 times for 1970 and 1.59 times for 1990, so that the "almost twice" comparison does not properly apply.

It should be mentioned that the cost of the HI program on an accrual basis are not yet known precisely for even the first 6 months of operation, July through December 1966. The principal reasons for this are: (1) incomplete financial control and reporting (e.g., no reconciliation is required between cash spent by intermediaries and claim vouchers submitted to SSA), and (2) data are not available in any complete and accurate form as to the adjustments that have been made as between the interim payments and the final payments, which involve the initial payments plus the final settlements made after cost audit.

Considering hospital, final settlements have been made by the fiscal intermediaries in only about 45% of the cases involved for the first fiscal years of operation of the various hospitals that ended after July 1, 1966. However, only about 60% of these final settlements made by the fiscal intermediaries have been submitted to the Social Security Administration. I have not yet obtained any basic tabulations of this material, so as to be able to determine the effect of the additional financial transactions on the interim payments. From certain fragmentary data, I believe that the upward adjustment to allow for the subsequent settlements is about 5% or 6%, but it is difficult to be certain about the overall effect when such a small proportion of the universe has been reported. An even lower proportion of final audited cost reports for ECF's have been submitted to SSA.

Chart 6

I concur with the conclusion that, unless taxes are raised (either through an increase in the rates or in the taxable earnings base), the HI Trust Fund will be

exhausted by 1976. In fact, if anything, I believe that this is an optimistic picture of the situation under the assmuption that no additional financing is provided, because of two factors that were made in the cost assumptions—(1) utilization rates are assumed to be level in the future (by age and sex), which has seemed to be the case for the early experience that I have examined. However, I now see a possibility that there is an increasing trend in hospital utilization over the long range, which if continued and compounded could have a significant effect and (2) the yearly increases in hospital costs have been assumed to diminish over the next few years (i.e., the rates of annual increase will become smaller), which did occur for 1968 as against 1967, but the continued pace of inflation and the continuing trend to more complex and expensive hospital procedures makes it more likely that the annual increases will be above those assumed than below.

Chart 7

I would agree that the actuarial balance of the HI program could be restored by increasing taxes by 20% (in any number of ways, including a straight 20% increase in the entire schedule of contribution rates, or by accelerating the schedule so as to have the ultimate combined employer-employee rate of 1.8% be effective within a few years, or by increasing the taxable earnings base to a sufficiently high level, or by a combination of these procedures). I also agree that this result could be achieved by increasing the initial deductible from $44 to $175 (provided, of course, that in either case the automatic provision for increasing the deductible in the future in line with rising hospital costs would be operative). I must say, however, that I cannot understand how the actuarial balance of the HI program can be restored by cost controls, since it would seem to me that, if the same services are to be provided, any cost controls could not by themselves provide sufficient savings to offset the sizeable lack of actuarial balance.

Chart 8

This chart deals with 1970 hospital costs per beneficiary. The text might have made it clear that what is being discussed here is not the average cost to the HI program per beneficiary, but rather such average cost *plus* the average cost effect of the deductible and coinsurance payments per beneficiary. Also, perhaps it might have been better to use the phrase "eligible person" or "potential beneficiary" rather than merely "beneficiary", since the latter might be interpreted as including only persons who were actually hospitalized in the year.

With regard to Chart 8, it is quite correct that the estimated average cost per beneficiary in 1970 was almost 50% higher for the estimate made in 1969 than for the estimate made in 1965. There are two primary reasons for this difference, each of which is of about equal importance.

First, the average daily hospital cost rose much more sharply after 1965 than was assumed in mid-1965, when the original estimates were made (and in fact, at that time no experts were predicting that either this trend, or the sharp increases in wages and general prices that took place, would occur).

Second, the actual experience as to hospital utilization was significantly higher than had been assumed (and was in fact, higher than the assumptions made by the insurance industry and by the Blue Cross in their cost estimates, even though they were above my assumptions). My assumptions were based on the results of several OASDI beneficiary surveys, and even though I adjusted the survey results upward significantly to allow for the presence of insurance for all persons involved and an additional safety margin as well, the survey base used with regard to the level of hospitalization was evidently far too low.

This has convinced me that beneficiary surveys, even though conducted highly scientifically from a statistical standpoint, may have gross inherent errors of understatement when it comes to inquiring about such elements as hospital usage, income, assets, etc. It is a possibility that some of the discrepancy between the hospital utilization shown by the surveys and the actual experience has resulted from the time differential between when the survey was made and the present time. In other words, there may actually be present a gradual long-term upward trend in hospital utilization among persons aged 65 and over. The measurement of any increasing secular trend in hospital utilization rates is very difficult, both because of the small annual changes that might occur and because of the absence, in the past, of continuous accurate experience data. If this small

upward trend is the case, the survey data would be closer to a suitable base. It should be noted that if the assumption of an increasing hospital utilization rate is built into the cost estimates, the cost of the program would be significantly increased.

Chart 10

The extended care facility benefit was designed to furnish a lower cost alternative to long-term hospital care. This objective can most economically be achieved through limitation of facilities to those which maintain a standard of care provided similar to that available to convalescing patients in hospitals and through strict review of utilization.

In the early 1960's, the cost estimates for the extended care facility benefits were based on the assumption that there would be relatively tight controls involved, so as to prevent use of these benefits for custodial or domiciliary care. At the same time, arguments were presented to me that not only was this approach feasible through strict standards and utilization review, but also that a reduction in hospital costs could be achieved through the transfer of patients from the more expensive hospital care to ECF care. This seemed quite reasonable, particularly for some of the early legislation that included only ECF's which were owned and operated by hospitals as an integral part thereof. Later, when the definition of ECF's was expanded to the basis in present law, I became more concerned about giving separate estimates for the hospital benefit cost and the ECF benefit costs, because I could foresee, in the long run, a great expansion of ECF's. Since if strictly administered (as possible within the administrative latitude permitted by the statute), there was the possibility of a reduction in the need for hospital facilities as high quality extended care facilities were expanded, I combined all estimates for hospital and extended care utilization and cost.

I did, however, make the estimate that ECF benefits would have a first-year cost of $25 to $50 million for insured persons, whereas the actual experience was about $250 million (or from 5 to 10 times as much). The principal reason for this relatively large difference between the actual experience and the initial estimate (for what was believed cost-wise to be a small portion of the total HI program) was that far more ECF beds were certified and thus used than I expected, since the requirements for certification were not as strict as I had anticipated.

It has been argued that the actual high ECF benefit costs have resulted in a decrease in hospital costs and that this will be increasingly so in the future as more and more ECF's become available. To what extent this has been the case cannot be established from any evidence now available, although the fact that the average duration of hospital stays remained unchanged as between July-December 1966 (when ECF benefits were not available) and later periods (when ECF benefits were available) argues that the effect, at least in the early period of operation, has not been substantial.

Chart 11

This chart shows the financial situation of the Supplementary Medical Insurance Trust Fund on an accrual basis. I agree entirely with the general presentation, but I do object to designating the balance in the trust fund as a "surplus". Quite naturally, the significantly worsening situation in fiscal year 1970 results from the actuarially-unwarranted freezing of the standard premium rate at $4 for this period. In fact, on the basis of the "actual cash operations" during the 1¼ years ending June 30, 1969, for which the $4 standard premium rate was initially established, I now believe that on an accrual basis this $4 rate was slightly inadequate—and thus will certainly be inadequate for the next premium period, fiscal year 1970. This small inadequacy in the past period can probably be attributed to the serious influenza epidemic in late 1968. Accordingly, I believe that, if there is a variation from the estimated financial status of the SMI Trust Fund in the future period shown in Chart 11, it will be somewhat on the unfavorable side.

Chart 12

This chart gives several alternative ways of restoring the actuarial soundness of the SMI program. As to the alternative of having a $4.40 standard premium rate for fiscal year 1970, this is what I originally recommended. Based

on more recent data, I now believe that this rate should be at least $4.50, and probably more likely $4.60.

As to the alternative of restoring actuarial soundness of the SMI program by putting into effect cost controls, I cannot believe that this is possible solely by any administrative action that can be taken. It is likely that such a procedure—just as any other types of economic controls that have been tried in the past—will be readily and frequently evaded, so that the end result might even be worse than if there had been no controls. One area of "overrun" is the administrative expenses, which element is discussed in detail subsequently.

Chart 13

This chart shows actual increases in physician fees as compared with the assumptions made in the cost estimates, I believe that there is a small error in plotting the data—so that the actual increase from 1968 to 1969 seems much larger than what was assumed. Specifically, as stated in the text accompanying Chart 13, the 1967 assumptions were for an increase of 5% from mid 1968 to mid-1969, whereas the actual increase was only slightly more—5.5% (based on the figures of 145 and 153 in Chart 13)—whereas the spread in the curves seems to indicate much more of a difference.

Chart 14

This chart analyzes intermediary and carrier costs. With regard to the HI program, it should be pointed out that the 1965 cost estimates assumed that the total administrative expenses would be 3% of benefit payments; the actual ratio currently on an accrual basis is only about 2½%, so that it can readily be said that the administrative expenses for this program have been in line with, and actually somewhat below, what had been assumed in the actuarial cost estimates made in 1965 (earlier cost estimates had assumed a 5% administrative-expense ratio).

Considering the SMI program, the original assumption was that, based on the experience of efficient insurance companies administering large group health insurance cases (after eliminating certain costs not present for SMI, such as taxes and selling costs), increased by about 50% to allow for the additional administration to be performed by the Social Security Administration (including enrollment and premium-collection costs), total administrative expenses would be about 8½% of benefit payments; however, the actual experience currently shows a ratio of about 12%, or about 40% higher relatively. The reasons for this difference are, in my opinion, primarily the result of extremely intensive and detailed administrative procedures of the program and the fact that SMI covers a much larger proportion of small bills than the typical private medical insurance program. Moreover, if the original estimate had been made on the basis of the Blue Shield experience, the estimate of administrative expenses as a ratio to benefit payments would have been significantly higher—and nearer to the actual 12% experienced. In my opinion, another factor is the collection of elaborate and detailed statistical information. The collection of this information, along with the detailed administrative procedures, resulted from very detailed regulations promulgated by the Social Security Administration (which prevented the carriers from using their normal methods).

Although it can be argued that this intensive administration will reduce charges sufficiently to more than offset the additional administrative expenses involved, I do not believe that this has been the case. The largest portion of the savings due to reducing physician charges comes from the larger bills and from a limited number of physicians with questionable practices. These categories, rather than all bills, could be examined by EDP or otherwise at much less cost and with virtually as large savings to the program (and probably also with resulting prompter claims payments). It should be pointed out that EDP reductions of charges do not always produce real savings in the end, because frequently the physician is then required to explain the higher charge—and can do so—so that in the end in such cases as much benefits may be paid, but there has been much more administrative work in doing so.

Chart 18

The Explanation points out certain problems caused by a lack of current program data. In my opinion, this is true.

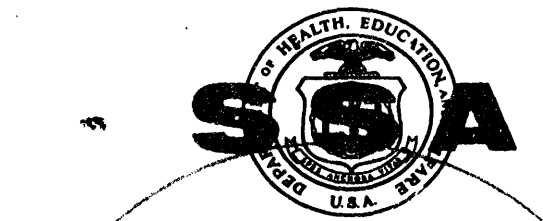
Although I have been able to obtain a considerable amount of valuable and necessary actuarial data that is required for the financial analysis of the program—the recommendations in the House and Senate committee reports on the 1965 Act that a special 0.1% Actuarial Sample should be established have been very effective in making these data available to me—much information that I requested in specific and definite form long before the program went into operation has never been furnished to me. Further, the data that I have received have been shown to have considerable error, and so I do not believe them sufficiently accurate as I would like to have them to serve as a basis for cost estimates. This is in part because the specifications that I furnished long before the beginning of the program for the manner in which actuarial data should be collected were not followed in some respects, and conflicting specifications promulgated by research and statistics personnel were followed.

An additional difficulty that I have had is the long delay in obtaining data and tabulations—in part because of the very slow submission of bills by providers of services and then by the intervening carriers, and in part because of delays in obtaining the required tabulations because so much manpower and machine time was utilized in collecting statistics that are really not needed for the operation of the program, but rather are gathered for subsidiary reasons.

APPENDIX C

Criteria for Determination of Charges, Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

CRITERIA FOR DETERMINATION OF REASONABLE CHARGES; REIMBURSEMENT FOR SERVICES OF HOSPITAL INTERNS, RESIDENTS, AND SUPERVISING PHYSICIANS



FEDERAL HEALTH INSURANCE FOR THE AGED

(CODE OF FEDERAL REGULATIONS, TITLE 20, CHAPTER III, PART 405)

REGULATIONS

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HIR-5 (11/67)

PREFACE

This document sets forth Subpart E of the Social Security Administration's Regulations No. 5 (Federal Health Insurance for the Aged – 20 C.F.R. 405). Sections 405.501 to 405.508 describe the criteria to be used for the determination of reasonable charges. Sections 405.520 to 405.525 describe the procedures for reimbursement for services of hospital interns, residents, and supervising physicians.

This document was prepared for use by those individuals and organizations which have a need for a convenient reference source concerning the criteria for determination of reasonable charges, and reimbursement for services of hospital interns, residents, and supervising physicians.

SUBPART E

CRITERIA FOR DETERMINATION OF REASONABLE CHARGES; REIMBURSEMENT FOR SERVICES OF HOSPITAL INTERNS, RESIDENTS, AND SUPERVISING PHYSICIANS

(This Subpart E was published in the Federal Register on August 31, 1967.)

SUBPART E

Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

Note: §§ 405.501 to 405.525 issued under sections 1102, 1814(b), 1833(a), 1842(b), and 1871, 49 Stat. 647, as amended, 79 Stat. 296, 79 Stat. 302, 79 Stat. 310, 79 Stat. 331; 42 U.S.C. 1302, 1395 et seq.

405.501 Determination of Reasonable Charges.—Payment for medical and other health services (*see* § 405.251) furnished by physicians or other persons (except for services furnished by group practice prepayment plans electing cost reimbursement and certain services furnished by, or under arrangements made by, a provider of services) is made on the basis of the "reasonable charge" for such service which is determined by the carriers selected by the Secretary to assist in the administration of the supplementary medical insurance program.

405.502 Criteria for Determining Reasonable Charges.—(*a*) *Criteria.*—The law does not contemplate the establishment of a general fee schedule applicable to all physicians or other persons furnishing medical and other services but calls for individual determinations which take into account the facts as to existing practice with respect to charges of the particular physician or other person as well as others in the locality. The two criteria set out in the law which are considered in determining reasonable charges are:

(1) The customary charges for similar services generally made by the physician or other person furnishing such services; and

(2) The prevailing charges in the locality for similar services.

(*b*) *Comparable Services Limitation.*—The law also specifies that the reasonable charge can be higher than the charge applicable for a comparable service under comparable circumstances to the carriers' own policyholders and subscribers.

(*c*) *Application of Criteria.*—In applying these criteria, the carriers are to exercise judgment based on factual data on the charges made by physicians to patients generally and by other persons to the public in general and on special factors that may exist in individual cases so that determinations of reasonable charge are realistic and equitable.

(*d*) *Responsibility of Administration and Carriers.*—Determinations by carriers of reasonable charge are not reviewed on a case-by-case basis by the Social Security Administration, although the general procedures and performance of functions by carriers are evaluated. In making determinations, carriers apply the provisions of the law under broad principles issued by the Social Security Administration. These principles are intended to assure overall consistency among carriers in their determinations of reasonable charge. The principles in §§ 405.503–405.507 establish the criteria for making such determinations in accordance with the statutory provisions.

405.503 Determining Customary Charges.—(*a*) *Customary Charge Defined.*—The term "customary charges" will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. In determining such uniform amount, token charges for charity patients and substandard charges for welfare and other low income patients are to be excluded. The reasonable charge cannot, except as provided in § 405.506, be higher than the individual physician's or other person's customary charge. The customary charge for different physicians or other persons may, of course, vary. Payment for covered services would be based on the actual charge for the service when, in a given instance, that charge is less than the amount which the carrier would otherwise have found to be within the limits of acceptable charges for the particular service. Moreover, the income of the individual beneficiary is not to be taken into account by the carrier in determining the amount which is considered to be a reasonable charge for a service rendered to him. There is no provision in the law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.

(*b*) *Variation of Charges.*—If the individual physician or other person varies his charges for a specific medical procedure or service, so that no one amount is charged in the majority of cases, it will be necessary for the carrier to exercise judgment in the establishment of a "customary charge" for such physician or other person. In making this judgment, an important guide, to be utilized when a sufficient volume of data on the physician's or other person's charges is available, would be the median or midpoint of his charges, excluding token and substandard charges as well as exceptional charges on the high side. A significant clustering of charges in the vicinity of the median amount

might indicate that a point of such clustering should be taken as the physician's or other person's "customary" charge. Use of relative value scales will help in arriving at a decision in such instances.

(c) *Use of Relative Value Scales.*—If, for a particular medical procedure or service, the carrier is unable to determine the customary charge on the basis of reliable statistical data (for example, because the carrier does not yet have sufficient data or because the performance of the particular medical procedure or service by the physician or other person is infrequent), the carrier may use appropriate relative value scales to determine the customary charge for such procedure or service in relation to customary charges of the same physician or person for other medical procedures and services.

(d) *Revision of Customary Charge.*—A physician's or other person's customary charge is not necessarily a static amount. Where a physician or other person alters his charges, a revised pattern of charges for his services may develop. Where on the basis of adequate evidence, the carrier finds that the physician or other person furnishing services has changed his charge for a service to the public in general, the customary charge resulting from the revised charge for the service should be recognized as the customary charge in making determinations of reasonable charges for such service when rendered thereafter to supplementary insurance beneficiaries. If the new customary charge is not above the top of the range of prevailing charges (*see* § 405.504(*a*)), it should be deemed to be reasonable by the carrier, subject to the provisions of § 405.508.

405.504 Determining Prevailing Charges.—(a) *Range of Charges.*—The term "prevailing charges" refers to those charges which fall within the range of charges most frequently and most widely used in a locality for particular medical procedures or services. The top of this range establishes, except as provided in § 405.506, an overall limitation on the charges which a carrier will accept as reasonable for a given medical procedure or service. Prevailing charges are derived from the overall pattern existing within a locality. For example, in a given locality the carrier may find that the charges most frequently and widely used by physicians for a particular medical procedure range from $150 to $175. If in another locality the carrier finds that the prevailing charges are different for the same procedure, then a different range of charges would be applied in making reasonable charge determinations for that locality. An acceptable method for the carrier to objectively determine the point at which such limitation is established would be the use of the mean (arithmetic average) of the customary charges of physicians or other persons in the locality for a given medical procedure or service, plus one standard deviation above the mean, rounded to the nearest dollar. However, the carrier will adopt an appropriate limit for each procedure or service with judgment being exercised to assure that with respect to each particular array of data the result reached is reasonable. If, for example, there is a point just above the standard deviation which represents the amount charged by a substantial number of physicians in the locality, the limitation might, in such a situation, be established so as to include this point. On the other hand, the "trailing off" of an appreciable number of charges above the mean plus one standard deviation might not justify an upward adjustment. The "standard deviation" is a basic statistical measure widely used in dealing with variations from a central tendency or norm. Its advantage over the approach that the "prevailing charge" is to include a fixed percentage of all charges lies in the fact that the standard deviation is flexible rather than rigid. It takes into account and is responsive to differences in the spread that exists in the underlying data.

(b) *Variation in Range of Prevailing Charges.*—The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns.

(c) *Reevaluation and Adjustment of Prevailing Charges.*—Determinations of prevailing charges by the carrier are to be reevaluated and adjusted from time to time on the basis of factual information about the charges made by physicians and other persons to the public in general. This information should be obtained from all possible sources including a carrier's experience with its own programs as well as with the supplementary medical insurance program.

405.505 Determination of "Locality."—"Locality" is the geographical area for which the carrier is to derive the prevailing charges for services. Usually, a locality will be a political or economic subdivision of a State. It should include a cross section of the population with respect to economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain medical care or service, localities may be reorganized on a basis constituting medical service areas (interstate or otherwise), comparable in concept to "trade areas." Localities may differ in population density, economic level, and other major factors affecting charges for services. Carriers therefore shall delineate "localities" on the basis of their knowledge of local conditions. However, distinctions between localities are not to be so finely made that a "locality" includes only a very limited geographic area whose population has distinctly similar income characteristics (e.g., a very rich or very poor neighborhood within a city).

405.506 Charges Higher Than Customary or Prevailing Charges.—A charge which exceeds either the customary charge of the physician or other person who rendered the medical or other health service, or the prevailing charge in the locality, or both, may be found to be reasonable, but only where there are unusual circumstances, or medical complications requiring additional time, effort or expense which support an additional charge, and only if it is acceptable medical or medical service practice in the locality to make an extra charge in such cases. On the other hand, the mere fact that the physician's or other person's customary charge is higher than prevailing would not justify a determination of reasonable charge higher than the prevailing charge.

405.507 Illustrations of the Application of the Criteria for Determining Reasonable Charges.—The following examples illustrate how the general criteria on customary charges and prevailing charges might be applied in determining reasonable charges under the supplementary medical insurance program. Basically, these examples demonstrate that, except where the actual charge is less, reasonable charges will reflect current customary charges of the particular physician or other person within the ranges of the current prevailing charges in the locality for that type and level of service:

The prevailing charge for a specific medical procedure ranges from $80 to $100 in a certain locality.

Doctor A's bill is for $75 although he customarily charges $80 for the procedure.

Doctor B's bill is his customary charge of $85.

Doctor C's bill is his customary charge of $125.

Doctor D's bill is for $100, although he customarily charges $80, and there are no special circumstances in the case.

The reasonable charge for Doctor A would be limited to $75 since under the law the reasonable charge cannot exceed the actual charge, even if it is lower than his customary charge and below the prevailing charges for the locality.

The reasonable charge for Doctor B would be $85, because it is his customary charge and it falls within the range of prevailing charges for that locality.

The reasonable charge for Doctor C could not be more than $100, the top of the range of prevailing charges.

The reasonable charge for Doctor D would be $80, because that is his customary charge. Even though his actual charge of $100 falls within the range of prevailing charges, the reasonable charge cannot exceed his customary charge in the absence of special circumstances.

405.508 Determination of Comparable Circumstances; Limitation.—(*a*) *Application of Limitation.*—The carrier may not in any case make a determination of reasonable charge which would be higher than the charge upon which it would base payment to its own policyholders for a comparable service in comparable circumstances. The charge upon which it would base payment, however, does not necessarily mean the amount the carrier would be obligated to pay. Under certain circumstances, some carriers pay amounts on behalf of individuals who are their policyholders, which are below the customary charges of physicians or other persons to other individuals. Payment under the supplementary medical insurance program would not be limited to these lower amounts.

(*b*) *When Comparability Exists.*—"Comparable circumstances," as used in the Act and this subpart, refers to the circumstances under which services are rendered to individuals and the nature of the carrier's health insurance programs and the method it uses to determine the amounts of payments under these programs. Generally, comparability would exist where:

(1) The carrier bases payment under its program on the customary charges, as presently con-

stituted, of physicians or other persons and on current prevailing charges in a locality, and

(2) The determination does not preclude recognition of factors such as specialty status and unusual circumstances which affect the amount charged for a service.

(c) *Responsibility for Determining Comparability.*—Responsibility for determining whether or not a carrier's program has comparability will in the first instance fall upon the carrier in reporting pertinent information about its programs to the Social Security Administration. When the pertinent information has been reported, the Social Security Administration will advise the carrier whether any of its programs have comparability.

405.520 Reimbursement for Services of Interns, Residents and Supervising Physicians; General.—(a) Under the health insurance program, almost all the aged have protection against hospital expenses, and the great majority also have protection against medical expenses. This health insurance coverage is intended to provide a substantial measure of freedom to beneficiaries in selecting hospitals and physicians of their choice. Whatever the choice, beneficiaries, as insured patients, are to be accorded the same status as other insured and paying patients in regard to the hospital and medical care they are provided.

(b) Many beneficiaries will choose to receive the care they need from hospitals with approved graduate medical education programs and from other institutions where services of interns and residents are provided. Many will receive care in these hospitals as patients of physicians who, in turn, will involve interns and residents in the care of their patients. The basis for reimbursement for such services by interns and residents is different from that applicable to such physicians' services.

405.521 Services of Attending Physicians Supervising Interns and Residents.—(a) Attending physicians' services rendered to beneficiaries in a teaching setting are covered under the supplementary medical insurance program and the payment for such services is on the basis of reasonable charges (*see* paragraphs (b) and (c) of this section). The costs to a hospital for teaching services furnished by a physician in connection with an approved graduate medical education program are allowable in accordance with the principles of reimbursement for provider costs (*see* paragraph (d) of this section).

(b) Payment on the basis of reasonable charges is applicable to the professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient. In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician. A charge should be recognized under Part B for the services of an attending physician who involves residents and interns in the care of his patient only if his services to the patient are of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients. The carrying out by the physician of these responsibilities would be demonstrated by such action as: Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission; confirming or revising diagnosis; determining the course of treatment to be followed; assuring that any supervision needed by the interns and residents was furnished; and by making frequent reviews of the patient's progress.

(c) Charges for such services of the attending physician may be billed either directly by him or by the hospital under arrangements between the physician and the hospital. In either case, the amount payable under the program for such services may be determined in accordance with the same criteria for the determination of reasonable charges as are applicable to the services which the physician renders to his other patients (*see* §§ 405.501–405.508 of this Subpart E).

(d) It is recognized that there will necessarily be situations where a patient will receive medical services in the teaching setting for which payment on the basis of reasonable charges will not be applicable. For example, there will be instances where it will neither be necessary from the standpoint of the medical needs of the patient nor appropriate from the standpoint of the continuing development of the residents' competence for there to be an attending physician who carries out the responsibilities referred to in paragraph (b) of this section. Whether or not a physician makes a charge recognized under the supplementary medical insurance program for services to patients which involve the participation of residents or interns, the hospital can receive reimbursement on a cost basis for an appropriate share of the compensation it pays its residents and interns. If the teaching program is an approved ed-

ucational activity of the hospital, reimbursement will also be available on a cost basis to the hospital for an appropriate share of the compensation it pays to physicians for teaching services (as opposed to professional services which contribute to the diagnosis or treatment of the patient) and for other costs of educational programs conducted by the hospital. These costs are allowable in accordance with the principles of reimbursement for provider costs (*see* § 405.421 of Subpart D).

(*e*) Nothing in the foregoing restricts the disposition of payments for services received either from the health insurance program or from beneficiaries, in accordance with agreements between hospital and physicians.

405.522 Interns' and Residents' Services in Approved Teaching Programs.—(*a*) Title XVIII of the Act gives recognition to hospital teaching programs which are duly approved in their respective fields by the Council on Medical Education of the American Medical Association, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or the Council on Dental Education of the American Dental Association.

(*b*) Services of interns and residents in such approved programs are explicitly excluded from the definition of "physicians' services" (*see* Subpart R) and are covered as hospital services. This exclusion applies whether or not the intern or resident may be authorized to practice as a physician under the laws of the State in which he performs his services. In accordance with the basis for payment under the health insurance program for services provided by participating hospitals, the cost of the services of interns and residents is reimbursable to the hospital, specifically as a component of allowable costs defined by the principles of reimbursement for provider costs set forth in Subpart D of Part 405. Under the principles discussed in Subpart D of this Part 405, an appropriate share of the provider's total allowable costs is reimbursable under the health insurance program. (For purposes of including services of interns and residents as an element of allowable cost in accordance with these principles, recording and reporting by the hospital of the specific services rendered to individual beneficiaries is not necessary.)

(*c*) Conversely, services of interns and residents are not reimbursable under the health insurance program on the basis which applies to physician's services, i.e., reasonable charges (*see* §§ 405.501–405.508 of this Subpart E). This distinction with respect to the basis for the health insurance program reimbursement applies to services of interns and residents whether covered by the hospital insurance program or the supplementary medical insurance program. The cost of outpatient diagnostic services (*see* § 405.145) covered under the hospital insurance program (*see* Subpart A of Part 405) and other outpatient services (*see* § 405.231) covered under the supplementary medical insurance program (*see* Subpart B of Part 405) which are provided by a hospital, including intern and resident services where involved, is reimbursed to the hospital under the health insurance program to the extent of 80 percent of the cost of services rendered to the beneficiaries after recognition of the deductible amount (*see* § 405.142 and § 405.240 (d)). The beneficiary will incur the expense of the deductible and coinsurance amounts as determined on the basis of the hospital's charges to the beneficiary. Hospital charges may include a charge for the services of interns or residents as a specific item, or these services may be included in the general charges to the beneficiary made by the hospital for the covered services it provides.

405.523 Interns' and Residents' Services Not in Approved Teaching Programs.—(*a*) The services of a hospital resident or intern who is not under an approved teaching program in the hospital are reimbursable to the hospital on a cost basis under the supplementary medical insurance program. For purposes of this section, such services shall be deemed to include services of a physician employed by the hospital who is authorized to practice only in a hospital setting. Even where such services are rendered to inpatients, the cost of the services is not an allowable cost under the hospital insurance program but is allowable under the supplementary medical insurance program.

(*b*) In this connection reimbursement under the health insurance program for services discussed in paragraph (*a*) of this section will be to the hospital in an amount of 80 percent of the cost of services rendered to the beneficiaries after recognition of the deductible. The beneficiary will incur the expense of the deductible and coinsurance amounts as determined on the basis of the hospital's charges to the beneficiary for its services that are covered under the supplementary medical insurance program.

405.524 Interns' and Residents' Services Outside the Hospital.—(*a*) Under the hospital insurance program, the allowable costs on which reimbursement to a participating extended care facility for covered services is based may include

the cost of services of an intern or resident who is under an approved teaching program in a hospital with which the facility has a transfer agreement (*see* § 405.1133) which provides, in part, for the transfer of patients and the interchange of medical records. Likewise, a participating home health agency may be reimbursed under the hospital insurance program for the cost of the services of an intern or resident who is under an approved teaching program of a hospital with which the home health agency is affiliated or under common control, where these services are furnished as part of the posthospital home health visits for a medicare beneficiary.

(*b*) Medical services of a resident or intern of a hospital which are furnished by a provider of services are reimbursed under the supplementary medical insurance program on an 80 percent of allowable cost basis if reimbursement is not provided under the hospital insurance program.

405.525 Basis of Reimbursement Under the Health Insurance Program for Services of Interns and Residents.—

Status of Patient	Status of Intern or Resident[1]	Reimbursement Provided Under[2]	Basis of Payment[3]
Hospital inpatient	Under approved program	Part A	Cost.
	Other	Part B	80 percent of cost.
Receiving outpatient hospital diagnostic services	Under approved program	Part A	Do.
	Other	Part B	Do.
Receiving therapeutic outpatient hospital services	Under approved program	----do	Do.
	Other	----do	Do.
Extended care facility inpatient.	Under approved program of a hospital with which facility has a transfer agreement.	Part A	Cost.
	Other	Part B	80 percent of cost.
Home health plan patient	Posthospital services furnished under approved programs of hospital with which the Home Health Agency is affiliated or under common control.	Part A	Cost.
	Other	Part B	80 percent of cost.

[1] An "approved program" means approval by the Councilon Medical Education of the AMA, by the Committee on Hospitals of the Bureau of Professional Education of the AOA, or by the Council of Dental Education of the ADA. "Other" interns and residents include, in addition to interns and residents-in-training, a physician employed by the hospital who is authorized to practice only in the hospital setting.

[2] "Part A" refers to the hospital insurance program and "Part B" refers to the supplementary medical insurance program.

[3] The term "cost" refers to reimbursement on a cost basis in accordance with the principles in Subpart D of Part 405.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

HI:PS:H

April 1969

BUREAU OF HEALTH INSURANCE
INTERMEDIARY LETTER NO. 372

SUBJECT: Part B payments for services of supervising physicians in a teaching setting

From questions which have been raised and from our onsite reviews, there appears to be a serious need to obtain a better and more uniform understanding among carriers, providers, and physicians of the conditions under which payment may be made under Part B for services rendered to patients by supervising physicians in the teaching setting and the method for determining the reasonable charge which may be recognized for such services. The enclosed guidelines are intended to clarify and supplement the criteria that govern reimbursement in this area as reflected in §§6102.7, 6335, and 6720 ff. of the Part B Intermediary Manual.

Carriers are urged to review their present reimbursement practices in light of these guidelines and to take appropriate action as soon as possible to bring practices into conformity with the guidelines. The Part B Intermediary Manual will be revised to incorporate these clarifications and additions.

Thomas M. Tierney, Director
Bureau of Health Insurance

Enclosure

Part B Payments for Services of Supervising Physicians in a Teaching Setting

A. Conditions Which Must be Met for a Teaching Physician to be Eligible for Part B Reimbursement as an Attending Physician

The physician* must be the patient's "attending physician." This means he must, as demonstrated by performance of the activities listed below, render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized; his services to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients.

1. To be the "attending physician" for an entire period of hospital care, the teaching physician must as a minimum:

   a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

   b. personally examine the patient; and

   c. confirm or revise the diagnosis and determine the course of treatment to be followed; and

   d. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and

   e. be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and

---

*The term "physician" does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff. For example, a senior resident who is referred to as an "assistant attending surgeon" or an "associate physician" would still be considered a resident since the senior year of the residency is essential to completion of the program.

f. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

EXAMPLE: A supervising physician carried out all of the activities listed above for a surgical patient but (e). He was not present in the OR when the major surgery was performed because supervision of the 5th-year resident performing the operation was not required. A physician's charge would not be recognized for the surgical procedure because criterion (e) was not met. Therefore, the physician would not be an attending physician for the period of hospital care although he might meet the criteria listed in A.2. below and be held as the attending physician for a portion of the care provided.

Even if the supervising physician chose to be present in the OR, payment could not be made to him for the surgical procedure since his presence was not medically necessary and he could not, therefore, function as the attending physician in connection with the surgery. However, if he was scrubbed and acted as an assistant, payment could be made to him as a surgical assistant if such an assistant was needed and another resident or physician did not fill the role (see item A.2. below).

If the supervising physician was present at surgery, and the surgery was performed by a resident acting under his close supervision and instruction, he would not be the attending surgeon unless it were customary in the community for such services to be performed in a similar fashion to private patients who pay for services rendered by a private physician.

EXAMPLE: A group of physicians share the teaching and supervision of the house staff on a rotating basis. Each physician sees patients every third day as he makes rounds. No physician can be held to be one of these patient's attending physician for any portion of the hospital care although consultations and other services they personally perform for the patient might be covered.

2. A teaching physician may be held to be the attending physician for a portion of a patient's hospital stay: if the portion is a distinct segment of the patient's course of treatment (e.g., the pre-operative or post-operative period) and of sufficient

duration to impose on the physician a substantial responsibility for the continuity of the patient's care; if the physician, as a minimum, performs all of the activities described above with respect to that portion of the stay; and if the physician is recognized as the patient's physician fully responsible for that part of the stay. If a teaching physician is not found to be the attending physician with respect to a portion of a patient's stay, he may not be reimbursed for any service provided to the patient for that portion of the stay unless it is an identifiable service that he personally rendered to the patient.

EXAMPLE: A physician carried out all of the activities listed above for a surgical patient until midway in the post-operative period, when the physician's teaching tour of duty ended. Since he was not responsible for the continuing care of the patient throughout the post-operative period, he cannot be reimbursed as the attending physician for that period.

3. Performance of the activities referred to above must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician.

4. The services of a teaching physician while visiting patients during grand rounds is basically teaching and does not contribute to an "attending" relationship with any of the patients visited.

5. An emergency-room supervising physician may not customarily be considered to be the attending physician of patients cared for by the house staff. It is only through his direct personal involvement with a patient that a charge may be recognized under Part B. Such an involvement would necessarily include personal examination of the patient as well as direction of and responsibility for the treatment provided.

B. Determining the Amount Payable Under Part B

1. The amount paid for direct medical services rendered by the teaching physician should be related to only that discrete portion of the patient's care for which the physician exercised the pertinent responsibilities of an attending physician outlined in A.1. For example, if the patient's personal physician furnishes services before the hospital admission and after the discharge and the teaching physician becomes the attending physician only with respect to the inpatient care, the lesser extent of the teaching physician's service should be taken into account in recognizing a charge; otherwise the out-of-hospital service would be billed for and paid twice. Similarly, if surgery was performed and the teaching physician rendered identifiable personal service to the patient in the operating

room, it is necessary to determine whether that physician performed services more nearly analogous to a consultant, an assistant at surgery (see first "Example" in part A), or as the "attending" surgeon in order to identify the appropriate reasonable charge. If the physician acted as the attending surgeon but did not render the pre- or post-surgical services generally performed by a private surgeon to a private patient, the difference in service should be reflected in the amount of reimbursement.

2. The following conditions should be taken into account in determining the "customary" charges of teaching physicians for services which they provide as attending physicians to Medicare beneficiaries.

   a. If the teaching physician has a substantial practice outside the teaching setting (i.e., more than half of the time spent in the practice of medicine is spent caring for people who were his patients before they were hospitalized or who were referred to him by physicians responsible for their care outside the hospital setting), his "customary" charges for services in the teaching setting will be related to the amounts he charges for similar services in his outside practice. Where the services performed in the teaching setting differ from those in the outside practice, reductions should be made for the lesser scope of services provided, time spent, visits or responsibility as an attending physician (not counting supervisory acts as time or visits).

   b. If the teaching physician does not have a substantial practice outside the teaching setting and the provider has established one or more schedules of charges which are collected for medical and surgical services furnished to a majority of non-Medicare teaching patients, his charges should be related to the provider's schedule of charges which are most frequently collected.

   EXAMPLE: A hospital with an approved teaching program receives payment for physicians' services rendered to 80 percent of its non-Medicare patients. Fifty percent are paid for by public assistance under a relatively low payment schedule; 20 percent are covered under a Blue Shield Plan with a somewhat higher fee schedule and the balances are covered under commercial plans. Since collections are made for a majority of patients and the most frequently used schedule of payment is the welfare schedule, the welfare schedule of charges should serve as the basis for determining the teaching physicians' customary charges for Medicare.

c. Where neither the physician nor the provider has established charges for the physician's services which are in effect for non-Medicare patients, the carrier and intermediary must make the necessary charge and cost determination based on that portion of the physician's compensation which is for services to patients, determined pursuant to the regulations governing reimbursement for the services of provider-based physicians.

3. Where teaching physicians of a hospital, billing through a hospital or other organization, adopt a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting, carrier acceptance of the schedule for reimbursement purposes should be based on a finding that the schedule does not exceed the average of reasonable charges which would be determined if each physician were individually reimbursed his reasonable charge for the services involved.

4. In determining the number of visits which may be considered reasonable, e.g., in a course of treatment for which a global fee is not ordinarily charged, the total number of visits which would have been made to the patient in a nonteaching setting should be used as a guide; visits in excess of this number are presumed to be primarily for teaching purposes. Similarly, total reasonable charges for a course of treatment in the teaching setting should be compared with and should not exceed the charges that would be expected in nonteaching settings for similar services. Also, the charges billed for an hour of a teaching physician's services should not exceed the amount of fees the physician generally receives for an hour's work in caring for nonteaching patients.

5. Where payment is made under Part B on a reasonable charge basis, payment may not also be made on a cost basis to the hospital for the same service as a teaching service. Part A payments to the hospital should therefore not be based on the total compensation of the physician if that compensation is in part for patient care. The total compensation should be reduced by the portion paid for patient care in accordance with the applicable provisions of the principles of reimbursement for services of hospital-based physicians to arrive at the hospital cost portion. Allocation of compensation received between both parts of the program should be in accordance with how the physician's time is actually spent. If a physician's only compensation for services in a teaching setting are paid by the hospital and the agreement states that only the supervisory, and not patient care, services are compensated, it is necessary to look behind the words of the agreement by reviewing the physician's actual obligations and activities and determining whether the compensation level is

reasonable for the supervisory and teaching services alone and insufficient to cover patient care services as well. The carrier and intermediary should make this finding jointly.

EXAMPLE: An employment agreement between a physician and the hospital states that he will be paid $50,000 a year for administration, supervision and teaching. However, he spends one-half of his time in providing patient care. The carrier and intermediary determined that if his compensation were allocated solely to the time the physician spent in the performance of his hospital duties, it would yield an hourly rate of compensation about double the rate paid for similar work elsewhere in the area. Therefore, the carrier and intermediary concluded that only a portion of the compensation was for hospital activities and reimbursable under Part A. Since charges were not customarily billed for the medical services the physician provided, the remainder would serve as a basis for computing the physician's reasonable charges for patient care in accordance with B.2.b. above.

C. Carrier Responsibilities for Claims Review and Verification

1. The carrier is responsible for assuring that the bills being submitted were prepared with an understanding of the conditions governing payment for physicians' services in the teaching setting.

   To help carry out this responsibility, carriers will not pay bills (SSA-1490 or SSA-1554) for services rendered in the teaching setting in any month after May 1969, unless:

   a. the chief of the department or service involved certifies on a form furnished by the carrier that each of the billed services for that month meets the pertinent requirements of A.1.; or

   b. the bill has been signed by the attending physician and he understands that he is certifying that he met the requirements for those services for which the claim is made.

2. The provision of personal and identifiable services must be substantiated by appropriate and adequate recordings entered personally by the physician in the hospital or, in the case of outpatient services, outpatient clinic chart. The carrier is expected as part of its responsibilities to make appropriate checks of patient records, examining admission, progress, and discharge notes to verify that services for which charges are billed met the appropriate coverage criteria. If the carrier

review shows that a significant portion of the services in the sample do not meet the criteria, appropriate steps should be taken to adjust the reimbursement.

3. Bills must indicate when services are furnished in the teaching setting, the name of the provider and attending physician involved, and the extent of the services provided as an attending physician. The services must be defined and quantified to avoid errors in applying the reasonable charge limitation--e.g., to avoid applying the reasonable charge for a global service where only the surgical procedure or another component service was provided as an attending physician.

4. The carrier will need to carry out the steps necessary to assure itself that these conditions set out in B.1. are met--for example, to assure itself that any schedule of charges proposed for the teaching setting is actually applied and collected.

D. Who May Bill

Where the supervising physician is a member of a group which provides teaching services in a hospital, the Part B payment for services rendered as attending physicians by the group may be billed for:

1. by the physician or a corporation, partnership, or other organization of physicians (including an association of teaching physicians organized for the purpose of billing for and distributing insurance monies and other payments received for professional services to patients) on form 1490;

2. by the hospital on form 1554 provided that the carrier has determined that the certification described in C.1.a. has been executed and complied with; and

3. if the services are performed by a physician who is a faculty member of a medical, osteopathic, or dental school, by the school on form 1490.

The individual physician's authorization is required to be on file in writing with the hospital or other organization to permit any of the above organizations to bill on his behalf. The organization must furnish to the Part B carrier the names of the physicians who have authorized the organization to bill on their behalf, and must agree to keep the carrier informed on a current basis of changes in membership in the group.

APPENDIX D

Detail, by Several Classifications, of the Status of Federal Housing Administration Loan Activity With Respect to Nursing Homes

(Material requested for the record at p. 269 of this hearing)

Detail, by Several Classifications, of the Status of Federal Housing Administration Loan Activity With Respect to Nursing Homes

TITLE II SECTION 232
NURSING HOME PROGRAM
BY NAME AND LOCATION OF SPECIFIC PROJECT
CUMULATIVE AS OF DECEMBER 31, 1968

TERMINATIONS OF MORTGAGE INSURANCE

PREPAYMENTS IN FULL

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF BEDS	CONST STATUS	PROC ST.
ALABAMA												
062-43003	PM		0	01	045	08	HUNTSVILLE	CRESTWOOD NURSING HM	737,259	120	3	A
060-43001	PM		0	01	049	01	MOBILE	MT PLEASANT	460,800	81	4	A
CALIFORNIA												
122-43005	PM		0	05	033	38	RIVERSIDE	ALTA VISTA CONV	272,500	64	4	A
136-43003	PM		0	05	034	03	SACRAMENTO	COTTAGE WAY VENTURES	360,000	50	4	A
CONNECTICUT												
017-43014	PM		0	07	002	06	BRISTOL	BRISTOL CONV HM	447,300	71	4	A
017-43002	PM	EC	1	07	001		FAIRFIELD	CAROLTON HOSPITAL	371,500	91	4	A
017-43006	PM	EC	1	07	001		FAIRFIELD	VAN DOREN HOSPITAL	299,465	50	1	A
017-43001	PM	EC	1	07	003	06	TORRINGTON	MIGEON MANOR INC	341,953	89	4	A
ILLINOIS												
072-43003	PM		0	14	057	17	BLOOMINGTON	HERITAGE MANOR N H	559,517	86	4	A
071-43004	PM		0	14	016		CHICAGO	MARINE MANOR	811,168	150	3	A
KENTUCKY												
083-43007	PM		0	18	056	03	LOUISVILLE	MT HOLLY N H INC	470,800	100	4	A
MICHIGAN												
044-43007	PM		0	23	082		DETROIT	LAW DEN NURSING HM	259,100	63	4	A
047-43018	PM		0	23	041	05	GRANDVILLE	BROOKCREST N H	370,300	62	4	A
047-43017	PM		0	23	059	10	LAKEVIEW	KELSEY MEMORIAL MED	383,000	62	4	A
047-43016	PM		0	23	061	09	MUSKEGON	MUSKEGON NURSING HM	345,000	60	4	A
044-43005	PM		0	23	074	08	PORT HURON	MARWOOD MANOR INC	180,700	50	4	A
044-43002	PM		0	23	063		ROYAL OAK	SHERWOOD HALL HOME	225,000	64	4	A
047-43008	PM		0	23	080	04	SOUTH HAVEN	RESTWOOD INN INC	274,600	52	4	A
NEBRASKA												
103-43001	PM		0	28	055	01	LINCOLN	HOMESTEAD N H	410,169	80	2	A
NEW JERSEY												
035-43001	PM		0	31	001	02	LINWOOD	LINWOOD N H	415,400	76	4	A
031-43033	PM		0	31	002	07	MAHWAH	MT CREST NURSING HM	194,824	100	1	A
NEW YORK												
013-43001	PM	EC	1	33	001	29	ALBANY	ALBANY GDNS NURSING	408,800	176	4	A
014-43001	PM		0	33	015		CHEEKTOWAGA	KING MANOR	318,000	80	4	A
OHIO												
046-43001	PM		0	36	029	07	XENIA	BRANTHAVEN INC	253,800	44	4	A
OKLAHOMA												
118-43001	PM	EC	1	37	021	02	GROVE	BETTY ANN N H	102,700	32	4	A
OREGON												
126-43002	PM		0	38	020	04	SPRINGFIELD	PACIFIC CONV FDN INC	306,400	74	4	A
TEXAS												
113-43009	PM		0	44	220		ARLINGTON	ARLINGTON CONV CT	162,000	50	4	A
VERMONT												
026-43002	PM		0	46	004		BURLINGTON	BIRCHWOOD NURSING HM	292,800	68	1	A
WISCONSIN												
075-43004	PM		0	50	032	03	WEST SALEM	MULDER NURSING HM	232,700	50	4	A
							29 TOTAL		$ 10,267,555	2195		

PREPAYMENTS WITH SUPERSESSION

GEORGIA												
061-43007	PM		0	11	044	04	DECATUR	MARY B MOODY NURS HM	639,600	100	4	B
MICHIGAN												
047-43013	PM		0	23	083	09	CADILLAC	LAKEVIEW MANOR INC	346,500	60	4	B
044-43001	PM		0	23	082		DETROIT	MOROUN NURSING HM	397,200	88	4	B
047-43019	PM		0	23	041	05	GRAND RAPIDS	GRAND VALLEY NURS HM	418,400	64	4	B
047-43014	PM		0	23	034	05	IONIA	IONIA MANOR INC	319,200	60	4	B
NEW MEXICO												
031-43001	PM		0	31	002		WESTWOOD	VALLEY NURSING HM	394,500	60	4	B
TENNESSEE												
081-43001	PM		0	43	079		MEMPHIS	BRIGHT GLADE NURS HM	255,400	47	4	B
WISCONSIN												
075-43002	PM		0	50	013	02	VERONA	FOUR WINDS MANOR INC	268,564	41	4	B
							8 TOTAL		$ 3,039,364	520		

Department of Housing and Urban Development
Federal Housing Administration
Division of Research and Statistics
Statistics Section 3/17/69

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF UNITS	CONST STATUS	PROC ST.
MORTGAGES ASSIGNED TO FHA HELD												
CALIFORNIA												
136-43002	PM	0	05	034	03	SACRAMENTO		PK SUTTER HOSPITAL	1,033,000	132	4	C
COLORADO												
101-43004	PM	0	06	003	02	DENVER		MAGDALENE GDNS N H	851,800	180	4	C
FLORIDA												
066-43002	PM	0	10	013		NORTH MIAMI		ARCH CREEK NURS HM	655,700	98	4	C
066-43004	PM EC	1	10	050	09	W PALM BEACH		PALM CREST NURS HM	357,600	57	4	C
ILLINOIS												
071-43010	PM R EC	1	14	016		CHICAGO		LAKE VISTA HMS	2,031,300	453	4	C
KENTUCKY												
083-43010	PM	0	18	071	01	AUBURN		AUBURN COMM NURS HM	162,000	30	4	C
MONTANA												
093-43005	PM	0	27	007	02	GREAT FALLS		PK PLACE NURS HM	337,500	60	4	C
OKLAHOMA												
117-43002	PM	0	37	055	05	OKLAHOMA CIT		GERIATRIC N H	956,000	148	4	C
TEXAS												
115-43001	PM	0	44	178	14	CORP CHRISTI		CORPUS CHRISTI N H	478,800	100	4	C
112-43016	PM	0	44	175	06	CORSICANA		MEL MAYEN CONV HM	472,900	100	4	C
114-43002	PM	0	44	101		HOUSTON		STONEY BROOK CONV HM	568,800	100	4	C
112-43015	PM	0	44	092	04	LONGVIEW		GOOD SAMARITAN N H	488,600	100	3	C
082-43002	PM	0	44	019	01	TEXARKANA		TANGLEWOOD CONV CT	291,600	50	4	C
112-43014	PM	0	44	212	04	TYLER		MEL ROSE CONV HM	468,900	100	4	C
						14 TOTAL			$ 9,154,500	1708		
MORTGAGES ASSIGNED TO FHA DISPOSED OF WITHOUT REINSURANCE												
NEW JERSEY												
035-43002	PM	0	31	001	02	PLEASANTVILL		GLENDALE NURS HM	769,679	102	4	E
PROJECTS ACQUIRED BY FHA HELD-												
MONTANA												
093-43002	PM	0	27	056	02	BILLINGS		NEW WESTERN MANOR	1,222,200	158	4	G
OREGON												
126-43007	PM	0	38	026		PORTLAND		W HILLS CONV CT	749,800	102	4	G
TEXAS												
112-43002	PM EC	1	44	057		DALLAS		CLIFF TOWERS NURS HM	1,911,600	312	4	G
						3 TOTAL			$ 3,883,600	572		
PROJECTS ACQUIRED BY FHA SOLD WITH MORTGAGE HELD BY FHA												
INDIANA												
073-43002	PM	0	15	034	05	HOWARD		KOKOMO CONV CT INC	367,200	60	4	J
TEXAS												
114-43003	PM	0	44	101		HOUSTON		SHARPVIEW NURS HM	940,000	131	4	J
133-43002	PM	0	44	152	19	LUBBOCK		COLONIAL MANOR NURS	509,600	132	4	J
						3 TOTAL			$ 1,816,800	323		
VOLUNTARY TERMINATIONS												
NEW YORK												
015-43001	PM	0	33	028		ROCHESTER		PAVILION NURS HM	1,241,198	176	3	N
PENNSYLVANIA												
034-43001	PM	0	39	051		PHILADELPHIA		ASHTON HALL NURS HM	502,000	82	4	N
						2 TOTAL			$ 1,743,198	258		
						60 TOTAL ALL TRANSACTIONS			$ 30,674,696	5678		
INSURANCE IN FORCE												
ALABAMA												
062-43001	PM	0	01	037		BIRMINGHAM		ROSE MANOR	691,000	108	4	S
062-43006	PM	0	01	037		BIRMINGHAM		BURGESS NURS HM	391,700	53	4	S
062-43005	PM	0	01	037		BIRMINGHAM		HANOVER HOUSE	561,400	80	4	S
060-43003	PM	0	01	002	02	FOLEY		FOLEY NURS CT	433,000	82	4	S
060-43002	PM	0	01	049	01	MOBILE		COOBURN NURS HM	525,000	88	4	S
062-43007	PM	0	01	051	02	MONTGOMERY		TYSON MANOR	854,100	125	4	S
062-43008	PM	0	01	051	02	MONTGOMERY		S HAVEN NURS HM	400,000	82	4	S
ARIZONA												
123-43009	PM	0	03	003	03	FLAGSTAFF		FLAGSTAFF NURS HM	232,700	40	4	S
123-43004	PM	0	03	007		PHOENIX		THE BELLS NURS HM	567,900	96	4	S
123-43010	NP	0	03	007	01	PHOENIX		TANNER CHAPEL MANOR	248,300	50	4	S
123-43011	PM	0	03	007		PHOENIX		DESERT TER NURS HM	277,700	64	4	S
139-43002	PM	0	03	010	02	TUCSON		SANTA ROSA NURS HM	498,700	100	4	S
ARKANSAS												
082-43001	PM	0	04	026	03	HOT SPRINGS		ROSEWOOD INC	730,300	100	4	S
082-43003	PM	0	04	005	03	HARRISON		HARRISON N H INC	235,800	50	4	S

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF UNITS	CONST STATUS	PROC ST.
CALIFORNIA												
122-43010	PM	0	05	030		ANAHEIM		LEISURE CARE CONV HM	401,700	81	4	5
121-43001	PM	0	05	041	11	BELMONT		CARLMONT VILLAGE CON	493,000	76	4	5
122-43004	PM	0	05	056	13	BUENA VENTUR		BRIERWOOD TERRA INC	572,803	79	4	5
136-43007	PM	0	05	034	03	CARMICHAEL		BEVERLY MANOR SACRA	587,700	80	4	5
136-43010	PM	0	05	007	02	CHICO		CRESTWOOD OF CHICO	685,800	92	1	5
122-43015	PM	0	05	019	23	COMPTON		ALONDRA W CONV	558,900	100	4	5
121-43025	PM EC	1	05	007	14	CONCORD		VALL MANOR GERIATRIC	840,400	107	1	5
122-43014	PM	0	05	030		COSTA MESA		LEISURE CARE NURS HM	419,100	79	4	5
121-43006	PM	0	05	041	11	DALY CITY		SKYLINE TERRACE	398,700	50	4	5
129-43003	PM	0	05	037		EL CAJON		T L C CO NURS HM	519,400	80	4	5
136-43008	PM	0	05	034	03	ELK GROVE		ELK GROVE NURS HM	305,400	50	4	5
136-43016	PM EC	1	05	034	03	ELK GROVE		ELK GROVE CONV HOSP	750,100	102	1	5
121-43008	PM EC	1	05	010	16	FRESNO		HOPE MANOR SANITAR	574,400	59	4	5
121-43019	PM	0	05	010	16	FRESNO		QUAD NURS HM	604,600	99	3	5
122-43003	PM	0	05	019		GLENDALE		CASA VERDUGO INC	374,400	46	4	5
122-43017	PM	0	05	019	31	INGLEWOOD		MANCHESTER CONV HM	1,611,000	200	4	5
121-43024	PM	0	05	044	10	LOS ALTOS		LOS ALTOS CONV HOSP	1,094,700	154	0	5
122-43009	PM	0	05	019		LOS ANGELES		L A CONV CENTER	1,431,000	180	4	5
121-43010	PM	0	05	043	10	LOS GATOS		BLOSSOM HILL NURS HM	553,300	72	4	5
121-43011	PM	0	05	043	10	LOS GATOS		TERRENO DE FLORES	462,600	64	4	5
121-43013	PM	0	05	043	09	MORGAN HILL		MONTA VILLA	402,200	51	4	5
121-43005	PM	0	05	028	01	NAPA		REDWOOD CONV HOSP	327,800	44	4	5
122-43016	PM	0	05	019	19	NORWALK		AUTUMN LEAVES CONV	578,900	99	1	5
121-43009	PM	0	05	001		OAKLAND		GLADMAN NURS HM	710,000	93	4	5
121-43007	PM	0	05	010	16	REEDLEY		VALLEY NURS HM	365,900	40	4	5
136-43001	PM	0	05	034	03	SACRAMENTO		CAMELLIA GDNS INC	314,411	50	4	5
136-43004	PM	0	05	034	03	SACRAMENTO		CENTRAL VALL CONV	361,800	58	4	5
136-43005	PM	0	05	034	03	SACRAMENTO		CAMELLIA TERRACE	323,500	50	4	5
136-43009	PM	0	05	034	03	SACRAMENTO		CAMELIA CENTER	814,500	99	4	5
136-43011	PM	0	05	034	03	SACRAMENTO		CAMELLIA MANOR	686,000	93	1	5
129-43001	PM EC	0	05	037		SAN DIEGO		CASA BLANCA CONV HM	405,020	52	4	5
121-43004	PM	0	05	038		SAN FRAN		CENTRAL CONV HMS INC	476,900	88	4	5
121-43015	PM	0	05	038	05	SAN FRAN		SAN FRAN TERRA NURS	1,099,300	120	4	5
121-43017	PM	0	05	038	05	SAN FRAN		FT PIERCE NURS INC	1,930,100	172	1	5
122-43007	PM	0	05	019	28	SANTA MONICA		SANTA MONICA CONV HM	350,100	64	4	5
122-43002	PM	0	05	019		VAN NUYS		W J MCKNIGHT NURS HM	431,400	90	4	5
121-43018	PM EC	1	05	054	18	VISALIA		VISALIA CONV CT	600,600	99	1	5
122-43006	PM	0	05	019		WHITTIER		SORENSON NURS HM CO	332,400	60	4	5
136-43014	PM EC	1	05	057	04	WOODLAND		WOODLAND CT CONV HOS	757,000	100	1	5
COLORADO												
101-43007	PM	0	06	007	02	BOULDER		BOULDER MANOR N H	566,800	100	4	5
101-43003	PM	0	06	016	01	DENVER		DAVIS N H INC	707,600	117	4	5
101-43005	PM	0	06	016	01	DENVER		BELLE VITA TOWERS	783,900	130	4	5
101-43006	PM	0	06	035	04	FT COLLINS		GOLDEN WEST N H	308,800	50	4	5
101-43009	NP		06	016	01	DENVER		CITY PK MANOR NURS	873,200	120	1	5
101-43002	PM	0	06	051	03	PUEBLO		HAVEN OF REST N H	364,400	81	4	5
CONNECTICUT												
017-43015	EC PM	1	07	001	04	BRIDGEPORT		GOLDEN HTS MANOR INC	928,600	124	3	5
017-43004	PM	1	07	001	05	DANBURY		GLEN HILL CONV CT	460,000	60	4	5
017-43008	PM	0	07	002	06	ENFIELD		ENFIELD NURS HM INC	464,400	90	4	5
017-43007	PM	0	07	001	04	GREENWICH		LAURELTON NURS HM	549,000	67	4	5
017-43011	PM	0	07	005	05	MERIDEN		WESTFIELD MANOR NURS	642,600	120	4	5
017-43020	PM	0	07	005	05	MERIDEN		MERIDEN MEMORIAL HM	780,500	120	4	5
017-43003	PM EC	1	07	005	03	MILFORD		POND POINT CONV HOSP	574,283	125	4	5
017-43017	PM	0	07	007	02	ROCKVILLE		ROCKVILLE NURS HM	729,700	120	4	5
017-43016	PM	0	07	001	04	SOUTHPORT		SOUTHPORT CONV HM	1,600,000	120	1	5
017-43005	PM	0	07	005	03	WEST HAVEN		SOUND VIEW MANOR HM	663,067	100	4	5
DELAWARE												
032-43005	PM	0	08	001	01	DOVER		COURTLAND MANOR NURS	955,000	100	1	5
032-43001	PM	0	08	002	01	WILMINGTON		EXETER HALL INC NURS	1,018,800	116	4	5
032-43002	PM	0	08	002	01	WILMINGTON		BRANDYWINE SPRINGS	691,500	100	4	5
DISTRICT OF COLUMBIA												
000-43001	PM EC	1	09	001	01	WASHINGTON		MAR SALLE	1,450,000	199	4	5
FLORIDA												
066-43026	PM	0	10	050	09	BOCA RATON		BOCA RATON CONV CT	907,200	100	0	5
066-43007	PM	0	10	050	09	BOYNTON BCH		BOULEVARD MANOR N H	635,900	100	4	5
067-43001	PM	0	10	041	07	BRADENTON		GROVEMONT NURS HM	242,100	50	4	5
067-43003	PM	0	10	041	07	BRADENTON		SUNCOAST MANOR NURS	651,600	105	4	5
067-43014	PM	0	10	052	08	CLEARWATER		HIGHLAND PINE NURS	390,000	73	4	5
066-43020	PM	0	10	006	10	DANIA		DANIA NURS HM	565,000	84	1	5
067-43004	PM	0	10	064	04	DAYTONA BEAC		CLYATT MEM GERIATRIC	723,000	101	4	5
063-43008	PM	0	10	001	02	GAINESVILLE		GAINESVILLE CONV CT	569,000	100	4	5
066-43011	PM	0	10	013	12	HOMESTEAD		HOMESTEAD MANOR N H	339,500	50	4	5
063-43003	PM	0	10	016	03	JACKSONVILLE		ST JUDE MANOR NURS	324,000	68	4	5
063-43005	PM	0	10	016	03	JACKSONVILLE		JACKSONVILLE CONV CT	651,900	100	4	5
067-43027	PM	0	10	005	05	MELBOURNE		BINZ NURS HM	746,100	101	1	5
066-43006	PM	0	10	013		MIAMI		MEMORIAL MED COMPLEX	1,049,116	130	4	5
066-43008	PM	0	10	013		MIAMI		SNAPPER CREEK N HM	730,800	100	4	5
066-43010	PM	0	10	013		MIAMI		LIVE OAKS N H	1,249,724	192	4	5
066-43022	PM	0	10	013	12	MIAMI		MIAMI CONV HM INC	895,500	147	1	5
066-43018	NP	0	10	013	12	MIAMI BEACH		JEWISH CONV HM	525,000	96	4	5
066-43027	PM	0	10	013	12	SOUTH MIAMI		S MIAMI CONV HM	1,020,600	126	1	5
066-43034	PM	0	10	013	12	MIAMI		GREENBRIAR NURS HM	1,620,000	200	0	5
063-43006	PM	0	10	042	04	OCALA		NEW HORIZON CONV HM	300,000	50	4	5
063-43015	PM EC	1	10	042	04	OCALA		NEW HORIZONS CONV	481,400	82	4	5
067-43007	PM	0	10	048	05	ORLANDO		BARRINGTON TERRACE	395,400	50	4	5
063-43011	PM	0	10	003	01	PANAMA CITY		PANAMA CITY NURS CT	324,900	50	4	5
063-43002	PM	0	10	017	01	PENSACOLA		N HILLS NURS HM	814,500	150	4	5

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF BEDS	CONST STATUS	PROC ST.
067-43010	PM EC	1	10	052	08	PETERSBURG		HUBER BESTORIUM	357,400	96	4	S
066-43014	PM	0	10	006	10	POMPANO BEAC		POMPANO COLONIAL HM	514,600	77	4	S
067-43024	PM	0	10	029	06	TAMPA		PADGETT NURS HMS INC	478,500	100	1	S
067-43013	PM	0	10	031	09	VERO BEACH		ROYAL PALM CONV CT	402,000	50	4	S
066-43013	PM	0	10	050	09	W PALM BEACH		CONV CT PALM BEACHS	583,011	91	4	S
067-43006	PM	0	10	053	07	WINTER HAVEN		GROVEMONT NURS HM	268,400	50	4	S
GEORGIA												
061-43002	PM	0	11	044	04	ATLANTA		FOUNTAIN VIEW INC	602,200	100	4	S
061-43016	PM	0	11	060	05	ATLANTA		SPRINGDALE NURS HM	727,200	100	4	S
061-43020	NP	0	11	060	05	ATLANTA		HAPPY HAVEN NURS HM	621,100	158	4	S
061-43010	PM	0	11	121	10	AUGUSTA		LEISURE HMS AUGUSTA	378,000	64	4	S
061-43017	PM	0	11	106	03	COLUMBUS		PINE MANOR NURS HM	540,200	87	4	S
061-43019	PM	0	11	078	09	COMMERCE		MINISM HM INC	226,500	50	4	S
061-43009	PM	0	11	155	07	DALTON		GERIATRICS INC	440,000	70	4	S
061-43022	PM	0	11	155	07	DALTON		GREATER DALTON NURS	655,200	100	2	S
061-43018	PM	1	11	044	04	DECATUR		MOODY NURS HM INC	1,367,100	209	4	S
061-43021	PM	0	11	034	08	DOUGLAS		SHADY ACRES INC	374,400	62	1	S
061-43008	PM	0	11	033	07	MARIETTA		THE SHOREHAM INC	768,700	100	4	S
087-43008	PM	0	11	146	07	ROSSVILLE		ROSSVILLE NURS HM	671,000	100	1	S
061-43005	PM	0	11	092	08	VALDOSTA		CRESTWOOD NURS HM	441,900	74	4	S
HAWAII												
140-43001	PM	0	12	002	01	HONOLULU		KIDA NURS HM	522,000	74	4	S
140-43003	PM	0	12	002	01	HONOLULU		THE CONV CT HONOLULU	1,252,200	150	4	S
IDAHO												
124-43001	PM	0	13	003	02	ALAMEDA		HILLCREST MANOR INC	849,800	64	4	8
124-43002	PM	0	13	001	01	BOISE		TREASURE VALL MANOR	378,000	84	4	S
124-43003	PM	0	13	010	02	IDAHO FALLS		GOOD SAMARITAN NURS CENTER	440,100	93	4	S
171-43001	PM	0	13	035	01	LEWISTON		LEWISTON MANOR NURS	198,943	50	4	S
171-43010	PM	0	13	005	01	ST MARIES		VALL VISTA CONV CT	359,100	60	3	S
171-43002	PM EC	1	13	009	01	SANDPOINT		SAND POINT MANOR	289,600	89	4	S
ILLINOIS												
072-43009	PM	0	14	029	19	AVON		AVON NURS HM	322,700	48	4	S
071-43022	PM	0	14	016	05	BRIDGEVIEW		BRIDGEVIEW VILLA	957,700	147	1	S
072-43006	PM	0	14	039	21	CARBONDALE		STYREST NURS HM	669,400	100	4	S
071-43002	PM	0	14	016		CHICAGO		SHERIDAN PAVILION	836,600	144	4	S
071-43020	PM	0	14	016	09	CHICAGO		BEACON VIEW NURS HM	836,900	141	3	S
071-43008	PM	0	14	016	02	DOLTON		SANDRA MEM NURS HM	359,500	61	4	S
071-43005	PM	0	14	089	16	FREEPORT		ORTIZ CONV HOUSE	170,000	42	4	S
072-43019	PM	0	14	018	22	GREENUP		CUMBERLAND NURS HM	307,500	50	1	S
071-43017	PM EC	1	14	049	12	HIGHWOOD		PAVILION HIGHLAND PK	570,000	89	3	S
072-43017	PM	0	14	068	23	HILLSBORO		HILLSBORO NURS HM	377,200	75	4	S
071-43013	PM EC	1	14	016	04	LA GRANGE		LA GRANGE NURS HM	1,027,800	180	4	S
071-43007	PM	0	14	016	04	LANSING		TRISTATE MANOR NURS	256,700	52	4	S
071-43015	PM	0	14	101	16	LOVES PARK		ENT TERRACE NURS HM	316,400	50	4	S
072-43007	PM	0	14	041	21	MT VERNON		HICKORY GROVE MANOR	637,697	100	4	S
072-43018	PM	0	14	041	21	MT VERNON		HICKORY GROVE MANOR	468,900	50	1	S
071-43006	PM	0	14	016		NILES		GROSS POINT MANOR	601,700	100	4	S
071-43009	PM	0	14	016		NILES		PLEASANTVIEW NURS HM	655,180	93	4	S
072-43005	PM	0	14	080	23	OLNEY		BURGIN NURS HM	350,000	74	4	S
071-43018	PM EC	1	14	016	13	PALATINE		PLUM GROVE NURS HM	556,000	67	3	S
071-43003	PM	0	14	101	16	ROCKFORD		ALMA NELSON MANOR	1,039,440	162	4	S
072-43010	PM	0	14	084	20	SPRINGFIELD		LINDSAY HOUSE CO	1,392,200	150	4	S
071-43024	PM	0	14	098	19	STERLING		WINDSOR ESTATES NO 7	396,400	60	1	S
INDIANA												
073-43009	PM	0	15	045	01	GARY		VILLA VISTA INC	597,600	100	4	S
073-43022	PM R	0	15	045	01	GARY	R 3	SIMMONS MILLER NURS	335,000	46	1	S
073-43004	PM	0	15	049		INDIANAPOLIS		GREENVIEW MANOR	1,070,000	150	4	S
073-43003	PM	0	15	046	03	LA PORTE		ANDERSON SANITARIUM	197,200	50	4	S
073-43019	PM	0	15	015	09	LAWRENCEBURG		ELSIE DREYER NURS HM	600,000	100	4	S
073-43011	PM	0	15	071	03	SOUTH BEND		FARRIS NURS HM NO 3	306,500	50	1	S
073-43004	PM	0	15	084	07	TERRE HAUTE		MEADOWS MANOR	650,400	100	4	S
073-43007	PM	0	15	064	02	VALPARAISO		EVERGREEN PK CONV HM	512,800	100	2	S
IOWA												
074-43002	PM	0	16	035	03	HAMPTON		HAMPTON NURS HM INC	222,300	46	4	S
074-43013	PM	0	16	064	04	MARSHALLTOWN		MARSHALLTOWN SR HM	483,300	80	1	S
074-43007	PM	0	16	033	02	OELWEIN		GRANDVIEW NURS HM	432,600	81	4	S
074-43006	PM	0	16	077	05	URBANDALE		KATER ARE AND KEEP	150,000	30	4	S
074-43017	PM	0	16	056	04	SIGOURNEY		MANOR HOUSE INC	184,300	46	4	S
074-43015	PM EC	1	16	007	01	WATERLOO		PARKVIEW NURS HM	900,000	160	2	S
KANSAS												
102-43002	PM	0	17	028	01	GARDEN CITY		BRIAR HILL MANOR INC	190,000	40	4	S
102-43005	PM EC	1	17	105	03	KANSAS CITY		UNIVERSITY N H INC	700,000	114	4	S
102-43001	PM	0	17	084	01	RUSSELL		GAGE N H	111,228	24	4	S
102-43007	PM	0	17	085	01	SALINA		KENWOOD VIEW N H	506,900	92	4	S
102-43009	PM	0	17	066	02	SENECA		CRESTVIEW MANOR	282,500	50	4	S
102-43006	PM	0	17	089	02	TOPEKA		TOPEKA CONV CT	725,100	100	4	S
KENTUCKY												
083-43001	PM	0	18	011	06	DANVILLE		FRIENDSHIP HOUSE INC	225,800	50	4	S
083-43018	PM	0	18	036	06	LEXINGTON		MERRICK MANOR INC	600,000	100	1	S
083-43004	PM	0	18	030	02	OWENSBORO		HILLCREST N H	455,949	100	4	S
083-43005	PM	0	18	073	01	PADUCAH		PARKVIEW N H	449,100	96	4	S
083-43008	PM	0	18	073	01	PADUCAH		RIVERSIDE N H INC	441,400	100	4	S
083-43017	PM	0	18	025	06	WINCHESTER		GLENWAY LODGE INC	261,000	50	4	S
LOUISIANA												
064-43002	PM	0	19	017	06	BATON ROUGE		THE GUEST HOUSE	590,400	100	4	S
064-43005	PM	0	19	017	06	BATON ROUGE		HOME CARE INC	447,500	100	4	S

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF [redacted]	CONST STATUS	PROC ST.
064-43009	PM	0	19	003	06	DONALDSONVIL		DVILLE HSE FALCON	235,000	50	4	S
064-43008	PM	0	19	026	02	HARVEY		MANHATTAN MANOR	585,000	100	4	S
059-43001	PM	0	19	009	04	SHREVEPORT		LOUISIANA NURS HM	549,200	98	4	S
059-43004	PM	0	19	009	04	SHREVEPORT		SUMMER GROVE QUEST	628,800	100	4	S
MAINE												
022-43003	PM	0	20	010	02	BANGOR		CHANDLER NURS HM	225,000	44	4	S
022-43005	PM	0	20	007	01	ROCKLAND		ROCKLAND NURS HM	330,000	60	1	S
022-43002	PM	0	20	016	01	SANFORD		HILLCREST MANOR NURS	414,000	74	4	S
022-43001	PM	0	20	008	01	WATERVILLE		LOVEJOY MANOR HM	415,000	74	4	S
MARYLAND												
052-43002	PM	0	21	003	07	BALTIMORE		3313 REALTY CORP	670,000	98	0	S
052-43003	PM	0	21	004		BALTIMORE		REALTY CORP	897,344	134	4	S
000-43002	PM	0	21	016	08	BETHESDA		UNIVERSITY NURS HM	1,083,200	150	4	S
052-43004	PM	0	21	003		CATONSVILLE		SUMMIT NURS HM INC	1,117,300	139	4	S
000-43010	PM	0	21	017	05	CLINTON		PINE VIEW GDN NURS	2,384,568	232	4	S
052-43001	PM	0	21	021	01	EASTON		HOUSE IN THE PINES	462,200	84	4	S
000-43009	PM	0	21	017	05	GREENBELT		GREENBELT CONV CT	772,700	94	4	S
000-43004	PM	0	21	017	05	LANHAM		THE L AND B NURS HM	759,300	99	4	S
000-43003	PM	0	21	016	08	ROCKVILLE		POTOMAC VALLEY NURS	1,132,100	160	4	S
000-43012	PM	0	21	016	08	TAKOMA PK		SLIGO GDNS NURS HM	940,200	100	1	S
MASSACHUSETTS												
023-43003	PM	0	22	001	12	BARNSTABLE		CENTERVILLE NURS HM	345,700	56	4	S
023-43001	PM	0	22	007	02	E LONGMEADOW		E LONGMEADOW NURS HM	394,963	75	4	S
023-43013	PM	0	22	001	12	FALMOUTH		FALMOUTH NURS HM	804,800	74	1	S
023-43002	PM	0	22	009	04	FRAMINGHAM		MEADOW BROOK MANOR 2	297,000	44	4	S
023-43007	PM	0	22	007	01	HOLYOKE		HOLYOKE NURS HM INC	845,700	100	4	S
023-43011	PM	0	22	001	12	HYANNIS		WHITEHALL MANOR NURS	585,400	76	1	S
023-43011	PM	0	22	009	05	MELROSE		ELMHURST NURS HM	625,500	44	1	S
023-43014	PM	0	22	005	07	METHUEN		WOODLAND NURS HM	850,000	100	1	S
023-43016	PM	0	22	005	07	SANGUS		N SHORE CONV CT INC	923,400	100	1	S
023-43008	PM	0	22	005	07	SAUGUS		LOUISE CAROLINE NURS	529,600	80	4	S
023-43005	PM EC	1	22	014	04	WORCESTER		CLARK MANOR NURS HM	423,400	100	4	S
023-43014	NP	0	22	014	04	WORCESTER		PEOPLES CHURCH NURS	725,500	80	1	S
MICHIGAN												
047-43015	PM	0	23	013	03	BATTLE CREEK		SPRINGHILL N H	430,900	64	4	S
047-43027	PM EC	1	23	089	09	CADILLAC		LAKEVIEW MANOR	696,100	112	1	S
044-43015	PM	0	23	081	02	CHELSEA		CHELSEA MED CT	960,800	110	0	S
044-43004	PM	0	23	082		DETROIT		EDGEWATER NURS HM	467,500	94	4	S
044-43010	PM EC	1	23	082		DETROIT		MOROUN NURS HM	1,150,000	164	4	S
044-43011	PM	0	23	082	13	DETROIT		GEORGIA COURT NURS	1,519,700	125	1	S
048-43009	PM	0	23	078	06	DURAND		DURAND CONV CT	357,300	50	4	S
044-43013	PM EC	1	23	063	19	FARMINGTON		GROSSE POINTE NURS	1,568,500	170	1	S
048-43002	PM	0	23	025	07	FLINT		C BARTON TERRACE INC	738,900	132	4	S
048-43007	PM	0	23	025	07	FLINT		EXTENDED CARE INC	853,200	92	1	S
047-43001	PM	0	23	041	05	GRAND RAPIDS		SPRINGBROOK RESU INC	469,300	65	4	S
047-43005	PM	0	23	041	05	GRAND RAPIDS		GREENVIEW NURS HM	409,312	60	4	S
047-43030	PM EC	1	23	041	05	GRAND RAPIDS		GRAND VALL NURS CT	1,317,700	162	2	S
048-43005	PM	0	23	009	10	HAMPTON		HAMPTON NURS HM	348,000	50	4	S
047-43010	PM	0	23	070	09	HOLLAND		BIRCHWOOD MANOR N H	326,000	60	4	S
047-43003	PM	0	23	033	06	HOLT		HOLT HM INC	572,900	64	4	S
047-43022	PM EC	1	23	034	05	IONIA		IONIA MANOR INC	687,700	120	4	S
047-43009	PM	0	23	038	06	JACKSON		MARLIN CONV CR	618,500	100	4	S
047-43012	PM	0	23	039	03	KALAMAZOO		KALAMAZOO N H INC	347,700	60	4	S
047-43028	PM	0	23	013	03	MARSHALL		MARSHALL MANOR INC	571,300	66	1	S
047-43011	PM	0	23	037	10	MT PLEASANT		PLEASANT MANOR INC	280,500	60	4	S
047-43006	PM	0	23	011	04	NILES		DOR A LIN OF NILES	312,400	50	4	S
047-43004	PM	0	23	024	11	PETOSKEY		PETOSKEY GERIATRIC	340,000	66	4	S
048-43001	PM	0	23	073	08	SAGINAW		HOYT N H INC	428,000	66	4	S
048-43004	PM	0	23	073	08	SAGINAW		MACCABEES GDNS	703,800	88	0	S
048-43006	PM	0	23	073	08	SAGINAW		HERITAGE NURS HM	430,000	66	4	S
047-43021	PM	0	23	011	04	ST JOSEPH		SHOREHAM MANOR INC	755,400	107	1	S
044-43005	PM	0	23	063	18	SOUTHFIELD		SOUTHFIELD NURS HM	500,000	100	4	S
044-43009	PM	0	23	063	18	SOUTHFIELD		BEDFORD VILLA NURS	319,500	59	4	S
048-43008	PM	0	23	025	07	TRENTON		CRESTMONT NURS HM	670,000	72	1	S
MINNESOTA												
092-43002	PM	0	24	007	02	MANKATO		MANKATO HOUSE	395,600	96	4	S
092-43009	PM	0	24	025	01	RED WING		RED WING N H	489,900	88	4	S
092-43001	PM	0	24	062	04	ST PAUL		HIGHLAND CHATEAU INC	595,000	92	4	S
092-43005	PM	0	24	051	02	SLAYTON		SLAYTON MANOR	333,000	60	4	S
092-43008	PM EC	1	24	053	02	WORTHINGTON		LAKE HAVEN NURS HM	463,500	87	1	S
MISSISSIPPI												
081-43004	PM	0	25	059	02	BOONEVILLE		ALETHA LODGE INC	129,100	37	4	S
065-43009	PM	0	25	043	03	BROOKHAVEN		BROOK MANOR N H	300,000	50	4	S
065-43005	PM	0	25	076	01	GREENVILLE		ARNOLD AVE NURS HM	125,000	41	4	S
065-43007	PM	0	25	025	03	JACKSON		WHISPERING PINES N H	254,000	50	4	S
065-43001	PM	0	25	024	05	P CHRISTIAN		MIRAMAR VILLAGE INC	744,600	100	4	S
065-43008	PM	0	25	049	01	WINONA		RIDELL NURS HM	407,000	60	4	S
MISSOURI												
084-43013	PM	0	26	068	08	CALIFORNIA		WINDSOR ESTATES INC	330,000	60	0	S
085-43001	PM	0	26	067	10	CHARLESTON		HOST HOUSES INC	498,900	100	4	S
085-43006	PM	0	26	010	08	COLUMBIA		THF HERITAGE NURS HM	810,900	141	4	S
084-43016	PM	0	26	048	04	INDEPENDENCE		WINDSOR ESTATES	500,000	81	1	S
084-43002	PM	0	26	048		KANSAS CITY		HOLMESDALE MANOR	716,900	100	4	S
084-43009	PM EC	1	26	048		KANSAS CITY		KANSAS CITY MTGE CO	970,200	199	4	S
085-43003	PM	0	26	095		MANCHESTER		MARIA DE VILLA RETIR	592,900	104	4	S
085-43007	PM	0	26	088	09	MOBERLY		VILLA DE SILVA N H	296,100	60	4	S
085-43002	PM	0	26	092	09	ST CHARLES		ST CHARLES HISTORIUM	578,500	112	4	S

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF UNITS	CONST STATUS	PROC ST.
085-43004	PM	0	26	095		ST LOUIS CO		CLAYTON HOUSE N H	1,662,500	150	4	S
084-43004	PM	0	26	011	06	ST JOSEPH		ST JOSEPH CONV CT	506,700	65	4	S
085-43006	PM	0	26	096		ST LOUIS		REGENCY NURS INN	5,199,300	380	4	S
084-43003	PM	0	26	080	04	SEDALIA		SEDALIA NURS HM	315,900	50	4	S
084-43005	PM EC	1	26	051	04	WARRENSBURG		WARRENSBURG NURS CT	979,100	83	4	S
MONTANA												
093-43004	PM	0	27	047	01	BUTTE		CREST NURS HM	297,300	60	4	S
093-43001	PM EC	1	27	032	01	MISSOULA		THE WAYSIDE SANITARIUM	168,300	48	4	S
NEBRASKA												
103-43004	PM	0	28	031	03	FRANKLIN		FRANK HM SR CITIZEN	340,500	60	4	S
103-43013	PM	0	28	014	01	HARTINGTON		HARTINGTON MANOR HS	330,300	60	4	S
103-43106	PM	0	28	053	03	KIMBALL		KIMBALL MANOR N H	279,000	50	4	S
103-43007	PM	0	28	055	01	LINCOLN		MILDER MANOR	531,000	84	4	S
103-43018	PM	0	28	028	02	OMAHA		THE OMAHA NURS HM	489,000	81	4	S
103-43023	PM	0	28	056	03	N PLATTE		VALL VIEW OF N PLATT	553,500	83	1	S
103-43005	PM	0	28	045	03	ONEILL		ONEILL HM SR CITIZEN	352,500	60	4	S
103-43002	PM	0	28	033	03	OXFORD		OXFORD S C H INC	321,800	60	4	S
103-43012	PM	0	28	091	03	RED CLOUD		RED CLOUD N H	225,800	50	4	S
103-43008	PM	0	28	019	01	SCHUYLER		SCHUYLER SR CITIZENS	351,000	60	4	S
103-43006	PM	0	28	011	01	TEKAMAH		TAKAMAH HM INC	358,300	60	4	S
103-43009	PM	0	28	054	01	WAUSA		VALLEY VIEW HOMES	287,162	42	4	S
NEVADA												
125-43001	PM	0	29	002	01	LAS VEGAS		DESERT RETREAT NURS	1,016,100	100	4	S
125-43002	PM	0	29	002	01	LAS VEGAS		LAS VEGAS CONV CT	429,200	53	4	S
125-43003	PM	0	29	016	01	RENO		RENO CONV CT	526,600	61	4	S
NEW HAMPSHIRE												
024-43001	PM	0	30	010	02	CLAREMONT		CLAREMONT NURS HM	304,700	50	4	S
024-43003	PM	0	30	001	01	LACONIA		LAKES REG CONV CT	500,000	50	1	S
024-43002	PM	0	30	006	02	MANCHESTER		HANOVER HILL NURS HM	757,000	100	4	S
NEW JERSEY												
031-43040	PM	0	31	002	07	ALLENDALE		ALLENDALE NURS HM	990,000	100	4	S
031-43018	PM	0	31	019	04	ANDOVER		ANDOVER NURS HM	1,345,200	146	4	S
031-43014	PM	0	31	007	10	CEDAR GROVE		HART WYCK W NURS HM	1,262,900	113	4	S
031-43040	PM	0	31	020	12	CRANFORD		CRANFORD HOUSE INC	1,336,400	128	3	S
031-43029	PM	0	31	002	07	CRESSKILL		CRESSKILL MANOR	1,149,100	100	3	S
031-43009	PM	0	31	012		EDISON		EDISON TOWER NURS HM	2,225,300	228	4	S
031-43005	PM	0	31	020	13	ELIZABETH		ELIZABETH NURS HM	911,600	116	4	S
031-43027	PM	0	31	007	11	E ORANGE		PK AVE NURS HM	2,016,200	210	4	S
031-43007	PM	0	31	002	07	ENGLEWOOD		INGEL MOOR NURS HM	716,700	62	4	S
031-43048	PM	0	31	011	04	HAMILTON TWP		MERCER CARE CENTER	971,500	100	1	S
031-43052	PM	0	31	013	03	HOLMDEL		ARNOLD WALTER NURS	1,212,200	124	1	S
031-43017	PM	0	31	014	05	LINCOLN PK		LINCOLN PK NURS HM	1,418,000	146	4	S
031-43028	PM	0	31	007	12	LIVINGSTON		LIVINGSTON NURS HM	1,260,000	120	4	S
031-43012	PM	0	31	012		MADISON		EMERY MANOR NURS HM	986,300	100	4	S
031-43019	PM	0	31	013	03	MIDDLETOWN		MIDDLETOWN NURS HM	1,225,200	125	4	S
031-43025	PM	0	31	007	10	MONTCLAIR		CHERRY NURS HM	605,500	58	3	S
031-43039	PM	0	31	007	10	MONTCLAIR		VAN DYKE NURS CONV	695,000	62	3	S
031-43053	PM	0	31	013	03	NEPTUNE		MEDICENTER	1,035,200	100	1	S
031-43020	PM	0	31	014	05	PARSIPPANY		TROY HILLS HAVEN NUR	1,233,700	128	4	S
035-43004	PM	0	31	017	02	PITTSGROVE		RAINBOW CONV CT	573,400	84	4	S
031-43051	PM	0	31	020	12	PLAINFIELD		PLAINFIELD NURS HM	1,059,200	100	1	S
031-43059	PM	0	31	011	04	PRINCETON		PRINCETON HOUSE	1,476,000	128	1	S
031-43011	PM	0	31	020	12	PROVIDENCE		GLENSIDE NURS HM	826,900	96	4	S
031-43002	PM	0	31	002	07	RIDGEWOOD		VAN DYKS NURS HM	818,093	92	4	S
031-43046	PM	0	31	002	07	RIVER VALE		RIVER VALE NURS HM	565,500	50	1	S
031-43004	PM	0	31	014	05	ROXBURY		MERRY HEART NURS HMS	299,700	32	4	S
031-43006	PM	0	31	012	03	SAYREVILLE		OAK VIEW NURS HM	985,000	100	4	S
035-43003	PM	0	31	004	01	STRATFORD		STRATFORD NURS HM	558,000	100	4	S
031-43003	PM	0	31	002	09	TEANECK		TEANECK NURS HM	675,400	107	4	S
031-43021	PM	0	31	013	03	WALL TWP		TOWER LODGE NURS HM	526,400	60	3	S
031-43036	PM	0	31	016	08	WAYNE		GERIATRIC NURS HM	982,300	100	1	S
031-43008	PM	0	31	007	11	W ORANGE		REDWOOD MANOR NURS	1,233,874	141	4	S
031-43010	PM	0	31	007	11	W ORANGE		NORTHFIELD MANOR NUR	1,072,600	125	4	S
031-43016	PM EC	1	31	002	07	WESTWOOD		VALLEY NURS HM	1,142,900	120	4	S
031-43026	PM EC	1	31	014	05	WHIPPANY		CRESTWOOD NURS HM	761,500	71	4	S
NEW MEXICO												
116-43002	PM	0	32	024	01	FARMINGTON		SAN JUAN MANOR	324,900	50	4	S
116-43001	PM	0	32	003	01	ROSWELL		ROSWELL NURS HM	353,600	50	4	S
NEW YORK												
014-43002	PM	0	33	015	39	AMHERST		AMHERST NURS HM	419,300	80	4	S
012-43028	PM	0	33	041	09	ASTORIA		ASTORIA GEN CONV HM	1,210,500	114	1	S
012-43011	PM	0	33	033	32	BOONVILLE		SUNSET NURS HM	283,500	38	4	S
012-43015	PM	0	33	003		BRONX		FAIRFIELD NURS HOME	1,692,900	155	4	S
012-43036	PM	0	33	003		BRONX		EASTCHESTER PK NURS	1,637,600	200	4	S
012-43030	PM	0	33	024	12	BROOKLYN		EATON PK NURS HM	1,199,700	114	4	S
012-43007	PM	0	33	015		BUFFALO		CARLTON HS NURS HM	1,919,700	246	4	S
012-43008	PM	0	33	015		BUFFALO		ABBOTT NURS HM	621,000	84	3	S
012-43012	PM	0	33	015		BUFFALO		DELAWARE PAVILION HM	1,477,800	151	3	S
012-43001	PM	0	33	041	10	FAR ROCKAWAY		CRESTWAVE NURS HM	1,179,900	116	4	S
012-43020	PM	0	33	030	04	FLORAL PK		GLEN OAKS GERIATRIC	594,000	60	4	S
012-43051	PM	0	33	041	08	FLUSHING		LONG ISLAND NURS HM	2,000,000	200	1	S
012-43061	PM	0	33	057	30	GLEN FALLS		EDEN PK NURS HM	922,500	80	1	S
012-43029	PM	0	33	030		HEMPSTEAD		FAIRVIEW NURS HM	1,733,100	200	2	S
012-43006	PM	0	33	041		HOLLIS L I		HOLLIS PK GDN NURS	658,100	80	4	S
012-43045	PM	0	33	052	02	HUNTINGTON		CARILLON NURS HM	1,200,000	120	1	S
012-43027	PM	0	33	032	40	LEWISTON		FAIRCHILD NURS HM	317,700	54	4	S
012-43038	PM EC	1	33	030	05	LONG BEACH		LONG ISLAND TIDES HM	1,593,000	180	4	S
012-43044	PM	0	33	060	27	MAMARONECK		S R NEWMAN CONT CARE	1,995,500	180	1	S

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF [illegible]	CONST STATUS	PROC ST.
012-43002	PM	0	33	060	26	NEW ROCHELLE		WOODLAND NURS HM	1,272,600	118	4	S
012-43021	PM	0	33	031	18	NEW YORK		F NIGHTINGALE NURS	4,068,000	407	4	S
012-43018	PM	0	33	060	26	OSSINING		CEDAR MANOR NURS HM	1,066,500	100	4	S
012-43017	PM	0	33	060	25	PEEKSKILL		WESTLEDGE NURS HM	1,228,500	100	4	S
012-43032	PM	0	33	030	05	ROCKVILLE CN		LAKESIDE NURS HM	1,571,400	152	1	S
012-43041	PM	0	33	044	27	SPRING VALL		HILLCREST NURS HM	1,654,200	180	1	S
012-43019	PM	0	33	034	34	SYRACUSE		JAMES SQUARE NURS HM	2,529,000	238	1	S
014-43003	PM	0	33	015	40	TONAWANDA		SHERIDAN MANOR NURS	670,700	100	4	S
012-43005	PM	0	33	060	26	WHITE PLAINS		WHITE PLAINS NURS HM	700,000	66	4	S
NORTH CAROLINA												
053-43001	PM	0	34	011	11	ASHEVILLE		BRENTWOOD MANOR	500,000	71	4	S
053-43005	PM	0	34	060	08	CHARLOTTE		MODERN CARE INC	810,800	122	4	S
NORTH DAKOTA												
094-43002	PM	0	35	028	02	GARRISON		GARRISON NURS HM	653,500	71	1	S
OHIO												
043-43005	PM	0	36	005	10	ATHENS		HILLCREST VIEW NURS	422,200	61	4	S
046-43004	PM	0	36	031	01	CINCINNATI		OAK PAVILION INC	1,008,100	150	4	S
046-43008	PM	0	36	031		CINCINNATI		ZION NURS HM	340,000	50	4	S
046-43010	PM	0	36	031	01	CINCINNATI		BEECH KNOLL NURS HM	773,100	100	2	S
042-43007	PM	0	36	018	22	CLEVELAND HT		WHITE CLIFF NURS HM	800,400	100	4	S
043-43003	PM	0	36	025		COLUMBUS		CONV HM FOR SUN RIDG	595,900	92	4	S
043-43007	PM	0	36	025	15	GROVE CITY		MONTERERY NURS INN	725,000	200	4	S
042-43001	PM	0	36	018	23	LAKEWOOD		WRIGHTS SANITARIUM	330,000	49	4	S
043-43017	PM	0	36	049	07	LONDON		MADISON NURS CARE	959,700	100	1	S
043-43013	PM	0	36	084	10	MARIETTA		CHRISTIAN ANCHORAGE	444,600	52	1	S
043-43009	PM	0	36	051	08	MARION		MARION MANOR	567,000	92	4	S
043-43012	PM	0	36	080	07	MARYSVILLE		MILLCREST NURS HM	320,000	48	3	S
043-43021	PM	0	36	045	17	NEWARK		NEWARK NURS CONV INN	1,494,000	200	1	S
042-43008	PM	0	36	018	21	PARMA		SNOWVIEW NURS HM	575,000	85	4	S
042-43003	PM	0	36	048	09	SYLVANIA		MARIGARUE MHS INC	203,100	49	4	S
042-43006	PM	0	36	048	09	TOLEDO		CHERRY HILL NURS HM	555,300	100	4	S
043-43015	PM	0	36	011	07	URBANA		INDEPENDENCE HOUSE	731,700	100	1	S
043-43001	PM EC	1	36	025	12	WESTERVILLE		ELMHURST CONV CT	234,963	62	4	S
043-43011	PM	0	36	025	12	WESTERVILLE		WESTERVILLE CONV CT	999,800	116	3	S
043-43004	PM	0	36	025	12	WORTHINGTON		WORTHINGTON NURS HM	534,300	87	4	S
043-43014	PM	0	36	025	12	WORTHINGTON		NORWORTH CONV CT	1,155,200	132	1	S
046-43006	PM EC	1	36	029	07	XENIA		HOSPITALITY HM	588,200	90	4	S
OKLAHOMA												
118-43004	PM	0	37	072	01	BROKEN ARROW		TIDINGS OF PEACE	207,000	40	4	S
118-43006	PM	0	37	045	03	BROKEN ARROW		MORGAN N T INC	170,000	32	4	S
118-43003	PM	0	37	058	02	COMMERCE		OGDEN MANOR NURS CT	237,600	50	4	S
117-43001	PM	0	37	069	06	DUNCAN CITY		PLATO CONV HM INC	192,600	50	4	S
117-43004	PM	0	37	055	05	OKLAHOMA		COLONIAL MANOR INC	646,200	132	4	S
117-43003	PM	0	37	044	05	PURCELL		BROADLAWN MANOR INC	300,000	64	4	S
OREGON												
126-43011	PM	0	38	020	04	EUGENE		PK MANOR MEDICAL	432,000	80	4	S
126-43005	PM	0	38	018	02	KLAMATH FALL		PONDEROSA INC	357,500	93	4	S
126-43001	PM	0	38	015	04	MEDFORD		W CONV FDN INC	470,500	102	4	S
126-43003	PM	0	38	003	01	MILWAUKEE		MILWAUKEE CONV HOSP	373,500	66	4	S
126-43004	PM	0	38	003	01	OREGON CITY		STRICKLAND NURS HM	125,800	30	4	S
126-43006	PM	0	38	026	03	PORTLAND		CRESTVIEW CONV CT	632,000	100	4	S
126-43008	PM	0	38	026	03	PORTLAND		REEDWOOD CONV HM	351,000	60	4	S
126-43009	PM	0	38	026	03	PORTLAND		COLUMBIA MANOR	436,400	96	4	S
126-43010	PM	0	38	026	03	PORTLAND		PARKVIEW NURS HM	892,600	120	4	S
126-43012	PM	0	38	026	03	PORTLAND		ALLISON GEN NURS HM	747,600	100	4	S
126-43016	PM	0	38	026	03	PORTLAND		VILLAGE SANITARIUM	430,200	64	4	S
126-43018	NP	0	38	026	03	PORTLAND		COLONIAL MANOR	547,900	100	4	S
126-43015	PM FC	1	38	010	04	ROSEBURG		GRAND VIEW HOME	418,500	85	4	S
PENNSYLVANIA												
033-43001	PM	0	39	063	26	CARROLL		HAVEN CREST INC	357,300	48	4	S
034-43005	PM	0	39	021	19	E PENNSBORO		PENNSBORO HEARTH	770,300	98	4	S
034-43006	PM	0	39	046	13	HAVERFORD		HAVERFORD MANOR INC	806,743	100	4	S
033-43005	PM	0	39	011	22	JOHNSTOWN		NEIL CLIFF NURS HM	1,080,000	164	4	S
034-43008	PM	0	39	041	17	LOYALSOCK		SYCAMORE NURS HM	556,100	75	4	S
033-43006	PM	0	39	002		MCCANDLESS		[illegible]	1,010,500	132	4	S
034-43003	PM	0	39	051		MT AIRY		PONCE DE LEON INC	739,900	96	4	S
033-43002	PM	0	39	002	20	MUNHALL BORO		ELDER CREST, INC	360,900	48	4	S
034-43002	PM	0	39	055	17	PENN TWP		SUSQUEHANNA NURS HM	287,300	48	4	S
034-43014	NP EC	1	39	051	02	PHILADELPHIA		SARAH ALLEN HMS	1,011,000	199	4	S
033-43005	PM	0	39	002		PITTSBURGH		NEGLEY HOUSE INC	941,900	148	4	S
033-43004	PM	0	39	002		PITTSBURGH		FORBES PAVILION NURS	1,622,200	199	4	S
033-43007	PM	0	39	002		PITTSBURGH		IVY NURS HM INC	1,239,900	150	1	S
034-43015	PM EC	1	39	055	17	SELINSGROVE		SUSQUEHANNA NURS HM	249,000	32	1	S
034-43011	PM	0	39	051	13	SOMERTON		MAYO NURS AND CONV	843,200	116	4	S
RHODE ISLAND												
016-43001	PM	0	40	004	02	N PROVIDENCE		PEZZELLI NURS HM	1,184,700	135	1	S
SOUTH CAROLINA												
054-43010	PM	0	41	001	03	ABBEVILLE		ABBEVILLE NURS HM	304,600	50	3	S
054-43002	PM	0	41	002	03	AIKEN		AIKEN NURS HM	258,000	44	4	S
054-43001	PM	0	41	010	01	CHARLESTON		RIVERSIDE GERIATRICT	765,000	108	4	S
054-43016	PM	0	41	016	06	DARLINGTON		OAKHAVEN	338,000	40	1	S
054-43014	PM	0	41	011	05	GAFFNEY		BROOKVIEW HOUSE INC	299,900	40	1	S
054-43008	PM	0	41	022	06	GEORGETOWN		WINYAH NURS HM	416,300	84	4	S
054-43009	PM	0	41	023	04	GREENVILLE		PIEDMONT NURS HM INC	512,400	81	4	S
054-43005	PM	0	41	002	03	N AUGUSTA		ANNE MARIE MED HM	277,900	40	4	S
054-43007	PM	0	41	038	02	ORANGEBURG		ST EUREKA SUNSHINE	292,800	49	4	S

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF BEDS	CONST STATUS	PROC ST.
054-43006	PM	0	41	042	04	SPARTANBURG		SPARTANBURG NURS HM	558,900	100	4	S
054-43004	PM	0	41	018	01	SUMMERVILLE		SUMMERVILLE NURS HM	325,000	50	4	S
SOUTH DAKOTA												
091-43001	PM	0	42	012	01	CLARK		CLARK NURS HM	194,000	40	4	S
091-43002	PM	0	42	050	01	FLANDREAU		RIVERVIEW MANOR	450,400	75	4	S
TENNESSEE												
087-43005	PM	0	43	082	01	BRISTOL		BRISTOL NURS HM INC	665,000	100	4	S
087-43002	PM	0	43	033	03	CHATTANOOGA		CHATTANOOGA CONV	518,900	96	4	S
087-43003	PM	0	43	033	03	CHATTANOOGA		ST BARNABAS N H	691,900	84	4	S
081-43005	PM	0	43	060	06	COLUMBIA		HILLVIEW HAVEN INC	405,400	75	4	S
081-43007	PM	0	43	022	06	DICKSON		GREEN VALLEY HAVEN	234,900	42	4	S
087-43001	PM	0	43	047	02	KNOXVILLE		KNOXVILLE CONV N H	611,000	108	4	S
086-43006	PM	0	43	019	05	MADISON		IMPERIAL MANOR N H	765,000	114	4	S
081-43002	PM	0	43	079		MEMPHIS		ROSEWOOD INC	926,100	150	4	S
081-43009	PM EC	1	43	079		MEMPHIS		BRIGHT GLADE NURS HM	396,600	50	4	S
081-43011	NP	0	43	079		MEMPHIS		HOWARD MANOR CHRIST	288,100	50	4	S
087-43006	PM	0	43	032	01	MORRISTOWN		DOWNTOWN NURS CONV	305,900	50	1	S
086-43009	PM	0	43	075	04	MURFREESBORO		BOULEVARD TERRACE	370,000	60	1	S
086-43002	PM	0	43	019	05	NASHVILLE		WELCOURT TERRA N H	269,100	61	4	S
086-43004	PM	0	43	019	05	NASHVILLE		BUCHANNAN NURS HM	561,600	100	4	S
TEXAS												
113-43003	PM	0	44	221	17	ABILENE		ABILENE GERIATRIC HM	249,400	100	4	S
133-44001	PM	0	44	188	18	AMARILLO		THURMONS CONV HM	325,000	100	4	S
114-43010	NP	0	44	123	09	BEAUMONT		SCHLESINGERS HM CARE	1,611,200	204	1	S
115-43002	PM	0	44	178	14	CORP CHRISTI		HORIZON CONV HS INC	1,114,200	144	4	S
114-43007	PM	0	44	113	02	CROCKETT		CROCKETT NURS HM	232,500	50	4	S
112-43007	PM	0	44	057		DALLAS		GASTON LTD	2,221,200	250	4	S
133-43004	PM	0	44	071	16	EL PASO		SUNTOWERS CONV NURS	2,702,000	252	4	S
113-43001	PM	0	44	220		FT WORTH		FIRESIDE LODGE INC	421,200	96	4	S
113-43002	PM	0	44	220		FT WORTH		HOWARD SANITARIUM	162,000	39	4	S
113-43006	PM	0	44	220		FT WORTH		ST AM NURS HM	401,000	98	4	S
113-43010	PM	0	44	220		FT WORTH		MED CT CONV NUMBER 1	527,800	128	4	S
112-43021	PM	0	44	049	13	GAINESVILLE		GOLDEN ACRES INC	538,100	100	4	S
114-43006	PM	0	44	101		HOUSTON		TWELVE OAKS NURS HM	996,500	150	4	S
112-43009	PM	0	44	057	03	IRVING		BR CONV CT INC	619,500	100	4	S
113-43004	PM	0	44	141	21	LAMPASAS		LAMPASAS NURS HM	207,300	50	4	S
133-43003	PM	0	44	152	19	LUBBOCK		NURS HM SPA CORP	513,800	100	4	S
112-43001	PM	0	44	073	11	MARLIN		GOLDEN YEARS REST HM	130,600	34	4	S
112-43006	PM	0	44	057	05	MESQUITE		BIG TOWN NURS HM	766,800	148	3	S
133-43006	PM	0	44	165	19	MIDLAND		PK VIEW MANOR NURS	489,300	100	4	S
113-43008	PM	0	44	182	17	MINERAL WELL		RESORT LODGE INC	177,300	50	4	S
113-43005	PM	0	44	224	17	THROCKMORTON		THROCKMORTON HOME	157,000	50	4	S
113-43010	PM	0	44	212	04	TYLER		TYLER NURS HM INC	585,000	100	4	S
UTAH												
105-43006	PM	0	45	029	01	OGDEN		DUNN CONV AND REST	392,400	69	4	S
105-43009	PM	0	45	029	01	OGDEN		OGDEN CONV CT	436,500	65	4	S
105-43002	PM	0	45	025	01	OREM		CENTRAL UTAH CONV CT	342,900	75	4	S
105-43005	PM	0	45	018	02	SALT LAKE C		HIGHLAND MANOR N H	279,900	50	4	S
105-43007	PM	0	45	018	02	SALT LAKE C		WASATCH VILLA CONV	660,600	112	4	S
105-43010	PM	0	45	018	02	SALT LAKE C		BONNEVILLE CONV N H	727,200	88	4	S
105-43011	PM	0	45	018	02	SALT LAKE C		TEMPLE GARDENS	476,100	100	4	S
VERMONT												
026-43001	PM	0	46	002	01	BENNINGTON		CRESTWOOD NURS HM	245,900	50	4	S
VIRGINIA												
000-43008	PM	0	47	101	10	ALEXANDRIA		WOODBINE NURS CT	1,133,800	150	4	S
000-43004	PM	0	47	029	10	FAIRFAX		FAIRFAX NURS HM	1,174,100	193	4	S
000-43006	PM	0	47	029	10	FAIRFAX		OAK MEADOW INC	420,200	60	4	S
051-43003	PM	0	47	117	01	NEWPORT NEWS		NEWPORT NURS HM	341,300	50	4	S
051-43005	PM	0	47	118	02	NORFOLK		LAFAYETTE VILLA INC	524,700	82	4	S
051-43002	PM	0	47	123	03	RICHMOND		LAKELAND MANOR NURS	676,800	88	4	S
WASHINGTON												
127-43001	PM	0	48	017		BELLEVUE		INTERLAKE MANOR INC	403,403	100	4	S
127-43007	PM	0	48	017		BELLEVUE		BELLEVUE CONV CT	507,700	65	4	S
129-43002	PM	0	48	013	38	EL CENTRO		VALLEY CONV HOSP	363,200	82	4	S
127-43004	PM	0	48	031	02	EVERETT		MERRICREST NURS HM	686,400	150	4	S
127-43003	PM	0	48	017		MERCER ISL		MERCER VIEW CONV CT	849,000	107	4	S
127-43002	PM	0	48	017		SEATTLE		MERRIVISTA NURS HM	572,300	156	4	S
127-43009	PM	0	48	017		SEATTLE		N GATE NURS CONV CT	770,000	106	4	S
127-43008	PM	0	48	017		SEATTLE		PK ROYAL CONV CT	571,000	100	4	S
127-43009	PM	0	48	017	07	SEATTLE		MERRI ACRE NURS HM	510,853	40	4	S
127-43010	PM	0	48	017	07	SEATTLE		W CREST CONV CT	684,900	100	1	S
127-43011	PM	0	48	017	01	SEATTLE		PK ROYAL CONV CTR	1,183,300	200	1	S
171-43005	PM	0	48	032	05	SPOKANE		UNIVERSITY MANOR	444,300	100	4	S
171-43006	PM	0	48	032	05	SPOKANE		LILAC CITY MANOR	206,000	50	4	S
171-43008	NP	0	48	032	05	SPOKANE		RIVERVIEW LUTHERAN	588,600	80	4	S
127-43006	PM	0	48	027	06	TACOMA		W GATE CONV CT	487,500	67	4	S
WEST VIRGINIA												
045-43001	PM	0	49	041	03	BECKLEY		PINE LODGE NURS HM	250,000	75	4	S
045-43011	NP	0	49	013	02	FAIRLEA		GREENBRIER COUNTY HM	850,000	100	1	S
045-43002	PM	0	49	006	04	HUNTINGTON		MODERN HEALTH CARE	524,200	70	4	S
WISCONSIN												
075-43021	PM	0	50	041	09	BAYSIDE		BAYSIDE NURS HM	522,000	100	3	S
075-43010	PM	0	50	030	01	KENOSHA		SHERIDAN NURS HM	553,788	100	4	S
075-43014	PM	0	50	013	02	MADISON		MANOR HOUSE INC	1,012,500	176	4	S
075-43012	PM	0	50	041		MILWAUKEE		PAVILION NURS HM INC	979,800	150	4	S

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF [illegible]	CONST STATUS	PROC ST.
075-43026	PM EC	1	50	041	09	MILWAUKEE		MILWAY NURS HM	599,100	89	1	S
075-43018	PM EC	2	50	013	02	VERONA		FOUR WINDS MANOR INC	408,800	70	4	S
075-43025	MP	0	50	041	04	WEST ALLIS		METH MANOR HLTH CT	1,200,000	168	1	S
075-43008	PM EC	1	50	065	01	WILLIAMS BAY		SHERWOOD REST HM	166,467	35	4	S
PUERTO RICO												
056-43008	PM	0	55	001	01	RIO PIEDRAS		VALLE ALTO NURS HM	1,726,400	160	1	S
						[illegible] TOTAL			$ 330, 381, 406	46761		

COMMITMENTS OUTSTANDING

ARKANSAS												
082-43007	PM	0	04	060	02	N LITTLE ROC		OAK HILL MANOR	860,300	168	0	T
CALIFORNIA												
136-43018	PM	0	05	034	03	CARMICHAEL		MT OLIVETTE CONV	603,000	104	0	T
121-43026	PM	0	05	010	16	FRESNO		NORTHSIDE HOSPITAL	864,800	117	0	T
122-43019	PM	0	05	019	32	LOS ANGELES		GOOD SHEPHERD NURS	141,900	32	0	T
COLORADO												
101-43008	PM EC	1	06	016	01	DENVER		DAVIS NURS HM INC	1,696,100	237	1	T
CONNECTICUT												
017-43019	PM	0	07	002	06	BRISTOL		EDEN PK CONV HM	809,700	120	0	T
017-43019	PM	0	07	005	03	WEST HAVEN		TERRACE DELL N H	698,100	90	1	T
DELAWARE												
032-43003	PM	0	08	002	01	WILMINGTON		HILLSIDE HOUSE INC	973,200	86	0	T
032-43004	PM	0	08	002	01	WILMINGTON		MERCY VILLA NURS HM	994,400	100	0	T
FLORIDA												
069-43017	PM	0	10	046	01	CRESTVIEW		CRESTVIEW NURS HM	293,100	60	1	T
069-43019	PM	0	10	045	02	FERNANDINA B		NASSAU HALL INC	338,400	60	1	T
063-43018	PM EC	1	10	016	03	JACKSONVILLE		ST JUDE MANOR INC	729,200	137	1	T
066-43059	PM	0	10	013	12	MIAMI BEACH		FOUR FREEDOMS NURS	1,745,100	200	0	T
067-43020	PM	0	10	052	08	PETERSBURGH		RAINBOW RESIDENCE	537,300	100	0	T
069-43014	NP	0	10	037	02	TALLAHASSEE		MIRACLE HILL NURS	369,900	60	1	T
GEORGIA												
061-43023	PM	0	11	025	01	SAVANNAH		SAVANNAH EXTENDED	886,500	100	0	T
061-43024	PM	0	11	092	08	VALDOSTA		THE LAKEWOOD CONV CT	704,700	110	0	T
IDAHO												
171-43017	PM	0	13	018	01	OROFINO		OROFINO NURS HM	433,800	60	0	T
ILLINOIS												
071-43019	PM	0	14	016	01	CHICAGO		HYDE PK NURS HM	939,700	150	0	T
071-43023	PM	0	14	052	16	DIXON		WINDSOR ESTATES NO 7	513,000	82	0	T
072-43026	PM	0	14	029	19	LEWISTOWN		CLARYTONA MANOR INC	990,000	146	0	T
071-43021	PM	0	14	016	04	POSEN		POSEN NURS HM	447,800	70	0	T
INDIANA												
073-43029	PM	0	15	048	05	ALEXANDRIA		THE WILLOWS NURS HM	915,000	40	0	T
073-43028	PM	0	15	068	10	WINCHESTER		RANDOLPH NURS HM INC	430,000	60	0	T
IOWA												
074-43020	PM EC	1	16	094	04	SIGOURNEY		MANOR HOUSE	522,800	34	0	T
KENTUCKY												
083-43026	PM	0	18	005	02	GLASGOW		HOMEWOOD NURS HM	480,000	94	1	T
083-43029	PM	0	18	056	03	LOUISVILLE		GEORGETOWN MANOR HM	631,600	100	0	T
083-43033	PM	0	18	056	04	LOUISVILLE		THE CHRISTOPHER E	988,400	150	0	T
083-43015	PM	0	18	028	01	MARION		BEST CARE NURS HM	228,000	50	1	T
083-43020	PM	0	18	098	07	PIKEVILLE		MOUNTAIN MANOR PIKE	769,600	100	0	T
083-43013	PM	0	18	036	07	PRESTONBURG		MOUNTAIN MANOR N H	300,000	56	2	T
083-43019	PM	0	18	100	05	SOMERSET		SUNRISE MANOR	539,500	92	1	T
083-43022	PM	0	18	086	05	TOMPKINSVILL		MONROE NURS HM	324,100	60	0	T
LOUISIANA												
084-43018	PM	0	19	036	02	NEW ORLEANS		VILLA ST CHARLES INC	1,714,500	220	0	T
MASSACHUSETTS												
023-43019	PM	0	22	003	12	S DARTMOUTH		HILLCREST NURS HM	1,152,000	100	0	T
023-43023	PM	0	22	014	04	WORCHESTER		CLARK MANOR NURS HM	1,364,300	60	0	T
MICHIGAN												
044-43012	PM	0	23	082		DETROIT		LAW DEN NURS HM	432,700	100	1	T
MISSISSIPPI												
081-43013	EC PM	1	25	059	02	BOONEVILLE		ALETHA LODGE INC	249,100	50	1	T
065-43011	PM	0	25	044	01	COLUMBUS		MEDI CT OF COLUMBUS	330,300	50	1	T
065-43010	PM	0	25	024	05	GULFPORT		DRIFTWOOD N H	342,100	50	1	T
065-43019	PM	0	25	015	03	HAZLEHURST		PINECREST GUEST HM	344,700	50	1	T
065-43022	PM	0	25	025	03	JACKSON		LAKELAND NURS CT	671,500	109	1	T
065-43023	PM	0	25	038	04	MERIDIAN		MERIDIAN NURS CT	379,400	75	1	T
065-43019	PM	0	25	066	05	WIGGINS		TWIN OAKS NURS HM	412,200	60	0	T
MISSOURI												
084-43015	PM	0	26	015	08	CAMDENTON		WINDSOR ESTATES	330,000	60	0	T
085-43018	PM	0	26	087	09	HANNIBAL		WINDSOR ESTATES	919,400	78	0	T

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF UNITS	CONST STATUS	PROC ST.
084-43014	PM	0	26	019	04	HARRISONVILL		BANNER CLARK NURS HM	377,300	60	0	T
085-43012	PM	0	26	072	10	MALDEN		SUNSHINE NURS HM	260,000	50	1	T
NEBRASKA												
103-43022	PM	0	28	028	02	OMAHA		MINNE LUSA GDNS	1,030,000	120	0	T
NEW JERSEY												
035-43005	PM	0	31	001	02	ATLANTIC CTY		BOARDWALK SEASHORE	1,300,800	135	0	T
031-43032	PM	0	31	002	07	EMERSON		EMERSON NURS HM	1,319,400	136	0	T
031-43042	PM	0	31	011	04	LAWRENCE		BLOSON HILL NURS HM	936,500	100	0	T
035-43007	PM	0	31	003	06	MT HOLLY		MT HOLLY N H	691,800	150	1	T
031-43062	PM	0	31	020	12	UNION		UNION NURS HM	1,012,700	100	1	T
031-43034	PM	0	31	016	08	WAYNE		MURRAY MANOR NURS HM	992,000	100	0	T
031-43060	PM	0	31	020	12	WESTFIELD		WESTFIELD CONV CT	1,481,900	150	0	T
031-43038	PM	0	31	016	08	W MILFORD		MILFORD NURS CONV HM	937,200	100	0	T
031-43064	PM	0	31	002	07	WOODCLIFF LK		WOODCLIFF LAKE MANOR	1,304,300	100	0	T
NEW YORK												
012-43046	PM	0	33	041	08	WHITESTONE		WHITESTONE NURS HM	2,142,000	200	0	T
OHIO												
046-43009	PM	0	36	057	03	DAYTON		FORESTVIEW INC	1,308,000	125	0	T
042-43013	NP	0	36	032	08	FINDLAY		WINEBRENNER EXTENDED	985,000	106	1	T
OKLAHOMA												
117-43009	PM	0	37	044	04	BLANCHARD		SENIOR VILLAGE	276,800	50	1	T
117-43006	PM	0	37	016	06	LAWTON		THE ORLANDO	432,500	96	0	T
OREGON												
126-43014	PM	0	38	004	01	GEARHART		EDGEWATER NURS HM	249,300	42	0	T
SOUTH CAROLINA												
054-43020	PM	0	41	007	01	BEAUFORT		BAYVIEW NURS CT INC	655,900	84	0	T
054-43021	PM	0	41	040	02	COLUMBIA		CAPITAL CONV CT	941,800	120	0	T
SOUTH DAKOTA												
091-43005	NP	0	42	049	01	SIOUX FALLS		LUTHER MANOR	910,200	84	0	T
TENNESSEE												
086-43010	PM	0	43	094	06	FRANKLIN		HARPETH TERRA NUR HM	420,000	52	0	T
TEXAS												
115-43010	PM	0	44	130	21	BOERNE		TWN COUNTRY MANOR	302,100	60	1	T
133-43015	PM	0	44	071	16	EL PASO		LOGAN HTS NURS HM	331,300	60	0	T
113-43012	PM	0	44	167	17	GOLDTHWAITE		HICKMAN NURS HM	225,000	60	1	T
114-43009	PM	0	44	101	07	HOUSTON		WINTER HAVEN	859,800	150	0	T
133-43013	PM EC	1	44	238	16	MONAHANS		MONAHANS CONV CT	125,000	54	1	T
112-43024	PM	0	44	155	11	WACO		FIRESIDE MANOR NURS	777,200	120	0	T
UTAH												
105-43018	PM BC	1	45	018	02	MURRAY		MIDGLEY MANOR	673,200	120	0	T
VERMONT												
026-43003	PM	0	46	011	01	RUTLAND		EDEN PARK NURS HM	1,094,600	120	0	T
VIRGINIA												
051-43009	PM	0	47	123	03	RICHMOND		FOREST HILLS NURS HM	1,200,200	150	1	T
051-43006	PM	0	47	098	09	WISE		WISE CTY STRYREST	402,900	50	0	T
WEST VIRGINIA												
045-43005	PM	0	49	017	01	CLARKSBURG		OAK MOUND NURS HM	787,500	100	0	T
045-43013	PM	0	49	020	03	S CHARLESTON		RIVERSIDE NURS HM	982,500	98	0	T
045-43007	PM	0	49	015	01	WEIRTON		WEIRTON CONV NURS HM	931,500	100	0	T
WISCONSIN												
075-43029	PM	0	50	041	05	MILWAUKEE		COMM HM FOR AGED	1,465,000	176	1	T
PUERTO RICO												
056-43005	PM	0	55	001	01	RIO PIEDRAS		CLAIBORNE GDNS NURS	1,354,500	124	0	T
					83	TOTAL			$ 61,709,100	8085		

APPLICATIONS IN PROCESS

ALASKA												
176-43002	PM	0	02	010	01	ANCHORAGE		GLENMORE NURS HM	1,321,000	100	0	U
CALIFORNIA												
122-43023	PM	0	05	019		CANOPA PK		HOLIDAY MANOR	600,000	92	0	U
122-43026	PM	0	05	019	30	LOS ANGELES		J ADDAMS CONV HM	689,293	94	0	U
136-43015	PM	0	05	004	02	OROVILLE		OROVILLE CONV HOSP	773,000	100	0	U
122-43030	PM	0	05	019	28	PALOS VERDES		PALOS VERDES NURS HM	755,100	120	0	U
122-43025	PM	0	05	019	49	SAN DIMAS		SAN DIMAS CONV CT	530,000	106	0	U
122-43027	PM	0	05	040	12	SAN LUIS		SAN LUIS CONV HOSP	900,000	140	0	U
DISTRICT OF COLUMBIA												
000-43014	NP	0	09	001	01	WASHINGTON		NAT MED ASSOC FOUND	2,195,000	204	0	U
FLORIDA												
066-43028	PM	0	10	006	10	PLANTATION		AMERICAN CONV CENTER	544,300	100	0	U
066-43031	PM	0	10	050	09	W PALM BEACH		PINNACLE CONV CT	654,300	120	0	U

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF UNITS	CONST STATUS	PROC ST.
GEORGIA												
061-43029	PM	0	11	008	07	CARTERSVILLE		CARTERSVILLE NURS HM	746,500	100	0	U
HAWAII												
140-43004	PM	0	12	001	01	HILO		HILO CONV HOSP	830,000	66	0	U
ILLINOIS												
071-43026	NP	0	14	016	01	CHICAGO		DELIVERANCE NURS HM	1,375,000	199	0	U
071-43027	PM	0	14	016	11	CHICAGO		BRIARWOOD FERR NURS	2,315,100	299	0	U
072-43025	PM	0	14	011	23	PANA		PANA NURS HM	535,000	84	0	U
KANSAS												
102-43010	NP	0	17	105	03	KANSAS CITY		DOUGLAS HOSP NURS HM	791,317	100	0	U
LOUISIANA												
066-43020	PM	0	19	026	02	GRETNA		OAKWOOD MANOR INC	1,004,800	140	0	U
066-43021	PM	0	19	027	02	METAIRIE		PHYSICIANS JEFFERSON	1,486,827	150	0	U
MASSACHUSETTS												
023-43051	PM	0	22	012	11	BROCKTON		BRAEMOOR NURS HM INC	1,296,000	120	0	U
023-43032	PM	0	22	011	08	BROOKLINE		BEACON HALL NURS HM	800,000	84	0	U
023-43017	PM	0	22	009	08	CAMBRIDGE		FRESH POND NURS HM	936,000	120	0	U
023-43029	PM	0	22	007	02	CHICOPEE		WILLIAMSETT N H	437,953	68	0	U
023-43052	PM	0	22	013	09	DORCHESTER		BEATRICE MARIE NURS	1,386,000	110	0	U
023-43028	PM	0	22	009	04	FRAMINGHAM		WINTER GABLES	800,000	50	0	U
023-43021	PM	0	22	005	06	LYNN		BIRCH KNOLL NURS HM	1,020,000	120	0	U
023-43022	PM	0	22	005	06	LYNN		CHATHAM ST NURS HM	918,000	108	0	U
023-43053	PM	0	22	005	12	NEW BEDFORD		BROOKLAWN NURS HM	1,080,000	120	0	U
023-43018	PM	0	22	014	04	NORTHBORO		NORTHBORO NURS HM	225,000	50	0	U
023-43042	PM	0	22	014	04	NORTHBORO		GREEN ACRES NURS HM	1,200,000	120	0	U
023-43041	PM	0	22	008	01	NORTHAMPTON		NORTHAMPTON NURS HM	1,660,000	160	0	U
023-43024	PM	0	22	011	11	NORWOOD		ELLIS CONV HM	1,364,100	100	0	U
023-43036	PM	0	22	004	12	TISBURY		VINYARD HAVEN NURS	717,000	78	0	U
023-43024	PM	0	22	009	05	WOBURN		HOLIDAY N H	1,170,000	120	0	U
MICHIGAN												
048-43010	PM	0	23	025	07	GRAND BLANC		THE CHATEAU	1,140,000	240	0	U
MINNESOTA												
092-43010	NP	0	24	041	06	HENDRICKS		HENDRICKS NURS HM	324,600	40	0	U
MISSOURI												
084-43010	PM	0	26	048		KANSAS CITY		MYERS NURS CONV CT	582,280	84	0	U
084-43011	NP	0	26	048	05	KANSAS CITY		THE MONTABAUR CLUB	2,117,254	136	0	U
085-43019	PM	0	26	072	10	PORTAGEVILLE		DELTA STRYREST CONV	348,600	50	0	U
084-43017	PM	0	26	021	06	SALISBURY		SALISBURY NURS HM	321,500	52	0	U
MONTANA												
093-43008	PM	0	27	027	01	LIBBY		LIBBY NURS HM	312,000	60	0	U
NEBRASKA												
103-43020	PM	0	28	028	02	OMAHA		TOWN VIEW MANOR	1,550,000	200	0	U
NEW JERSEY												
031-43079	PM	0	31	018	05	BRIDGEWATER		RELDS NURS HM	1,643,000	162	0	U
031-43057	PM	0	31	018	05	GREENBROOK		GREEN OAKS NURS HM	998,000	100	0	U
031-43091	PM	0	31	014	05	MENDHAM BORO		HOLLY MANOR NURS HM	1,125,000	114	0	U
031-43085	PM	0	31	014	05	MILLINGTON		MILLTONIA NURS HM	995,000	98	0	U
031-43058	PM	0	31	019	04	NEWTON		BARN HILL NURS HM	850,000	100	0	U
031-43093	PM	0	31	002	07	PARAMUS		DELLRIDGE NURSING HM	735,700	78	0	U
031-43063	PM	0	31	010	04	RARITAN		COUNTRY LANE NURS	1,050,000	100	0	U
031-43071	PM	0	31	011	04	TRENTON		CARE CTS OF AM	1,100,000	100	0	U
031-43069		0	31	009	14	UNION		HUDSON PALISADES	3,350,000	250	0	U
031-43056	PM	0	31	013	03	WALL		ALLAIRE NURS HM	998,000	165	0	U
031-43078	PM	0	31	016	08	WAYNE		PLEASANT VIEW NURS	1,145,600	100	0	U
NEW YORK												
012-43052	PM	0	33	001	29	GUILDERLAND		GUILDERLAND CT NURS	993,600	120	0	U
012-43047	PM	0	33	041		LITTLE NECK		LITTLE NECK NURS HM	1,035,000	120	0	U
012-43050	PM	0	33	043	16	STATEN ISL		VANDERBILT NURS HM	3,633,397	320	0	U
013-43006	PM	0	33	093	32	UTICA		EDEN PARK NURS HM	957,000	80	0	U
OHIO												
043-43022	PM	0	36	025	15	ARLINGTON		ARLINGTON COURT NURS	1,302,300	120	0	U
046-43012	PM	0	36	031	01	CINCINNATI		VERNON CONV CT	1,448,600	150	0	U
042-43017	NP	0	36	018	21	CLEVELAND		BELMORE MANOR	937,800	100	0	U
043-43016	NP	0	36	025		COLUMBUS		WESLEY GLEN NURS HM	420,000	42	0	U
PENNSYLVANIA												
034-43016	PM	0	39	048	15	EASTON		NORTHAMPTON NURS HM	1,122,000	120	0	U
RHODE ISLAND												
016-43003	PM	0	40	004	02	CRANSTON		MEDICO NURS HM INC	958,000	90	0	U
TENNESSEE												
081-43014	PM	0	43	079	01	ELLENDALE		TRANQUILAIRE NURS HM	937,500	68	0	U
TEXAS												
112-43034	PM	0	44	074	04	BONHAM		SEVEN OAKS NURS HM	351,300	60	0	U
112-43033	PM EC	1	44	073	11	MARLIN		GOLDEN YEARS REST HM	335,000	73	0	U
VERMONT												
026-43006	PM	0	46	004	01	S BURLINGTON		DORSET MANOR NURS HM	1,129,000	120	0	U

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	COMG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF BEDS	CONST STATUS	PROC ST.
WASHINGTON												
171-43013	PM	0	48	032	05	SPOKANE		RIVERSIDE CONV HOSP	800,000	120	0	U
171-43014	PM	0	48	032	05	SPOKANE		S CREST CONV CTR	1,428,000	212	0	U
WEST VIRGINIA												
045-43006	PM	0	49	038	02	MARLINTON		TWILIGHT DAWNS	350,000	50	0	U
045-43012	NP	0	49	031	02	MORGANTOWN		SUNDALE REST HM	1,926,500	250	0	U
						70 TOTAL			$ 73,824,121	8286		

FEASIBILITY LETTERS OUTSTANDING

COLORADO												
101-43010	PM	0	06	026	04	GUNNISON		COLONIAL MANOR NURS		50	0	Y
CONNECTICUT												
017-43023	PM	0	07	003	06	CANAAN		GREER MEM CONV HM		120	0	Y
FLORIDA												
063-43021	PM	0	10	016	03	JACKSONVILLE		ARLINGTON MANOR INC		120	0	Y
067-43038	PM	0	10	029	06	TAMPA		MANHATTAN CONV CTR		156	0	Y
GEORGIA												
061-43026	PM	0	11	121	10	AUGUSTA		R A ROBINSON NURS		100	0	Y
061-43027	PM EC	1	11	063	08	BRUNSWICK		BRUNSWICK NURS CT		162	0	Y
INDIANA												
073-43031	PM	0	15	047	09	BEDFORD		CONVALESCENT CARE		80	0	Y
MARYLAND												
052-43017	PM	0	21	004	04	BALTIMORE		GREATER BALTIMORE		120	0	Y
MASSACHUSETTS												
023-43045	PM	0	22	009	05	BILLERICA		COUNTRYVIEW NURS HM		120	0	Y
023-43034	NP	0	22	005	06	HAVERHILL		NURSING HOME		120	0	Y
023-43039	NP	0	22	011	11	QUINCY		QUINCY NURS HM		200	0	Y
023-43037	NP	0	22	014	04	SOUTHBORO		HIGH OAKS CONV HM		60	0	Y
MICHIGAN												
048-43011	PM	0	23	025	07	FLINT		LAFAYETTE NURS HM		226	0	Y
MINNESOTA												
092-43011	NP	0	24	046	02	TRUMAN		LUTHERAN RETIRE HM		65	0	Y
MISSISSIPPI												
065-43027	PM	0	25	042	01	GREENWOOD		PEMBERTON PL NURS HM		60	0	Y
065-43026	PM	0	25	019	03	MEADVILLE		FRANKLIN COUNTY NURS		60	0	Y
065-43028	PM	0	25	038	04	MERIDIAN		QUEEN CITY NURS HM		60	0	Y
065-43029	PM	0	25	062	04	MORTON		SCOTT COUNTY NURS HM		60	0	Y
MISSOURI												
084-43012	PM	0	26	024	06	LIBERTY		GOLDEN AGE LODGE		132	0	Y
NEW JERSEY												
031-43086	PM	0	31	013	03	RED BANK		RED BANK MEDI CT		104	0	Y
NEW YORK												
013-43009		0	33	014	28	POUGHKEEPSIE		EDEN PK NURS HM		210	0	Y
013-43007		0	33	014	28	POUGHKEEPSIE		EDEN PK NURS HM		120	0	Y
013-43008		0	33	047	29	SCHENECTADY		KNOLLS NURS HM		60	0	Y
012-43056		0	33	043	16	STATEN ISL		RALPH AVE DANUBE AV		240	0	Y
OHIO												
042-43020		0	36	039	13	BELLEVUE		BELLEVUE NURS HM		60	0	Y
042-43018	PM	0	36	018	20	CLEVELAND		ARISTOCRAT SOUTH INC		120	0	Y
TEXAS												
112-43035	PM	0	44	212	04	TYLER		THE VILLAGE EAST		120	0	Y
VERMONT												
026-43007		0	46	014	01	SPRINGFIELD		SPRINGFIELD NURS HM		120	0	Y
PUERTO RICO												
056-43009	PM	0	55	001	01	BAYAMON		SAN MARTIN NURS HM		100	0	Y
						29 TOTAL				3325		

REQUESTS IN PROCESS

ARKANSAS												
082-43009	PM	0	04	062	01	FORREST		KINGWOOD NURS HM		70	0	F
CALIFORNIA												
121-43039	PM	0	05	012	01	ARCATA		VALL W CONV HOSPITAL		72	0	F
121-43034	PM	0	05	007	14	CONCORD		ADOBE CONV HOSPITAL		96	0	F
121-43038	PM	0	05	007	14	CONCORD		VIRGINIA LANE CONV		102	0	F
122-43048	PM	0	05	030	34	COSTA MESA		MEMORIAL CONV CTR		198	0	F
121-43030	PM	0	05	010	16	FRESNO		PACIFIC MED FAC CORP		102	0	F
121-43040	PM	0	05	027	12	PACIFIC GROV		ASILIMAN CENTER		83	0	F

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF BEDS	CONST STATUS	PROC ST.
122-43032	PM	0	05	033	38	PALM SPRINGS		PALM SPRS CONV CT		99	0	F
121-43037	PM	0	05	049	01	PETALUMA		PETALUMA RANCHO NURS		93	0	F
122-43035	PM	0	05	019	24	POMONA		POMONA CONV GERIATRI		99	0	F
136-43025	PM	0	05	045	02	REDDING		CRESTWOOD CONV HOSP		92	0	F
122-43043	PM	0	05	033	38	RIVERSIDE		RIVERSIDE NURS HM		153	0	F
122-43047	PM	0	05	042	13	SANTA BARBAR		SANTA BARBARA CONV		200	0	F
121-43035	PM	0	05	044	12	SANTA CRUZ		SPRORUP SANITARIUM		27	0	F
136-43022	PM	0	05	039	15	STOCKTON		MONACO CONV CENTER		95	0	F
122-43044	PM	0	05	033	38	SUN CITY		SUN CTY CONV HOSP		99	0	F
COLORADO												
101-43011	PM	0	06	039	04	GD JUNCTION		COLONIAL MANOR WEST		120	0	F
FLORIDA												
063-43016	NP	0	10	066	01	DE FUNIAK SP				60	0	F
066-43039	PM	0	10	006	10	FT LAUDERDAL		SWEETING NURS HM		120	0	F
066-43041	NP	0	10	036	07	LEHIGH ACRES		LEHIGH ACRES NURS HM		50	0	F
066-43024	NP	0	10	013	12	MIAMI		LUTHERAN MEMORIAL		200	0	F
067-43040	PM	0	10	064	04	ORMOND BEACH		OAKRIDGE MANOR		120	0	F
063-43022	PM	0	10	062	03	PERRY		PERRY NURS CONV CTR		59	0	F
066-43037	NP	0	10	008	09	PT CHARLOTTE		ST JOSEPH NURS CT		100	0	F
067-43039	PM EC	1	10	052	08	ST PETERBURG		COLONIAL MANOR NURS		259	0	F
GEORGIA												
061-43031	PM	0	11	064	07	CALHOUN		ACREE NURS HM		50	0	F
061-43033	PM	0	11	106	03	COLUMBUS		COLUMBUS MED NURS HM		100	0	F
061-43028	EC	1	11	044	04	DECATUR		DECATUR CONV CT		100	0	F
061-43030	PM	0	11	033	07	SMYRNA		HEALTH SERVICES		100	0	F
061-43032	PM	0	11	033	07	SMYRNA		HALLMARK NURS HM		60	0	F
ILLINOIS												
071-43029	PM	0	14	004	16	BELVIDERE		BELVIDERE MANOR NURS		108	0	F
071-43028	PM	0	14	016	12	CHICAGO		MONTROSE CONV HM		244	0	F
071-43032	PM	0	14	016	08	CHICAGO		NORMANDY CONV HM		300	0	F
071-43033	PM	0	14	016	11	CHICAGO		A SHERIDAN B STENDER		290	0	F
071-43030	PM	0	14	089	16	FREEPORT		CRESTVIEW MANOR INC		101	0	F
071-43031	PM	0	14	022	14	WINFIELD		ZACE NURS HM		100	0	F
INDIANA												
073-43032	PM	0	15	018	10	MUNCIE		FAULKNER REST HM		50	0	F
IOWA												
074-43022	PM EC	1	16	052	01	IOWA CITY		GREENWOOD ACRES NURS		50	0	F
MARYLAND												
052-43019	PM	0	21	024	01	BERLIN		BERLIN NURS HM		33	0	F
052-43014	PM	0	21	011	06	BRADDOCK		BRADDOCK CONV CT		87	0	F
052-43016	PM EC	1	21	002	09	MILLERSVILLE		KNOLLWOOD MANOR		95	0	F
MASSACHUSETTS												
023-43048	PM	0	22	009	05	LOWELL		FAIRVIEW NURS HM		120	0	F
023-43055	PM	0	22	014	09	NORTHBRIDGE		BEAUMINT HOUSE		80	0	F
023-43040	PM	0	22	005	06	PEABODY		PILGRIM HOUSE		120	0	F
023-43026	PM	0	22	012	12	PLYMOUTH		MAYFLOWER N H		120	0	F
023-43038	PM	0	22	005	06	SALEM		NORTHSHORE NURS HM		160	0	F
023-43046		0	22	005	07	SAUGUS		BROOK SIDE NURS HM		120	0	F
023-43047	PM	0	22	007	02	SPRINGFIELD		MAPLE SHADE NURS HM		120	0	F
MICHIGAN												
044-43016	NP	0	23	082	13	DETROIT		[redacted]		168	0	F
MISSISSIPPI												
065-43030	PM	0	25	018	05	HATTIESBURG		HATTIESBURG MEDICAL		120	0	F
065-43031	PM	0	25	047	04	HOLLY SPRING		HOLLY HAVEN NURS CTR		60	0	F
065-43032	PM	0	25	051	04	NEWTON		NEWTON COUNTY NURS		60	0	F
MISSOURI												
084-43018	PM	0	26	074	06	HOPKINS		HOPKINS NURS HM		50	0	F
085-43020	NP	0	26	078	10	STEELE		STEELE NURS HM		60	0	F
NEW JERSEY												
031-43096	PM	0	31	014	05	CHATHAM TWP		KING JAMES NURS HM		108	0	F
031-43094	PM	0	31	018	05	FRANKLIN TWP		KING JAMES NURS HM		180	0	F
031-43098	PM	0	31	018	05	GREENBROOK		GREENBROOK MANOR HM		178	0	F
031-43097	PM	0	31	018	05	RARITAN		RARITAN HOUSE		128	0	F
NEW YORK												
012-43066	PM	0	33	003	24	BRONX		SPLIT ROCK NURS HM		240	0	F
012-43058		0	33	028	37	GREECE		CREST MANOR NURS HM		80	0	F
013-43009		0	33	034	32	UTICA		MINOA NURS HM		80	0	F
OHIO												
046-43014	PM	0	36	008	06	RIPLEY		OHIO VALLEY MANOR		35	0	F
PENNSYLVANIA												
034-43022	PM	0	39	054	06	FRACKVILLE		BROAD MNT MANOR		126	0	F
033-43013	PM	0	39	063	26	N STRABANE		MCCLELLAND NURS HM		104	0	F
033-43014		0	39	002	14	PITTSBURGH		HIGHLAND HALL NURS		150	0	F
SOUTH DAKOTA												
091-43008	PM	0	42	055	02	ARTESIAN		PIONEER MEMORIAL HM		35	0	F
TEXAS												
115-43011	NP	0	44	227	10	AUSTIN		AUSTIN GERIATRIC CTR		126	0	F

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF BEDS	CONST STATUS	PROC ST.
112-43036	PM	0	44	175	06	CORSICANA		ENNA MANOR INC		60	0	F
113-43016	PM	0	44	243	13	WICHITA FALL		WOODS CONV NURS HM		100	0	F
VERMONT												
026-43005		0	46	002	01	BENNINGTON		EDEN PK NURS HM		120	0	F
026-43008		0	46	012	01	BERLIN		BERLIN NURS HM		120	0	F
026-43009		0	46	013	01	BRATTLEBORO		EDEN PK NURS HM		120	0	F
VIRGINIA												
051-43010	NP	0	47	123	03	RICHMOND		VA STATE BAPT DEACON		40	0	F
WASHINGTON												
127-43017		0	48	021	03	CENTRALIA		GREEN ACRES ESTATE		180	0	F
127-43014	NP	0	48	017	07	ZENITH		JUDSON PK HLTH CT		97	0	F
WEST VIRGINIA												
045-43009		0	49	035	01	WHEELING		WHEELING NURSING HM		105	0	F
						76 TOTAL				8506		

EXPIRATIONS AND REJECTIONS DURING REPORTING PERIOD-

EXPIRED COMMITMENTS

MICHIGAN												
047-43029	PM EC	1	23	070	09	HOLLAND		BIRCHWOOD MANOR	592,800	107	0	V
MISSISSIPPI												
065-43012	PM	0	25	025	03	JACKSON		FOUNTAIN BLEU NRS CT	350,000	50	0	V
TEXAS												
115-43006	PM	0	44	015	21	SAN ANTONIO		AM NURS CONV CT INC	1,076,000	120	0	V
WASHINGTON												
171-43009	PM	0	48	032	05	SPOKANE		SPOKANE CONV CT	393,400	53	0	V
WEST VIRGINIA												
045-43003	PM	0	49	020	03	S CHARLESTON		RIVERSIDE CONV NURS	960,000	98	0	V
						5 TOTAL			$ 3,372,200	428		

REOPENED PRELIMINARY REJECTED APPLICATIONS

CALIFORNIA												
136-43015	PM	0	05	004	02	OROVILLE		OROVILLE CONV HOSP	773,000	100	0	U

REOPENED FINAL REJECTED APPLICATIONS

IOWA												
074-43020	PM EC	1	16	054	04	SIGOURNEY		MANOR HOUSE	522,800	34	0	T

FINAL REJECTED APPLICATIONS

IOWA												
074-43020	PM EC	1	16	054	04	SIGOURNEY		MANOR HOUSE	522,800	34	0	T
KENTUCKY												
083-43021	NP	0	18	050	02	HORSE CAVE		CAVERNA CONV HM	433,000	50	0	W
MICHIGAN												
047-43025	PM EC	1	23	041	05	GRAND RAPIDS		SPRINGBROOK RESIDENC	1,077,800	135	0	W
047-43023	PM EC	1	23	039	03	KALAMAZOO		RIDGEVIEW MANOR NURS	723,800	102	0	W
047-43024	PM EC	1	23	061	09	MUSKEGON		KNOLLVIEW MANOR NURS	635,000	104	0	W
NEBRASKA												
103-43024	PM	0	28	055	01	LINCOLN		VILLA MANOR NURS HM	277,721	50	0	W
NEW JERSEY												
031-43047	PM	0	31	014	05	PEQUANNOCK		SUNSET RD NURS HM	995,100	100	0	W
NEW MEXICO												
116-43003	PM EC	1	32	003	01	ROSWELL		SUNSET VILLA CARE	794,500	50	0	W
SOUTH DAKOTA												
091-43007	PM	0	42	003	02	MARTIN		MCKEE N RS HM	260,900	40	0	W
TEXAS												
115-43007	PM	0	44	031	15	HARLINGEN		RETAMA MANOR	652,000	120	0	W
						10 TOTAL			$ 6,372,621	785		

EXPIRED FEASIBILITY LETTERS

ALASKA												
176-43003		0	02		01	ANCHORAGE		PARK TERRACE NURS HM		100	0	I
CALIFORNIA												
121-43032	PM	0	05	021	01	SAN RAFAEL		CASA BONITA CONV CT		27	0	I

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF BEDS	CONST STATUS	PROC ST.
MASSACHUSETTS												
023-43033	PM	0	22	009	04	WORCESTER		REX REGINA NURS HM		160	0	I
NEW HAMPSHIRE												
024-43005	PM EC	1	30	008	01	HAMPTON		PLIMPTON MANOR NURS		75	0	I
OHIO												
042-43021	PM	0	36	018	20	CLEVELAND		SCIDEM INC		94	0	I
OREGON												
126-43020		0	38	002	01	CORVALLIS		OLSON COV CT		50	0	I
WASHINGTON												
171-43016	NP EC	1	48	032	09	FAIRFIELD		GD SAMARITAN CT		66	0	I
						7 TOTAL				572		
REOPENED REJECTED REQUESTS												
CALIFORNIA												
121-43034	PM	0	05	007	14	CONCORD		ADOBE CONV HOSPITAL		96	0	F
121-43030	PM	0	05	010	16	FRESNO		PACIFIC MED FAC CORP		102	0	F
122-43035	PM	0	05	019	24	POMONA		POMONA CONV GERIATRI		99	0	F
122-43049	PM	0	05	073	38	RIVERSIDE		RIVERSIDE NURS HM		153	0	F
COLORADO												
101-43011	PM	0	06	039	04	GD JUNCTION		COLONIAL MANOR WEST		120	0	F
FLORIDA												
066-43039	PM	0	10	006	10	FT LAUDERDAL		SWEETING NURS HM		120	0	F
066-43038	PM	0	10	013	12	MIAMI		17TH AVE DEV CORP		120	0	L
ILLINOIS												
072-43027	NP	0	14	054	22	LINCOLN		ST CLARAS MANOR		140	0	L
LOUISIANA												
064-43020	PM	0	19	026	02	GRETNA		OAKWOOD MANOR INC		140	0	U
MASSACHUSETTS												
023-43037	NP	0	22	014	04	SOUTHBORO		HIGH OAKS CONV HM		60	0	Y
NEW JERSEY												
031-43096	PM	0	31	014	05	CHATHAM TWP		KING JAMES NURS HM		108	0	F
031-43094	PM	0	31	018	05	FRANKLIN TWP		KING JAMES NURS HM		180	0	F
031-43086	PM	0	31	013	03	RED BANK		RED BANK MEDI CT		104	0	Y
NEW YORK												
012-43058		0	33	028	37	GREECE		CREST MANOR NURS HM		80	0	F
PENNSYLVANIA												
033-43013	PM	0	39	063	26	N STRABANE		MCCLELLAND NURS HM		104	0	F
033-43014		0	39	002	14	PITTSBURGH		HIGHLAND HALL NURS		150	0	F
SOUTH DAKOTA												
091-43008	PM	0	42	055	02	ARTESIAN		PIONEER MEMORIAL HM		35	0	F
						17 TOTAL						
REJECTED REQUESTS												
ARKANSAS												
082-43008	PM	0	04	017	03	ALMA		COLONY MANOR OF ALMA		70	0	L
CALIFORNIA												
136-43024	PM	0	05	031	03	AUBURN		AUBURN MANOR		46	0	L
122-43046	PM	0	05	019	17	CARSON		CARSON CONV HM		99	0	L
121-43034	PM	0	05	007	14	CONCORD		ADOBE CONV HOSPITAL		96	0	F
121-43036	PM	0	05	008	01	CRESCENT CTY		CRESCENT CTY CARE		82	0	L
121-43021	PM EC	1	05	041	11	DALY CITY		SKYLINE TERRA ADD		30	0	L
121-43020	NP	0	05	010	16	FRESNO		TWILIGHT HAVEN		56	0	L
122-43033	PM	0	05	030	35	HUNTINGTON B		RANCHO VIAU CONC CT		153	0	L
122-43034	PM	0	05	030	35	HUNTINGTON B		HUNTINGTON BEACH CON		118	0	L
122-43043	PM	0	05	033	38	RIVERSIDE		RIVERSIDE NURS HM		153	0	F
136-43023	PM	0	05	031	03	ROSEVILLE		GOLDEN YEARS CONV HM		99	0	L
122-43045	PM	0	05	030	35	SANTA ANA		EUCLID HMS FOR CONV		262	0	L
121-43022	PM	0	05	043	10	SANTA CLARA		SANTA CLARA SANITAR		100	0	L
121-43031	PM	0	05	007	14	WALNUT CREEK		WALNUT CREEK NURS HM		99	0	L
FLORIDA												
066-43039	PM	0	10	006	10	FT LAUDERDAL		SWEETING NURS HM		120	0	F
066-43038	PM	0	10	013	12	MIAMI		17TH AVE DEV CORP		120	0	L
066-43040	PM	0	10	006	10	POMPANO BCH		N DISTRICT CONV CT		120	0	L
ILLINOIS												
071-43034	PM	0	14	016	11	CHICAGO		STERLING NURS HM		420	0	L
072-43027	NP	0	14	054	22	LINCOLN		ST CLARAS MANOR		140	0	L
INDIANA												
073-43030	PM	0	15	071	03	SO BEND		ESSEX NURSING HM		80	0	L
IOWA												
074-43021	PM	0	16	077	05	DES MOINES		MEDICENTER OF AM		93	0	L
LOUISIANA												
064-43022	PM	0	19	028	03	LAFAYETTE		MED COMPLEX OF		245	0	L

PROJ NUMBER	PROJ SUFFIX	FOOT NOTE	ST.	CTY.	CONG DIST.	CITY	URA NUMBER	PROJ NAME	MORTGAGE AMOUNT	NO OF BEDS	CONST STATUS	PROC ST.
MASSACHUSETTS												
023-43054	PM	0	22	003	10	FALL RIVER		FALL RIVER NURS HM		160	0	L
023-43056	PM	0	22	014	03	WEBSTER		FENTREAS NURS HM		80	0	L
NEW HAMPSHIRE												
024-41006	NP	0	30	007	01	CONCORD		HAVENWOOD NURS HM		58	0	L
NEW JERSEY												
031-43096	PM	0	31	014	05	CHATHAM TWP		KING JAMES NURS HM		108	0	F
031-43094	PM	0	31	018	05	FRANKLIN TWP		KING JAMES NURS HM		180	0	F
031-43095	PM	0	31	012	15	MONROE TWP		MONROE NURS HM		120	0	L
035-43013		0	31	015	06	PT PLEASANT		CLAREMONT CONV CTR		100	0	L
OHIO												
043-43023	PM	0	36	025	12	COLUMBUS		NORTHLAND CONV CT		240	0	L
042-43022		0	36	076	16	PERRY TWP		FOUNTAIN VIEW CENTER		96	0	L
PENNSYLVANIA												
033-43013	PM	0	39	063	26	N STRABANE		MCCLELLAND NURS HM		108	0	F
034-43023	NP	0	39	051	05	PHILADELPHIA		ZION BAPTIST CHURCH		100	0	L
033-43014		0	39	002	14	PITTSBURGH		HIGHLAND HALL NURS		150	0	F
SOUTH DAKOTA												
091-43008	PM	0	42	055	02	ARTESIAN		PIONEER MEMORIAL HM		40	0	F
091-43009	PM	0	42	049	01	DELL RAPIDS		DELL RAPIDS NURS HM		52	0	L
TENNESSEE												
086-43011	PM	0	43	083	06	HENDERSONVIL		LAKEBROOK CONV CTR		54	0	L
VERMONT												
026-43010		0	46	002	01	MANCHESTER		EQUINOX NURS HM		54	0	L
WEST VIRGINIA												
045-43010	PM	0	49	046	02	GRAFTON		MEADOW HILLS NURS		50	0	L
045-43004	NP	0	49	010	05	OAK HILL		FAYETTE COMM MED		66	0	L
045-43008	PM	0	49	054	04	PARKERSBURG		CHATEAU PK NURS HM		86	0	L
						41 TOTAL				4719		

PROCESSING STATUS CODES	DEFINITIONS
A	Prepayments in full
B	Prepayments with supersession
C	Mortgages assigned to FHA (held)
D	Mortgages assigned to FHA (sold with reinsurance)
E	Mortgages assigned to FHA (disposed of without reinsurance)
F	Requests in process (includes reopened rejected requests)
G	Projects acquired by FHA (held)
H	Projects acquired by FHA (sold with reinsurance)
I	Expired letters of feasibility
J	Projects acquired by FHA (sold with mortgage held by FHA)
K	Projects acquired by FHA (disposed of by other methods)
L	Rejected requests
M	Withdrawals (termination of insurance wherein mortgagee retains title to property)
N	Voluntary terminations
P	Matured loans
Q	Transfer with reinsurance
R	Other terminations
S	Insurance in force (Initial and Final endorsements)
T	Commitments outstanding (includes reopened expired commitments)
U	Applications in process (includes reopened rejected applications)
V	Expired commitments
W	Final rejected applications
X	Preliminary rejected applications
Y	Letters of feasibility outstanding (includes reopened expired letters of feasibility)

PROJECT SUFFIX CODES	DEFINITIONS
M or MAN	Management-type Cooperative
LDA	Limited Distribution Association
LDC	Limited Distribution Corporation
LDI	Limited Distribution Individual
LDP	Limited Distribution Partnership
LDT	Limited Distribution Trust
LPA	Request for Pre-application Analysis Submitted by Local Public Agency
SUP or SU	Rent Supplement
PM	Profit Motivated
PB	Public Body
S	Section 213 Sales-Type Cooperative
P	Public Housing Sales
A	Section 207 Housing for the Elderly
RC	Rehabilitation Project
M	Section 207 Mobile Home Courts
R	Located in Redevelopment or Urban Renewal Area (except Section 220)
COND	Condominium Housing
AP	Section 221 and 236 projects involving a loan under the Appalachian Housing Assistance Program
RC	Project mortgage containing release clause provisions
RS	Section 213: purchase of existing structures Section 221: refinancing of existing structures in urban renewal areas
NP	Non-profit
NP/d	Non-profit Dual Processing (Cooperative)
NP/MAN	Non-profit project sold to a Cooperative
INV	Investor Sponsor Housing
INV/NP	Investor sponsor sold to a Non-profit Mortgagor
INV/MAN	Investor Sponsor sold to a Cooperative
INV/RE	Investor Sponsor project which two years after completion failed to be sold and must be operated as a Rental Housing project
INV/LDA,C,I,P,or T	Investor Sponsor project for which the sale to a Cooperative failed to materialize
BS	Builder Seller (to non-profit)
BS/NP	Builder Project sold to a Private Non-profit Corporation
BS/LDA,C,I,P,or T	A Builder Project for which the sale to a Non-profit Corporation failed to materialize

FOOT NOTE (FT. NT.) CODES	DEFINITIONS
0	New Construction
1	Existing Construction
2	Refinanced or Reinsured Transaction

CONSTRUCTION STATUS CODES	DEFINITIONS
0	Not Started
1	Started
2	First Units Ready
3	All Units Ready
4	Final Endorsement

All State, County, and Cong. Dist. Codes used in this Report are BUREAU OF THE BUDGET Codes

NR: 3802

Department of Housing and Urban Development
Federal Housing Administration
Division of Research and Statistics
Statistics Section 3/17/69